UNIVERSIDAD COMPLUTENSE DE MADRID

FACULTAD DE PSICOLOGÍA

Departamento de Personalidad, Evaluación y Tratamientos Psicológicos I

TESIS DOCTORAL

Eficacia y aceptabilidad de un programa de intervenciones psicológicas positivas versus un programa cognitivo-conductual para el tratamiento de los trastornos depresivos

MEMORIA PARA OPTAR AL GRADO DE DOCTOR

PRESENTADA POR

Irene López Gómez

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ESTRUCTURA DE LA TESIS DOCTORAL

La presente tesis doctoral sigue un formato de tesis por compendio de publicaciones. Incluye un total de cuatro artículos científicos relativos a un estudio clínico. Tres de ellos constituyen parte integral de la tesis y se incluyen en sendos capítulos, y un cuarto artículo se añade en forma de anexo. Se presenta además una introducción general, dividida en dos capítulos y una discusión y conclusiones generales.

Los artículos científicos que componen la tesis doctoral son los siguientes:

Artículo 1: Chaves, C.*, López-Gómez, I.*, Hervás, G. y Vázquez, C. (2017) [Chaves, C. y López-Gómez, I. contribuyeron de la misma forma al artículo]. A comparative study on the efficacy of a positive psychology intervention and a cognitive behavioral therapy for clinical depression. *Cognitive Therapy and Research*, 41, 417–433. https://doi.org/10.1007/s10608-016-9778-9

Artículo 2: López-Gómez, I., Chaves, C., Hervás, G. y Vázquez, C. (2017). Pattern of Changes During Treatment: A Comparison Between a Positive Psychology Intervention and a Cognitive Behavioral Treatment for Clinical Depression. *Spanish Journal of Psychology*, en prensa.

Artículo 3: López-Gómez, I., Chaves, C., Hervás, G. y Vázquez, C. (2017). Comparing the acceptability of a positive psychology intervention versus a cognitive-behavioral therapy for clinical depression. *Clinical Psychology & Psychotherapy*, en prensa. https://doi.org/10.1002/cpp.2129

Anexo III: Chaves, C., López-Gómez, I., Hervás, G. y Vázquez, C. The Integrative Positive Psychological Intervention for Depression (IPPI- D) (bajo revisión editorial)

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RESUMEN

En las últimas décadas, la investigación acerca de la intervención psicológica ha mostrado indudablemente la eficacia de ciertas intervenciones para el tratamiento de la depresión (Barth et al., 2013; Cuijpers, Andersson, Donker y van Straten, 2011a; Linde et al., 2015). Sin embargo, las tasas de recuperación alcanzadas están lejos de ser satisfactorias (Paykel, 2007; Vittengl, Clark, Dunn y Jarrett, 2007).

Existe una gran necesidad de ofrecer a la población tratamientos eficaces (Kohn, Saxena, Levav y Saraceno, 2004) que puedan ajustarse a sus necesidades y preferencias (Gelhorn, Sexton y Classi, 2011; Lyubomirsky y Layous, 2013). En los últimos años se han comenzado a desarrollar intervenciones que parten de los modelos de bienestar (Diener, 1984; Ryff, 1989) y persiguen dotar a las personas de recursos positivos y promover su bienestar, en vez de centrarse en reducir sus síntomas y déficits (Dunn, 2012; Lyubomirsky, 2008). En este sentido, distintos metaanálisis han manifestado que las intervenciones psicológicas positivas (IPP) reducen los síntomas depresivos y aumentan el bienestar de manera significativa en muestras no clínicas y clínicas (Bolier et al., 2013; Sin y Lyubomirsky, 2009; Weiss, Westerhof y Bohlmeijer, 2016).

Los recientes estudios acerca de la eficacia específica de programas de IPP en la depresión sugieren que son eficaces en la reducción de los síntomas depresivos y aumento del bienestar de los pacientes (Seligman, Rashid y Parks, 2006; Cuadra-Peralta, Veloso-Besio, Iberagay y Rocha, 2010; Asgharipoor, Farid, Arshadi y Sahebi, 2012). No obstante, esta investigación es aún escasa y adolece de algunas limitaciones. En consecuencia, el objetivo general de este trabajo fue superar dichas limitaciones analizando la eficacia y aceptabilidad de un programa de IPP y compararlas con las de un programa cognitivo-conductual en una muestra de personas con trastornos depresivos. Con este objetivo se llevó a cabo un estudio

clínico controlado en el que se comparó un programa de IPP avaladas por la investigación que combina componentes hedónicos y eudaimónicos (IPPI-D; Chaves, López-Gómez, Hervás y Vázquez, bajo revisión editorial), con un programa cognitivo-conductual (Muñoz, Aguilar-Gaxiola y Guzmán, 1995), tratamiento empíricamente validado para la depresión y recomendado por diversas guías clínicas (p.ej., National Collaborating Centre for Mental Health, 2009).

El estudio contó con una muestra de 128 mujeres adultas con un diagnóstico DSM-IV-TR (American Psychiatric Association, 2000) de depresión mayor o distimia que fueron asignadas a uno de los dos programas de intervención. El estudio incluyó evaluaciones pre-post, así como dos evaluaciones intermedias durante el tratamiento. Se utilizaron diversas medidas de autoinforme y entrevistas clínicas diagnósticas. Ambos programas de intervención compartieron la misma estructura y constaron de 10 sesiones semanales en formato grupal, de dos horas de duración. Las características de dichos programas se presentan en esta tesis, incluyéndose como Anexo un artículo con la descripción detallada del programa de IPP diseñado por el equipo de investigación.

En el primer artículo de la tesis se describen los análisis de eficacia pre-post de los programas de intervención. Los resultados mostraron que ambos programas fueron eficaces estadística y clínicamente, y no se encontraron diferencias entre ambos en las variables principales (i.e., síntomas depresivos y diagnóstico clínico) ni secundarias (p.ej., funcionamiento cognitivo, emocional, bienestar). En el subgrupo de participantes con síntomas depresivos severos se hallaron resultados equivalentes.

En el segundo artículo de la tesis se explora el patrón de cambio durante los programas de intervención y se comparan ambos programas. Los análisis confirmaron la ausencia de diferencias en los patrones de cambio de las distintas condiciones de intervención, pero mostraron diferencias en ellos entre las variables evaluadas. Así, la mejora

en síntomas depresivos fue observable desde el principio de las intervenciones y ocurrió antes que la mejora en las medidas de bienestar. De hecho, la reducción en los síntomas depresivos fue significativamente mayor durante las primeras semanas de intervención que en las posteriores. El bienestar recordado mejoró de forma continua a lo largo de la intervención, sin diferencias significativas en el porcentaje de mejora en cada tramo temporal evaluado. En cuanto a las experiencias positivas y negativas vividas durante las 24 horas previas, los resultados muestran que el aumento de experiencias positivas se produjo de forma más temprana que la reducción de las experiencias negativas, que tuvo lugar en el último periodo de intervención principalmente.

El tercer artículo de la tesis aborda la aceptabilidad de los programas de intervención aplicados. Los resultados evidencian que ambos programas de intervención fueron altamente aceptables para las participantes, con tasas de adherencia y satisfacción muy elevadas. Al comparar las condiciones de intervención, el programa de IPP mostró ser significativamente más satisfactorio que el de TCC en dos de las medidas utilizadas. La aceptabilidad no difirió en función de la severidad de los síntomas depresivos y no hubo un programa de intervención más aceptable que otro en el subgrupo de participantes con síntomas depresivos severos.

El estudio llevado a cabo supone un avance en la investigación en psicoterapia, pues muestra la eficacia y aceptabilidad de un nuevo programa de intervención y las compara con las de un tratamiento activo empíricamente validado. Al contrario que en la mayoría de los estudios del incipiente campo de las IPP, todas las participantes cumplían criterios diagnósticos de un trastorno depresivo. Asimismo, con el fin de explorar los límites de uso de estas intervenciones, se analizó la eficacia y aceptabilidad de los programas para las participantes con sintomatología depresiva severa y se informó de los resultados en las publicaciones incluidas en la tesis. De confirmarse los resultados encontrados en futuras investigaciones, las IPP podrían postularse como alternativa terapéutica eficaz a disposición

de profesionales y pacientes. Esto permitiría ampliar el abanico de elección disponible, especialmente al haberse mostrado que en este estudio las IPP fueron más satisfactorias para las personas con trastornos depresivos que las intervenciones cognitivo-conductuales, ampliamente extendidas. Adicionalmente, los resultados acerca del patrón de cambio durante las intervenciones constituyen un acercamiento preliminar a un área hasta ahora poco explorada y enfatizan la necesidad de evaluar variables clínicas y de bienestar en la investigación sobre intervenciones psicológicas, independientemente de su orientación teórica.

ABSTRACT

In the last decades, psychotherapy research has undoubtedly demonstrated the efficacy of several interventions for the treatment of depression (Barth et al., 2013; Cuijpers, Andersson, Donker, & van Straten, 2011a; Linde et al., 2015). However, the rates of recovery achieved are far from satisfactory (Paykel, 2007; Vittengl, Clark, Dunn, & Jarrett, 2007).

There is a need to offer effective treatments to the population (Kohn, Saxena, Levav, & Saraceno, 2004) to satisfy their needs and preferences (Gelhorn, Sexton, & Classi, 2011; Lyubomirsky & Layous, 2013). In the last years, interventions based on well-being models (Diener, 1984; Ryff, 1989) have been developed to help people building positive resources and increase their well-being, instead of focusing on decreasing symptoms and deficits (Dunn, 2012; Lyubomirsky, 2008). Different meta-analyses have shown that positive psychological interventions (PPI) reduce depressive symptoms and increase well-being in clinical and non-clinical samples (Bolier et al., 2013; Sin & Lyubomirsky, 2009; Weiss, Westerhof, & Bohlmeijer, 2016).

Recent research about PPI programs for depression has suggested that they are effective at reducing depressive symptoms and increasing well-being (Seligman, Rashid, & Parks, 2006; Cuadra-Peralta, Veloso-Besio, Iberagay, & Rocha, 2010; Asgharipoor, Farid, Arshadi, & Sahebi, 2012). Nevertheless, research is still scarce and has some limitations. Consequently, the main aim of the present study was to overcome such limitations by analyzing the efficacy and acceptability of a PPI program and comparing it with a cognitive-behavioral therapy (CBT) program in a sample of participants with depressive disorders. A clinical controlled study was conducted to compare a program composed by a selected array of PPI that have been tested in previous studies (IPPI-D; Chaves, Lopez-Gomez, Hervas, & Vazquez, submitted), with a CBT program (Muñoz, Aguilar-Gaxiola, & Guzman, 1995), an

empirically validated treatment for depression that has been recommended by several clinical guides (e.g., National Collaborating Centre for Mental Health, 2009).

The sample consisted of 128 adult women with a DSM-IV-TR (American Psychiatric Association, 2000) diagnosis of major depression or dysthymia who were assigned to one of the intervention conditions. The study included pre-post assessments as well as two intermediate assessments. Several self-report measures and clinical diagnostic interviews were applied. Both intervention programs shared the same structure; 10-weekly 2-hour sessions in a group format. The rationale of the intervention programs is presented in this work, and an article describing the PPI program developed by the research team is included in the Annex.

The first article of the dissertation describes the pre-post intervention changes. Results show that both intervention programs were statistically and clinically effective. There were no differences between them either in the main outcome measures (i.e., depressive symptoms and clinical diagnosis) or in the secondary ones (e.g., emotional functioning, well-being). Equivalent results were found in the severely depressed participants' subgroup.

The second article explores the pattern of changes during the interventions and compares it between the intervention programs. Results confirm the absence of differences in the time pattern of changes between intervention programs, but pointed significant differences in them between the measures studied. The improvement on depressive symptoms was observable from the beginning of the interventions and occurred before the improvement in well-being measures. Furthermore, improvements in depression symptoms were significantly higher during the first weeks of intervention than in the following ones. Subjective well-being improved continuously, with no differences in the percentage of improvement between the intervention periods assessed. In regard to the experience of positive and negative experiences that occurred in the previous 24 hours, results showed that

the increase on positive experiences took place before than the decrease on negative experiences, which happened mainly during the last period of intervention.

The third article is focused on the acceptability of the intervention programs. Results indicate that both programs were very acceptable for participants, with high rates of adherence and satisfaction. When comparing both intervention conditions, the PPI program was significantly more satisfactory than the CBT program in two of the measures used. Acceptability did not differ depending on symptoms' severity and there was no superior program in acceptability for the severely depressed participants' subgroup.

The present study represents a step forward in the psychotherapy research area as it proves the efficacy and acceptability of a new intervention program in depression and compares it with an empirically-validated treatment. Contrary to most of the incipient research in the field of PPI, all participants met a DSM-IV-TR (American Psychiatric Association, 2000) diagnosis of depressive disorders. Furthermore, to explore the limits of the interventions, this study also analyzed the efficacy and acceptability of the programs for the most severely depressed participants, which are reported in the publications of the dissertation. If further research confirms these results, PPI may be considered as an effective therapeutic alternative for both professionals and patients. This would widen the treatment options available, especially due to the fact that PPI program was found to be more satisfactory for the depressed participants than the CBT program, a widely used intervention. Moreover, results regarding the pattern of changes during interventions constitute a preliminary approach to a scarcely explored area and emphasize the need to assess clinical and well-being variables in research on psychological interventions, regardless of their theoretical orientation.

INTRODUCCIÓN

CAPÍTULO 1. FUNDAMENTOS TEÓRICOS

Las declaraciones de la Organización Mundial de la Salud (OMS) acerca de la importancia de la salud mental y el bienestar en la salud han tenido una gran repercusión. La OMS declara en 2001 que no hay salud sin salud mental y que la salud mental es más que la ausencia de trastornos mentales. Siguiendo una tradición que se remonta a la pionera declaración de 1948 (Organización Mundial de la Salud, 1948), se define la salud mental como "*... un estado de bienestar en el que el individuo desarrolla sus habilidades, es capaz de afrontar el estrés habitual en la vida, puede trabajar de forma productiva y fructífera y es capaz de contribuir a su comunidad"* (Organización Mundial de la Salud, 2001, p.1). Por tanto, la salud mental se describe en términos positivos, más que como la ausencia de malestar, respaldando así el papel esencial del bienestar.

1. Depresión, prevalencia e impacto

Cuando hablamos de depresión unipolar (a la que denominaremos depresión a partir de este punto) nos referimos a un cuadro que se caracteriza por un bajo estado de ánimo persistente en el que la persona siente una elevada tristeza, irritabilidad y/o una pérdida generalizada del interés o placer, también llamada anhedonia (p.ej., American Psychiatric Association, 2013). Además de los síntomas afectivos, son característicos los síntomas motivacionales y conductuales, como la falta de iniciativa, la pasividad y los conflictos interpersonales. En cuanto a los síntomas cognitivos, la autocrítica, los pensamientos recurrentes de suicidio y las dificultades de concentración son muy habituales en las personas con depresión. A nivel fisiológico, las personas con depresión muestran alteraciones del sueño, del apetito y de la actividad psicomotora, así como una elevada fatiga o falta de

energía. Cabe destacar la notable heterogeneidad que existe dentro del diagnóstico de depresión, tanto en la presentación sintomática como en el curso de ésta (Lorenzo-Luaces, 2015). Resulta también interesante constatar que, aunque la investigación se ha centrado en estos síntomas, su selección no deja de ser un tanto arbitraria. Como han demostrado recientemente Fried, Epskamp, Nesse, Tuerlinckx y Borsboom (2016), en realidad los síntomas acotados por sistemas como los DSM o los CIE son muy restrictivos y no más informativos de la depresión que otros síntomas que no suelen considerarse (p.ej., ansiedad, irritabilidad, etcétera).

En cuanto a la distimia, ha sido considerada durante años un cuadro depresivo de menor gravedad y mayor cronicidad que la depresión mayor. Sin embargo, en la última versión del DSM (*DSM–5*; American Psychiatric Association, 2013), la distimia se incluye junto con el trastorno depresivo mayor crónico dentro del trastorno depresivo persistente.

La edad de inicio del episodio depresivo mayor suele establecerse temprano en la edad adulta, en la década de los 20 años (Kessler y Bromet, 2013; Rohde, Lewinsohn, Klein, Seeley y Gau, 2013). El curso es variable, y aunque la mayoría de las personas afectadas se ha recuperado un año después del inicio del episodio, hay otras que sufren episodios de forma recurrente o crónica a lo largo de su vida (DeRubeis, Strunk y Lorenzo-Luaces, 2016; Lorenzo-Luaces, 2015).

Los estudios epidemiológicos habitualmente muestran que la edad, el estado civil y el género son variables que se asocian a la depresión (Kessler y Bromet, 2013). Desde las primeras descripciones, la depresión ha sido un problema más prevalente en las mujeres. La probabilidad de que una persona sea diagnosticada de este trastorno es aproximadamente el doble si es mujer (Alonso et al., 2004; Kessler et al., 2003; Van de Velde, Bracke y Levecque, 2010), manteniéndose esta diferencia en diversos grupos demográficos y culturales (Andrade et al., 2003). En cuanto a la comorbilidad, la mayoría de las personas que tienen un

trastorno de depresión mayor, presentan otro trastorno, habitualmente de ansiedad (Kessler et al., 2003). Para una revisión actualizada de la fenomenología y curso de la depresión véase DeRubeis et al. (2016) y Kessler y Bromet (2013).

La depresión es uno de los problemas mentales más prevalentes y discapacitantes en nuestra sociedad. El informe *The Size and Burden of Mental Disorders in Europe* (Wittchen et al., 2011), recogiendo los datos de los estudios epidemiológicos de mayor calidad efectuados en Europa, mostró que el trastorno depresivo mayor ocupa el tercer lugar en prevalencia-año (6,9%) entre los trastornos mentales, tras los trastornos de ansiedad y el insomnio. En el caso de España, según los datos de la *World Mental Health Survey Initiative*, la prevalencia-año de episodios de depresión mayor es de 4,0% y la prevalencia-vida es de 10,6% (Bromet et al., 2011).

Los datos mencionados son alarmantes en diversos sentidos. En primer lugar porque la depresión es el trastorno mental más asociado al suicidio (p.ej., Henriksson et al., 1993) y la cifra anual de suicidios en la mayoría de los países europeos es mayor que la cifra anual de muertes por accidentes de tráfico (Organización Mundial de la Salud, 2002). Por otro lado, la depresión es el trastorno mental más incapacitante (Wittchen et al., 2011). La depresión por sí sola causa un 6% de discapacidad general, siendo la tercera causa de discapacidad en Europa (Chisholm, Sanderson, Ayuso-Mateos y Saxena, 2004; Ustun, Ayuso-Mateos, Chatterji, Mathers y Murray, 2004). La relevancia de los trastornos depresivos también se evidencia en los estudios que evalúan calidad de vida. Por ejemplo, en una amplia encuesta con población general, se encontró que el trastorno depresivo mayor y la distimia se asociaban a las mayores pérdidas de años de vida ajustados por calidad de vida o QALYs (*quality-adjusted life years*) (Saarni et al., 2007). Asimismo, la distimia también se encontraba a la cabeza en los problemas mentales con mayor pérdida de calidad de vida relacionada con la salud o HRQoL (*health-related quality of life*) (Saarni et al., 2007). Unido a esto, la depresión supone el

motivo de consulta más frecuente en los servicios de Atención Primaria (Collins et al., 2011). En suma, aunque existe una cierta variabilidad en los datos de prevalencia y discapacidad resultantes de diversos estudios, lo que parece deberse al uso de diferentes criterios de evaluación (Simon, Goldberg, Von Korff y Üstün, 2002), la literatura acerca de la prevalencia y de la discapacidad asociada a la depresión deja patente su relevancia como objeto de estudio e intervención.

2. El papel ignorado del bienestar

Como indicábamos anteriormente, la OMS define la salud mental como un estado de bienestar y de ahí la necesidad de que haya una formalización teórica del mismo. Existen dos tradiciones, enraizadas en la filosofía, que describen el bienestar desde una perspectiva hedónica y desde una perspectiva eudaimónica (Ryff, 2014). En los últimos años se ha llegado a la conclusión de que ambos tipos de bienestar son diferentes, a pesar de estar relacionados, y tienen papeles complementarios (Deci y Ryan, 2000; Avia y Vázquez, 2011). A continuación, definiremos el bienestar hedónico y eudaimónico así como el modo en que se ven afectados en la depresión.

2.1. El bienestar hedónico

El bienestar hedónico, también llamado bienestar subjetivo (Diener, 1984), hace referencia al balance entre el afecto positivo y negativo así como a la satisfacción con la vida. Por tanto, el bienestar subjetivo se operativiza como un elevado afecto positivo, un bajo afecto negativo y una alta satisfacción con la vida (Diener, 1984). Esta distinción de componentes ha mostrado ser válida y puede ayudar a orientar la evaluación y la intervención

en el ámbito clínico y de la salud (Diener et al., 2016). Mientras que el afecto obviamente cubre el aspecto más relacionado con el bienestar emocional, la satisfacción con la vida tiene un enfoque más cognitivo pues supone una valoración genérica sobre la valía de la propia vida y constituye un elemento relativamente estable del bienestar psicológico (Lucas, Diener y Suh, 1996). La satisfacción vital se refiere, por tanto, a una valoración global de la vida desde el nacimiento hasta el momento actual, aunque también se puede considerar la satisfacción vital en dominios específicos como la salud, la educación, las relaciones sociales, las actividades laborales o el ocio (López-Gómez, Chaves y Vázquez, 2017).

2.1.1. El afecto positivo y negativo

La perspectiva dimensional de las emociones, que diferencia entre afecto positivo y negativo, cuenta con una larga tradición en la investigación sobre emociones (Russell, 1980; Watson y Tellegen, 1985). Se sustenta en el componente hedónico de las emociones, básicamente agradable o desagradable, y su distinción funcional ha sido validada por la investigación a nivel psicológico, neurofisiológico y filogenético (Diener, Smith y Fujita, 1995; Keyes, 2000; Avia, 1997; Nettle, Nott y Bateson, 2012; Watson y Clark, 1992).

En cuanto a la relación entre el afecto positivo y negativo, la investigación apunta a que se trata de dos dimensiones distintas y relativamente independientes (Watson, 2005). En contra de la concepción del afecto como un continuo con polos negativo y positivo, se trata de dos factores que en determinados momentos pueden presentar una relación inversa, aunque generalmente se muestran prácticamente independientes (Avia y Vázquez, 2011). Es por ello, que nuestra compleja vida afectiva permite que percibamos emociones de valencia positiva y negativa en el mismo momento, con diferente intensidad y duración. Esta relativa

independencia es relevante para entender el funcionamiento psicológico normal y anormal desde una perspectiva más amplia e integradora (p.ej., Vázquez, 2017).

Desde una perspectiva evolucionista, todas las emociones son adaptativas y cumplen funciones esenciales para el ser humano (Lazarus, 1991). Ostentan una función clave en la supervivencia y el control individual, dirigiendo la atención a los aspectos clave del entorno, preparando el organismo para actuar de forma rápida a las demandas, guiando la acción ante objetivos relevantes, adaptando el estilo cognitivo a las demandas, facilitando la toma de decisiones y mejorando la capacidad de la memoria episódica (Gross, 1999; 2014; Keltner y Haidt, 1999). A nivel social, las emociones son esenciales para la comunicación con otros (Avia y Vázquez, 2011). Tienen un papel facilitador de las interacciones sociales al informar de nuestras intenciones y necesidades, además de flexibilizar patrones complejos de comportamiento social (Gross, 2014; Keltner y Haidt, 1999).

Sin embargo, la investigación acerca de las funciones de las emociones negativas ha sido mucho más extensa que la dedicada a las emociones positivas. Las emociones negativas tienen una función clave para la supervivencia permitiendo detectar amenazas y responder ante el peligro (a nivel físico, emocional y social), así como intentar evitarlos en el futuro (Nesse y Ellsworth, 2009; Watson y Clark, 1992). Por ejemplo, el miedo facilita la identificación de la amenaza y la respuesta de huida-ataque, además de fomentar comportamientos de protección (Watts, 1992; Avia y Vázquez, 2011). La tristeza por su parte reduce la actividad del individuo preservando así su energía y promueve la empatía de otros (Watts, 1992). La ira del mismo modo cumple una función, la de promover la eliminación de las fuentes de frustración y prevenir futuros ataques (Watts, 1992).

Al igual que ocurre con las emociones negativas, las emociones positivas son absolutamente funcionales (Diener, Kanazawa, Suh y Oishi, 2015). La investigación ha mostrado que poseen características biológicas y conductuales distintivas (Garland et al.,

2010) y efectos beneficiosos en la salud y funcionamiento (Dockray y Steptoe, 2010). A nivel general, las emociones positivas facilitan el aprovechamiento de las oportunidades, la construcción y utilización de los recursos disponibles para potenciar la supervivencia y la reproducción (Fredrickson, 1998; Shiota, Campos, Keltner y Hertenstein, 2004). Por ejemplo, la alegría indica que una mejora en el entorno es inminente y que por tanto es adecuado invertir energía para conseguirla (Fredrickson, 1998; Lazarus, 1991). La supervivencia del ser humano depende de los vínculos sociales, por lo que el papel de las emociones positivas (como el amor y la compasión) en la creación de los vínculos entre padres e hijos, en las relaciones de pareja, de amistad o grupales es vital (Bowlby, 1979; Panksepp, 1998). Además, la expresión de emociones positivas no sólo favorece la comunicación y la creación del vínculo, sino que incentiva los comportamientos socialmente deseables (Keltner y Kring, 1998). Por último, emociones positivas como la diversión o la admiración facilitan la respuesta efectiva a oportunidades informativas (Shiota et al., 2004) y se asocian con una mayor flexibilidad cognitiva, planificación activa y creatividad (Ashby, Valentin y Turken, 2002; Davis, 2009).

Una de las aportaciones más destacadas acerca de la función de las emociones positivas ha sido la Teoría de la ampliación y construcción descrita por Fredrickson (1998, 2001). Ésta postula que las emociones positivas amplían el repertorio cognitivo y conductual de las personas. La evidencia avala que cuando se experimentan emociones positivas se produce una mayor amplitud atencional, un aumento del pensamiento creativo y del repertorio conductual (véase Fredrickson, 2013 para una revisión de la literatura científica). La teoría postula que dicha ampliación de las tendencias de pensamiento y acción lleva consigo una construcción de recursos personales (físicos, intelectuales y sociales) duraderos que serán útiles a largo plazo para la persona. A su vez, esta construcción de recursos va transformando a la persona haciéndola más creativa, sabia, resistente, socialmente integrada y

sana (Fredrickson, 2006). Además, parece que las emociones positivas tienen un papel amortiguador de las emociones negativas (Fredrickson, Mancuso, Branigan y Tugade, 2000) y, a través de lo que la autora denomina espirales ascendentes, traen consigo más emociones positivas (Fredrickson, 2001, 2002).

En resumen, tanto las emociones positivas como negativas pueden ser consideradas como mecanismos para afrontar situaciones difíciles, pero también para desplegar planes de conducta y alcanzar objetivos vitales (Nesse, 2004).

Afecto positivo y negativo en la depresión

Como se ha descrito previamente, el balance afectivo entre emociones positivas y negativas ha de ser a favorable a las primeras para contribuir al bienestar subjetivo de la persona (Diener, 1984). Ello no implica de ninguna manera la ausencia de emociones negativas ni un exceso abrumador de emociones positivas. Al igual que ocurre con las emociones negativas, el exceso o defecto de emociones positivas se considera una vulnerabilidad ante los trastornos emocionales (Gruber, Oveis, Keltner y Johnson, 2011).

Tradicionalmente, en la depresión se ha subrayado como síntoma afectivo principal el estado de ánimo triste. Pero, además, siguiendo tradiciones clínicas seculares (Olivares y Berrios, 1998) también se postula capital la anhedonia, es decir, la dificultad para experimentar interés o placer, como un síntoma central de la depresión (p.ej., American Psychiatric Association, 1980). De hecho, los criterios diagnósticos actuales, por ejemplo los correspondientes al DSM-5 (American Psychiatric Association, 2013), siguen esta tradición de considerar el estado de ánimo depresivo y la anhedonia como criterios necesarios para el diagnóstico de la depresión mayor.

A pesar del reconocimiento de la anhedonia como síntoma central de la depresión, ha sido relativamente olvidada en la investigación y en el tratamiento. Sin embargo, hay datos

sólidos que muestran que la baja emocionalidad positiva se asocia estrechamente con la depresión (p.ej., Watson y Naragon-Gainey, 2010) y de hecho caracteriza a este trastorno frente a otros problemas emocionales como los de ansiedad (Stanton y Watson, 2014). El metaanálisis de Bylsma, Morris y Rottenberg (2008) mostró que las personas con depresión presentan mucha menor reactividad a estímulos positivos que los controles en estudios de laboratorio. Además, la anhedonia se ha visto asociada con el curso temporal de la depresión (Peeters, Berkhof, Rottenberg y Nicolson, 2010; Rottenberg, Kasch, Gross y Gotlib, 2002). La depresión por tanto, se caracteriza no sólo por un elevado nivel de afecto negativo sino por un deficitario nivel de afecto positivo (Diener et al., 2016).

Teniendo en cuenta la relevancia de las emociones para la supervivencia del ser humano y la necesidad de que haya un balance afectivo positivo para hablar de bienestar subjetivo, es posible concluir que este elevado afecto negativo y reducido afecto positivo característico de la depresión supone un gran lastre para las personas que la padecen.

Regulación emocional en la depresión

A pesar del valor adaptativo de las emociones, se requieren estrategias y habilidades para regularlas. Cuando la regulación emocional no es eficaz, los estados de ánimo pueden persistir suponiendo un desgaste para el funcionamiento de la persona tornándose disfuncionales (Hervás, 2011).

Las personas con depresión presentan un gran descontrol afectivo, y es por ello que se ha considerado específicamente como un trastorno de la regulación del estado de ánimo (Hervás, 2011). En primer lugar, se evidencia que tanto las personas con depresión como con vulnerabilidad a la depresión, presentan mayor persistencia emocional negativa (Peeters Nicolson, Berkhof, Delespaul y deVries, 2003; Gilboa y Gotlib, 1997; Beevers y Carver, 2003) lo que revela un problema para reparar o regular eficazmente estos estados

emocionales. Las estrategias como la rumiación, la evitación y la supresión emocional son estrategias contraproducentes que potencian la experiencia emocional negativa (Dalgleish, Yiend, Schweizer y Dunn, 2009; Gross y Levenson, 1997). El metaanálisis de Aldao, Nolen-Hoeksema y Schweizer (2010) muestra cómo la depresión se asocia de manera importante a la evitación, supresión y rumiación. Parece que las dificultades de regulación emocional potencian la rumiación, que a su vez facilita el desarrollo de la depresión (Hervás y Vázquez, 2006; Nolen-Hoeksema, 2000; Salovey, Mayer, Goldman, Turvey y Palfai, 1995). De forma coherente, los estudios muestran que las personas con depresión tienden a presentar mayor rumiación ante las emociones negativas (Papageorgiou y Wells, 2001; D'Avanzato, Joormann, Siemer y Gotlib, 2013).

En segundo lugar, las personas con depresión presentan dificultades para utilizar estrategias funcionales para el manejo de las emociones negativas (Joormann y Vanderlind, 2014). Muestra de ello son los resultados que apuntan a que las personas con depresión, presentan una mayor atención emocional y una menor claridad y reparación emocional a mayor gravedad de síntomas (p.ej., Williams, Fernández-Berrocal Extremera, Ramos-Díaz y Joiner, 2004; Rude y McCarthy, 2003). Igualmente, datos sobre mecanismos atencionales selectivos, sugieren que las personas con un trastorno depresivo tienen dificultades para desengancharse de estímulos negativos (Sánchez, Vázquez, Marker, LeMoult y Joormann, 2013; Duque y Vázquez, 2015), lo que posiblemente ayuda a perpetuar sus estados depresivos (Sánchez et al., 2013). Asimismo, las estrategias de regulación basadas en la aceptación, la reatribución y la solución de problemas se han visto inversamente asociadas a la depresión en el metaanálisis de Aldao y colaboradores (2010), aunque los tamaños del efecto de dichas asociaciones son menores a los de las estrategias disfuncionales. Diversos estudios asocian un menor uso de reatribución con la gravedad de los síntomas depresivos (Garnefski y Kraaij, 2006; Gotlib y Joormann, 2010; D'Avanzato et al., 2013). Además, es

posible que las personas con depresión cuenten con un repertorio reducido de estrategias de regulación emocional. Esto dificultaría el uso flexible de dichas estrategias en función de la circunstancia, aspecto especialmente importante para una regulación eficaz (Kashdan y Rottenberg, 2010).

Aunque se ha desarrollado mucha menos investigación acerca de la regulación de las emociones positivas, la regulación desadaptativa de las emociones positivas se ha relacionado con los síntomas anhedónicos depresivos (Werner-Seidler, Banks, Dunn y Moulds, 2013). Parece que la disforia se asocia con cierta incapacidad para mantener la experiencia de las emociones positivas una vez que éstas han aparecido (McMakin, Santiago y Shirk, 2009). Adicionalmente, se ha evidenciado un déficit en la utilización de la reatribución y la amplificación de las emociones positivas en las personas con depresión (Heller et al., 2009; Werner-Seidler et al., 2013). Las personas con depresión no sólo tienen dificultades para mantener las emociones positivas, sino que muestran un elevado nivel de saboteo de éstas (Eisner, Johnson y Carver, 2009; Feldman, Joormann y Johnson, 2008). Este resultado es coherente con el papel predictivo de los síntomas depresivos de un reducido saboreo del presente, pasado y futuro (Eisner et al., 2009; Bryant, 2003).

En resumen, las personas con depresión hacen uso de estrategias de regulación emocional principalmente disfuncionales así como un reducido uso de estrategias funcionales, lo que trae consigo importantes dificultades a la hora de regular emociones tanto negativas como positivas.

2.1.2. La satisfacción vital en la depresión

Además del impacto de los trastornos mentales y físicos en términos de pérdida de calidad de vida, o años de vida no vividos plenamente, en los últimos años se ha enfatizado el

papel del impacto de los problemas de salud en el bienestar subjetivo (Forward Scotland and Scottish Council Foundation, 2008; Layard, 2010). En concreto, la satisfacción vital parece estar seriamente afectada en las personas con depresión. En un estudio realizado con una amplia muestra representativa, Vázquez y colaboradores (Vázquez, Rahona, Gómez, Caballero y Hervás, 2015) encontraron que el impacto de los problemas mentales en la satisfacción vital era en conjunto mayor que el de los problemas físicos. Entre los problemas mentales estudiados, la depresión fue el más asociado a la reducción de la satisfacción vital. Este resultado apoya los encontrados en el estudio Bergsma, Veenhoven, Ten Have y de Graaf (2010), que indicaban que las personas con problemas mentales se sentían significativamente menos felices que los controles, siendo en concreto las personas con depresión mayor las que informaban de menor felicidad.

Por lo tanto, los trastornos depresivos se dibujan como un ejemplo paradigmático de la pérdida de bienestar y satisfacción vital. A pesar de que estas variables han recibido escasa atención en la literatura psicológica tradicional, su relevancia se ha ido evidenciando en las últimas décadas. Metaanálisis y revisiones de estudios retrospectivos y prospectivos sugieren que el bienestar está muy vinculado a una mejor salud y longevidad (p.ej., Chida y Steptoe, 2008; Howell, Kern y Lyubomirsky, 2007). La literatura científica ha mostrado que las personas felices tienden a ser más sociables y populares (Boehm y Lyubomirsky, 2008), y, entre otros resultados, tiene una mayor probabilidad de emparejarse, mantener la relación y tener hijos (p.ej., Luhmann, Lucas, Eid y Diener, 2013). Asimismo, diversas investigaciones muestran que la felicidad se relaciona con el éxito laboral (Boehm y Lyubomirsky, 2008; Judge y Kinger, 2007). Por tanto, estos resultados no hacen más que mostrar la difícil situación de las personas con depresión, que ven afectadas áreas tan esenciales para el ser humano como son la salud, las relaciones sociales y la probabilidad de crear una familia, así como su capacidad para adaptarse a las demandas del medio en el que viven.

2.2. El bienestar eudaimónico

El componente eudaimónico del bienestar, también llamado bienestar psicológico, es definido como el desarrollo del potencial de la persona para vivir una vida plena (Ryff, 1989). Este componente no se centra en la felicidad como motivación principal, sino en el funcionamiento en los desafíos existenciales de la vida tales como desarrollarse como persona, perseguir objetivos significativos o crear vínculos significativos con otros (Ryff y Keyes, 1995; Ryff y Singer, 1998).

El modelo del bienestar psicológico de Ryff ha recibido gran atención por aglutinar en seis dimensiones de bienestar psicológico las aportaciones previas de numerosos autores y tradiciones filosóficas y psicológicas (Ryff y Singer, 2006). Las dimensiones que recoge este modelo son:

- La auto-aceptación, que consiste en la valoración positiva de uno mismo, conociendo y aceptando sus limitaciones
- El crecimiento personal que consiste en el conocimiento y puesta en práctica del propio potencial y capacidades
- El propósito vital o percepción de que la propia vida tiene dirección, significado y propósito
- El dominio del entorno, siendo la persona capaz de seleccionar, manejar y modificar el entorno para satisfacer sus necesidades
- La autonomía, que consiste en considerar que se vive de acuerdo con los propios valores
- Las relaciones positivas con otros, siendo la persona capaz de crear relaciones cálidas y de confianza

A pesar de que la estructura del modelo de Ryff ha sido objeto de controversia (p.ej., Springer y Hauser, 2006), ha traído consigo un importante avance en el estudio del bienestar (Ryff, 2014).

Dentro de la aproximación eudaimónica, englobaríamos también la concepción que Ryan y Deci (2000) plasmaron en la teoría de la autodeterminación. Esta teoría parte de que el bienestar es consecuencia de un funcionamiento óptimo psicológico que implica la adecuada satisfacción de las necesidades básicas de la persona y un sistema de objetivos coherentes entre sí y congruentes con los valores personales (Vázquez y Hervás, 2008). Definen como necesidades básicas psicológicas la autonomía, la competencia y la relación, que coinciden parcialmente con las dimensiones incluidas en el modelo de Ryff.

Keyes (1998) añade dentro del bienestar lo que denomina como bienestar social. Éste constructo se compone de la aceptación social, que define como el mantenimiento de actitudes positivas y de aceptación de las diferencias individuales; de la actualización social, que se muestra en la creencia de que las personas, grupos y sociedades pueden crecer; de la contribución social, que consiste en percibir que las actividades diarias propias tienen valor para la sociedad; de la coherencia social, que consiste en percibir que la vida social es comprensible y tiene sentido; y de la integración social, que se define como la sensación de pertenencia a la comunidad y apoyo por parte de ella.

Los modelos revisados de bienestar son claramente compatibles y Gallagher, López y Preacher (2009) han mostrado que el bienestar hedónico, eudaimónico y social pueden considerarse factores de segundo orden bajo un factor general de bienestar. A pesar de ello, los componentes más habitualmente diferenciados en la investigación sobre bienestar son el subjetivo o hedónico y el psicológico o eudaimónico. Éstos han mostrado comportarse como factores relacionados, pero distintos (Keyes, Shmotkin y Ryff, 2002; Ryff y Keyes, 1995;

Waterman, 1993). En cuanto a la relación entre ellos, Keyes et al. (2002) propusieron un modelo tipológico basado en la clasificación conjunta de los individuos en función de su nivel de bienestar subjetivo y bienestar psicológico. De esta forma, puede haber individuos que tengan niveles similares de bienestar subjetivo y psicológico que se complementen, mientras otros puedan tener niveles dispares (i.e., alto nivel en bienestar subjetivo y bajo en bienestar psicológico o viceversa) que se compensen.

2.2.1. El bienestar eudaimónico en la depresión

Un reducido nivel de bienestar psicológico se ha visto asociado a la depresión (Ryff, 1989; Ryff y Keyes, 1995; Ryff, Lee, Essex y Schmutte, 1994), y lo más importante, ha mostrado ser un factor de riesgo para el desarrollo de este trastorno. Wood y Tarrier (2010) mostraron en un estudio longitudinal con una amplia muestra que las personas que tenían bajas puntuaciones en las escalas de bienestar psicológico de Ryff (Ryff, 1989), eran sustancialmente más proclives a presentar una depresión clínica 10 años más tarde. Estos resultados se mantenían al controlar el efecto de los niveles previos de depresión, rasgos de personalidad, variables demográficas y condiciones médicas. También, el dominio del entorno, el propósito vital y la autonomía, factores integrantes del modelo de Ryff, han mostrado ser mejores predictores de la depresión en la vejez que la presencia de enfermedades o de discapacidad (Davison, McCabe, Knight y Mellor, 2012). Así mismo, parece que a pesar de la remisión de los síntomas clínicos de los trastornos afectivos, el nivel de bienestar psicológico de las personas que han sufrido estos problemas en el pasado no alcanza el nivel de los controles sanos generalmente (Rafanelli et al., 2000). En este mismo sentido, Nieremberg et al. (2010) encontraron que las personas con depresión menor presentaban déficits en las dimensiones de bienestar psicológico comparado con controles,

especialmente en dominio del entorno, autoaceptación, propósito en la vida y relaciones positivas. Ya que la depresión menor puede darse en personas que no se han recuperado totalmente de un trastorno de depresión mayor, así como ser un paso previo a cumplir los criterios para diagnosticarla, se evidencia que la afectación de las dimensiones de bienestar psicológico es un aspecto relevante en este problema y por tanto que ha de ser objeto de las intervenciones psicológicas.

3. ¿Cómo explican la depresión los modelos conductuales y cognitivos?

Una vez revisados los modelos de bienestar y cómo se entiende la depresión desde esta óptica, cabe revisar brevemente algunos de los modelos explicativos clásicos de la depresión. Aunque existe un amplio número de modelos explicativos, nos detendremos en los conductuales y cognitivos pues son los que sustentan el tratamiento de comparación del estudio clínico objeto de la presente tesis.

3.1. Modelos conductuales de la depresión

Los modelos conductuales de la depresión consideran que las interacciones negativas entre el individuo y el ambiente traen consigo un proceso de aprendizaje operante que explica la depresión. Existen diversos modelos conductuales de la depresión (Lewinsohn, 1974; Lewinsohn, Hoberman, Teri y Hautzinger, 1985; McLean, 1982; Rehm, 1977; Wolpe, 1979; Nezu, 1987). A grandes rasgos sitúan el origen del problema en la ausencia o pérdida de contingencias positivas y/o el predominio de contingencias negativas, que generan una progresiva inactividad de la persona, déficits en habilidades, sensibilización ante los eventos negativos y una reducción paulatina de la capacidad para disfrutar.

El modelo conductual original de Lewinsohn (Lewinsohn, 1974, Lewinsohn, Muñoz, Youngren y Zeiss, 1978) se basaba en que la persona que recibe una baja tasa de reforzamiento positivo desarrolla un comportamiento depresivo (emocional y somático). La tasa de reforzamiento positivo depende según este modelo del número de eventos potencialmente reforzantes para la persona, de la disponibilidad de estos eventos y de su comportamiento instrumental para elicitar tal reforzamiento.

Posteriormente, Lewinsohn y colaboradores (Lewinsohn et al., 1985) desarrollaron un modelo reformulado que ha tenido gran impacto a nivel teórico, clínico y de investigación (Dimidjian, Barrera, Martell, Muñoz y Lewinsohn, 2011). Los autores buscaron solventar algunas deficiencias del modelo original y complementarlo integrando los conocimientos provenientes del modelo conductual, cognitivo, interpersonal y biológico. En términos generales, presentan la depresión como un producto de factores ambientales y disposicionales. Describen que, a raíz de un cambio en las condiciones ambientales de la persona, debido por ejemplo a un evento vital estresante, se interrumpen los patrones de conducta automáticos del sujeto, aumentando las experiencias aversivas y/o disminuyendo el reforzamiento positivo. Dicho cambio será especialmente problemático en personas que presentan vulnerabilidad o ausencia de factores de protección para la depresión. Cuando una persona en situación de vulnerabilidad experimenta este cambio ambiental es probable que comience a auto-observarse y aumente la conciencia de sí misma, la autocrítica y las expectativas negativas. Esto promueve la disforia, que tiene como consecuencia el desarrollo de los demás síntomas depresivos (conductuales, cognitivos, emocionales, psicofisiológicos e interpersonales). Según este modelo, dichos síntomas se mantienen y exacerban a través de bucles de retroalimentación.

3.2. Modelos cognitivos de la depresión

Los modelos cognitivos subrayan la importancia de los aspectos cognitivos en el desarrollo y mantenimiento de la depresión (Beck, 1967; Weissman y Klerman, 1992). Entre ellos, el modelo de Beck (1967) ha sido el que ha recibido más atención y sobre el cual se ha realizado mayor investigación (Clark y Beck, 1999; Scher, Ingram y Segal, 2005; Dozois y Beck, 2008).

El modelo cognitivo de la depresión de Beck (Beck, 1967; 2008) considera que la vivencia de experiencias adversas tempranas genera actitudes disfuncionales que se incorporan en unas estructuras cognitivas denominadas esquemas. Estos esquemas funcionan como filtros cognitivos dirigiendo la percepción, codificación, organización, almacenamiento y recuperación de la información (Vázquez, Hervás, Hernangómez y Romero, 2010). Los esquemas disfuncionales (habitualmente relacionados con ser incapaz, no digno de ser amado y sin valor) son considerados el factor cognitivo de vulnerabilidad a la depresión y pueden permanecer latentes hasta ser activados por un evento vital crítico. Este modelo propone que la activación de los esquemas da lugar a sesgos sistemáticos en el procesamiento de la información. Estos sesgos consisten en una atención selectiva hacia los aspectos negativos de las experiencias, interpretaciones negativas de éstas, y un bloqueo de los eventos y recuerdos positivos (Beck, 2008). Dichos sesgos provocan pensamientos automáticos negativos que reflejan la denominada triada cognitiva. Esto es, una visión negativa de uno mismo, del mundo y del futuro que se considera el precursor inmediato del episodio depresivo. Desde este modelo, el resto de síntomas del síndrome depresivo (emocionales, motivacionales, conductuales y fisiológicos) son consecuencia de los patrones cognitivos negativos.

Desde la orientación cognitiva se han propuesto reformulaciones del modelo de Beck en base a los avances científicos posteriores de mayor relevancia. Este es el caso del modelo

cognitivo de la depresión de Vázquez et al. (2010), en el que se enfatiza algunos aspectos no incluidos en el modelo original de Beck. Dentro de las experiencias tempranas, estos autores otorgan importancia a los estresores crónicos además de a los agudos. A la descripción tradicional de los esquemas cognitivos, añaden el papel de la autoestima, en especial su inestabilidad y la discrepancia entre autoestima implícita y explícita en la vulnerabilidad a la depresión. Vázquez y colaboradores incluyen en su modelo el papel del estrés, destacando que los estresores agudos parecen tener un papel más importante en el desencadenamiento de un primer episodio de depresión, mientras que los estresores crónicos son más frecuentes en personas con historia de depresión. Explican así el efecto de *kindling*, que supondría una reactivación continua de los esquemas cognitivos y que produciría un efecto de sensibilización (Monroe y Harkness, 2005). Los sesgos cognitivos descritos por Beck en su modelo, son complementados en el modelo de Vázquez y colaboradores con los sesgos de memoria y atención que la investigación experimental ha confirmado en los últimos años (Dalgleish y Werner-Seidler, 2014; Duque y Vázquez, 2015; Mathews y MacLeod, 2005; Romero, Sánchez y Vázquez, 2014; Sánchez et al., 2013). Este modelo refrenda que los sesgos cognitivos promueven cogniciones negativas, que generan un estado de ánimo depresivo. E incluye, a su vez, que este estado de ánimo depresivo retroalimenta los sesgos cognitivos facilitando el desarrollo del trastorno depresivo. Los autores enfatizan que, más allá del estilo atribucional tradicionalmente denominado depresogénico, la inflexibilidad de éste parece tener un papel clave en la depresión. Junto con los sesgos cognitivos, este modelo subraya la relevancia de la rumiación y de la supresión de pensamientos negativos como factores generadores y mantenedores de la sintomatología. Como queda patente, este nuevo modelo cognitivo se nutre de los avances en la investigación experimental, complementando y actualizando el modelo clásico de Beck para explicar la depresión de forma más comprehensiva.

Cabe destacar que también Beck ha reformulado su modelo clásico recientemente, definiendo un modelo unificado en el que explica la función adaptativa de los síntomas depresivos (Beck y Bredemeier, 2016), que parecen ir en contra del instinto más básico del ser humano, la supervivencia. En él, Beck y Bredemeier consideran la depresión como una adaptación a una pérdida percibida de una inversión realizada en un recurso vital (como puede ser una relación personal, una identidad grupal o un bien personal) que excede las competencias y capacidades del individuo. La depresión tendría una función de mitigar el impacto de la pérdida mediante el ahorro de energía y la vigilancia ante posibles pérdidas adicionales. Sin embargo, a niveles elevados esta respuesta sobrepasa al individuo, trayendo consigo los síntomas clínicos de la depresión grave que presumiblemente fueron adaptativos para nuestra especie antaño, pero que son desadaptativos en el momento actual. Beck y Bredemeier (2016) proponen que las creencias más asociadas con el bienestar de las personas son las relacionadas con los recursos vitales y las expectativas acerca de la explotación de estos recursos. Subrayan que los sesgos positivos de las personas no deprimidas, como los sesgos positivos atencionales y mnésicos, son adaptativos recogiendo así la evidencia científica al respecto. Así mismo, Beck (Beck, 2008; Beck y Bredemeier, 2016) explica también el efecto de *kindling*, describiendo que los eventos precipitantes de sucesivos episodios depresivos son progresivamente más leves.

Hay ciertos aspectos de este modelo unificado que merecen especial atención. Por un lado, el valor adaptativo que se otorga a los cambios cognitivos a raíz de una pérdida vital que sobrepasa a la persona, lejos de ser un fallo o error del sistema cognitivo. Por otro, la asunción de la importancia de los sesgos positivos cognitivos en las personas sanas, ampliando la perspectiva del modelo clásico. En este sentido, Beck y Bredemeier (2016) añaden que las cogniciones negativas que se producen en la depresión grave reflejan una desactivación extrema de los esquemas cognitivos positivos y una activación de los

negativos. De esta forma, Beck y Bredemeier (2016) enfatizan el papel de los esquemas positivos además del de los negativos, observan los síntomas depresivos desde el prisma de la adaptación y se acercan a una visión mucho más comprehensiva y sensible a los nuevos resultados de la investigación.

Tras revisar los modelos teóricos de bienestar, conductuales y cognitivos, procedemos a describir las intervenciones psicológicas derivadas de ellos en el próximo capítulo.

CAPÍTULO 2. LA INVESTIGACIÓN SOBRE INTERVENCIONES PSICOLÓGICAS EFICACES PARA LA DEPRESIÓN

Existe una larga tradición de investigación acerca de la intervención psicológica para la depresión. En las últimas tres décadas, más de 250 estudios comparativos y controlados han examinado la eficacia de los tratamientos psicológicos para depresión (Barth et al., 2013; Cuijpers, Andersson, Donker y van Straten, 2011a; Linde et al., 2015). La terapia cognitivo-conductual (TCC), la terapia de solución de problemas, la terapia conductual y la terapia interpersonal han mostrado ser especialmente eficaces para tratar la depresión hasta la fecha (Barth et al., 2013; Cuijpers et al, 2011a; Hollon y Ponniah, 2010). No obstante, a pesar de la variedad de tratamientos psicológicos empíricamente validados para la depresión, los estudios de seguimiento muestran elevadas tasas de recaída y recurrencia (Paykel, 2007; Vittengl, Clark, Dunn y Jarrett, 2007) y no se pueden obviar las altas cifras de abandono de los tratamientos psicológicos actualmente estudiados (Fernández, Salem, Swift y Ramtahal, 2015; Hans y Hiller, 2013).

Cabe resaltar las diferencias en el volumen de investigación acerca de la eficacia de las intervenciones basadas en los modelos teóricos revisados en el capítulo anterior. Esto puede deberse a una razón claramente histórica; en las décadas de los años 60 y 70 se desarrollaron los modelos conductuales y cognitivos. Consecuentemente, la investigación acerca de su eficacia y eficiencia se ha desarrollado enormemente de forma posterior, dando importantes frutos en el campo de la intervención psicológica en general y de la depresión específicamente (p.ej. Cuijpers, 2015). Por tanto, el proceso natural tras el desarrollo de los modelos psicológicos de bienestar que comienza a adquirir vigor a finales los años 90, la evidencia de los resultados revisados previamente sobre la relación del bienestar con la salud mental, y la demostración de que buena parte del bienestar se debe a la

actividad intencional de la persona (Lyubomirsky, Sheldon y Schkade, 2005), han de conducir a la puesta en marcha de investigaciones que evalúen intervenciones basadas en dichos modelos de bienestar. Se trata de un paso necesario y relevante en el avance de la investigación sobre las intervenciones psicológicas y que todavía está muy lejos de alcanzarse.

1. Intervenciones psicológicas para la depresión

A continuación se revisan los aspectos generales de las intervenciones que se basan en los modelos teóricos abordados en el primer capítulo: las intervenciones cognitivo-conductuales y las intervenciones psicológicas positivas.

1.1. Intervenciones cognitivo-conductuales

La terapia cognitivo-conductual (TCC) para la depresión es una de las más ampliamente estudiadas, y existe extensa evidencia que avala su eficacia (Antony y Stein, 2009; Barlow, 2004; Chambless et al., 1998; Cuijpers, Clignet, van Meijel, van Straten, Li y Andersson, 2011b; National Collaborating Centre for Mental Health, 2009). Este tipo de intervención se ha desarrollado a partir de la combinación de los modelos cognitivos (Beck, Rush, Shaw y Emery, 1979) y conductuales (Lewinsohn et al., 1985) comentados previamente. Persigue principalmente tres objetivos; el incremento de las actividades agradables y la reducción de las desagradables a través de la planificación de actividades, el entrenamiento de habilidades sociales a través del role-playing y la psicoeducación, así como la modificación de cogniciones disfuncionales utilizando estrategias y técnicas de reestructuración cognitiva (Lewinsohn, Gotlib y Hautzinger, 1998).

La TCC se caracteriza por centrarse en el aquí y ahora, el "empirismo colaborativo" (el terapeuta se encuentra en continua actividad e interactúa con el paciente requiriendo su participación y colaboración), el establecimiento explícito de la agenda de cada sesión, la intervención activa intra e intersesión (a través de las tareas para casa pautadas), la puesta a prueba de hipótesis, la evaluación continua del proceso de intervención y la duración limitada en el tiempo de la intervención (Beck et al., 1979).

Las guías clínicas han ido proliferando en las últimas décadas para facilitar al profesional la toma de decisiones en el tratamiento de los problemas de salud. Las guías y recomendaciones clínicas para la intervención con adultos con trastornos mentales con mayor repercusión actualmente son las elaboradas por el Instituto Nacional para la Salud y la Excelencia de Reino Unido (NICE), la División 12 de la Asociación Americana de Psicología (APA), la Organización Cochrane y la Sociedad Australiana de Psicología (APS). Una revisión de las conclusiones de estas guías y recomendaciones clínicas de este mismo año (Moriana, Gálvez-Lara y Corpas, 2017), muestra que los tratamientos basados en TCC tienen el mayor nivel de apoyo empírico en el tratamiento de los trastornos mentales. No obstante, la revisión concluye con un dato sorprendente, existe en general un pobre acuerdo en las conclusiones alcanzadas por las instituciones mencionadas. En el caso del tratamiento de la depresión, la revisión indica que existen 23 tipos de tratamientos con algún tipo de apoyo empírico, pero ninguno de ellos recibe el apoyo de las cuatro organizaciones, esto es, NICE, APA, APS y Cochrane (Moriana et al., 2017). En el caso de la TCC, las tres primeras organizaciones la avalan como tratamiento efectivo para la depresión, sin embargo la Organización Cochrane considera que su apoyo empírico es muy bajo según sus revisiones (Barbato y D'Avanzo, 2006; Churchill et al., 2013; Hunot et al., 2013). A pesar de esta falta de apoyo por parte de la Organización Cochrane, es evidente el aval de las recomendaciones clínicas actuales a la TCC para el tratamiento de la depresión. En el ámbito nacional, la Guía

de Práctica Clínica sobre el Manejo de la Depresión en el Adulto publicada por el Sistema Nacional de Salud (Grupo de trabajo de la Guía de Práctica Clínica sobre el Manejo de la Depresión en el Adulto, 2014) recomienda la TCC tanto en la depresión leve-moderada mediante una intervención breve, como para niveles moderados-graves con mayor número de sesiones de tratamiento. Esta guía también aconseja aplicarla en personas que no responden adecuadamente a otras intervenciones o con una historia previa de recaídas y/o presencia de síntomas residuales. Estas recomendaciones de la Guía del Sistema Nacional de Salud, coinciden en términos generales con las recomendaciones de la guía NICE para el manejo de la depresión (National Collaborating Centre for Mental Health, 2009). Cabe mencionar que la guía NICE recomienda aplicar en el caso de personas con síntomas depresivos o depresión leve-moderada, intervenciones basadas en la TCC en formato de autoayuda, terapia computerizada basada en TCC o TCC en formato grupal. En concreto, recomienda la TCC grupal basada en modelos como el de *Coping with Depression Course* (Lewinsohn, Antonuccio, Breckenridge y Teri, 1984), del que proviene el programa de intervención que se aplica en el presente estudio.

1.2. Intervenciones psicológicas positivas

Teniendo como sustrato los modelos de bienestar, en los últimos años se han empezado a desarrollar intervenciones que persiguen dotar a la persona de recursos positivos y promover su crecimiento y bienestar, en vez de centrarse en reducir sus síntomas y déficits (Dunn, 2012; Lyubomirsky, 2008).

Las denominadas intervenciones psicológicas positivas (IPP) promueven emociones, comportamientos y/o pensamientos positivos que traen consigo un aumento del bienestar a nivel individual o grupal (Parks y Biswas-Diener, 2013). Tal y como señalan Schueller,

Kashdan y Parks (2014), esta definición consta de dos componentes clave: el objetivo principal de la intervención debe ser el aumento del bienestar y la intervención perseguirá alcanzarlo promoviendo emociones, comportamientos y/o pensamientos positivos, no siendo su enfoque directo reducir o solucionar patrones disfuncionales. En este punto se diferencian claramente de las intervenciones tradicionales.

Existe abundante evidencia que muestra cómo intervenciones experimentales cortas pueden aumentar el bienestar (p.ej., Parks y Schueller, 2014; Quoidbach, Mikolajczak y Gross, 2015). La mayor parte de la investigación acerca de la eficacia de las IPP se ha realizado en población no clínica (Wood y Tarrier, 2010), permitiendo así conocer sus efectos en el funcionamiento normal. Sin embargo, se han publicado diversos metaanálisis que han mostrado que las IPP reducen de manera significativa los síntomas depresivos y aumentan el bienestar tanto en muestras no clínicas como clínicas (Bolier et al., 2013; Sin y Lyubomirsky, 2009; Weiss et al., 2016). El foco de estos metaanálisis ha sido diverso, puesto que Weiss y colaboradores analizaron los efectos de dichas intervenciones en el bienestar psicológico, Sin y Lyubomirsky en el bienestar subjetivo, y Bolier y colaboradores analizaron resultados en ambos tipos de bienestar. Además, los dos últimos metaanálisis incluyeron sólo intervenciones que específicamente se considerasen intervenciones positivas, mientras que el de Weiss y colaboradores tuvo en cuenta diversas intervenciones terapéuticas (Terapia del Bienestar, Intervenciones Positivas, Terapia de Aceptación y Compromiso, intervenciones basadas en *Mindfulness* e intervenciones focalizadas en la identidad). No obstante, los resultados a corto plazo en los diferentes tipos de bienestar hallados en los tres metaanálisis fueron significativos, aunque varían en el tamaño del efecto encontrado (pequeño o moderado). Todos ellos revelaron el mantenimiento de los cambios en el seguimiento, aunque los tamaños del efecto fueron pequeños tanto en bienestar subjetivo como psicológico. Por ello, resulta necesario llevar a cabo más estudios que ayuden a clarificar estos resultados.

De forma paulatina ha ido aumentando el número de estudios que analizan la eficacia de diferentes modalidades de IPP en diversas muestras clínicas. Por ejemplo, se ha explorado su eficacia en el tratamiento de la depresión unipolar (Bolier et al., 2013; Sin y Lyubomirsky, 2009), los trastornos psicóticos (Meyer, Johnson, Parks, Iwanski y Penn, 2012), la ansiedad social (Kashdan y McKnight, 2013), las conductas suicidas (Huffman et al., 2014), o la deshabituación tabáquica (Kahler et al., 2014).

Dentro de las intervenciones basadas en psicología positiva o IPP se suele incluir la Terapia de Bienestar (Ruini y Fava, 2004), la Terapia de Calidad de Vida (Frisch, 2014), el consejo psicológico basado en Fortalezas (Smith, 2006), la Terapia centrada en Fortalezas (Wong, 2006), la Terapia de la Esperanza (López, Floyd, Ulven y Snyder, 2000), la Psicoterapia Positiva (Rashid, 2008) y en ocasiones la Terapia de Aceptación y Compromiso (Hayes, Strosahl y Wilson, 1999). Con el objetivo de mejorar el bienestar de las personas con depresión específicamente, destacan la Terapia de Bienestar y la Psicoterapia Positiva principalmente.

La Terapia del Bienestar (Fava, 1999) se basa en el modelo de bienestar eudaimónico originalmente descrito por Jahoda (1958) y reelaborado por Ryff (1989). Es una estrategia psicoterapéutica de corta duración que promueve la introspección, el uso de un diario estructurado y de tareas para casa, así como la interacción entre pacientes y terapeutas.

La terapia del Bienestar ha sido aplicada habitualmente de forma secuencial en combinación con otras estrategias de intervención, especialmente la TCC. Los estudios realizados, normalmente en el marco de instituciones psiquiátricas, revelan su eficacia como intervención terapéutica coadyuvante en el tratamiento de la depresión recurrente y de los síntomas residuales (Fava, Rafanelli, Cazzaro, Conti y Grandi, 1998a; Fava, Rafanelli, Grandi, Conti y Belluardo, 1998b). Esta intervención se ha aplicado tanto en adultos con depresión (Fava et al., 1998a; 1998b; Stangier et al., 2013) como en niños y adolescentes

(Kennard et al., 2014), obteniéndose menores porcentajes de recaída que en los tratamientos que no incluían la Terapia del Bienestar. Moeenizadeh y Salagame (2010) compararon la eficacia de la Terapia del Bienestar como tratamiento único para el trastorno distímico frente a un tratamiento de TCC. Los resultados fueron superiores para la primera intervención, aunque la severidad de los síntomas no fue evaluada y probablemente éstos eran leves. En palabras de Fava (2016), la Terapia del Bienestar no ha sido creada para "curar" trastornos mentales sino como herramienta terapéutica a incluir dentro de un plan de intervención, que en el caso del autor y su grupo suele ser de tipo farmacológico, por lo que no la contemplan como una opción terapéutica alternativa a las tradicionales.

La Psicoterapia Positiva por su parte fue diseñada para fomentar las emociones positivas, las fortalezas personales y el significado como forma de reducir la psicopatología y promover la felicidad (Rashid, 2008; Seligman et al., 2006). Es un enfoque basado en modelos de bienestar hedónico y eudaimónico que, al contrario que la Terapia del Bienestar, sí persigue ser una alternativa de tratamiento per se. La Psicoterapia Positiva se sustenta en dos supuestos principales; el primero es que todas las personas son susceptibles de presentar problemas de salud mental y a la vez tienen capacidad para ser felices (Rashid, 2008). El segundo supuesto enfatiza que las emociones positivas y las fortalezas personales son un objetivo terapéutico tan relevante como las emociones negativas y los déficits (Rashid, 2008).

En los últimos años se han empezado a aplicar programas de Psicoterapia Positiva en población con depresión con resultados alentadores. Éstos sugieren que la Psicoterapia Positiva es eficaz para el tratamiento de los síntomas depresivos y mejora el bienestar de los pacientes (Seligman et al., 2006; Cuadra-Peralta, Veloso-Besio, Iberagay y Rocha, 2010; Asgharipoor, Farid, Arshadi y Sahebi, 2012). También se ha realizado recientemente un estudio combinando la Psicoterapia Positiva con TCC cuyos resultados son superiores al tratamiento habitual (Carr, Finnegan, Griffin, Cotter y Hyland, 2016). Sin embargo, como

suele ocurrir durante los inicios de un área de investigación, los estudios realizados hasta la fecha presentan limitaciones dignas de mención. Éstas consisten principalmente en el uso de muestras pequeñas y comparación de las IPP con terapias no validadas, principalmente el tratamiento habitual. En el artículo 1 de la tesis se revisan en profundidad los estudios previos acerca de la eficacia de las IPP en el tratamiento de la depresión y se indican claramente estas limitaciones que, en la medida de lo posible, la presente tesis doctoral trata de solventar.

2. Motivación y objetivo general del estudio

Existe una gran necesidad de ofrecer a la población intervenciones terapéuticas y preventivas de calidad (Kohn et al., 2004) y coincidimos con Bolier y colaboradores (2013) en que las IPP pueden ayudar a reducir las carencias existentes en el campo de la salud mental. Además, es esencial aumentar la accesibilidad a los tratamientos y ofertar la mayor cantidad de opciones terapéuticas eficaces posibles a la población que puedan ajustarse a sus necesidades y preferencias (Gelhorn et al., 2011; Lyubomirsky y Layous, 2013). Por ello, resulta necesario investigar acerca de la eficacia de nuevos tratamientos basados en modelos teóricos avalados por la investigación (Tortella-Feliu et al., 2016a).

Sin embargo, la investigación sobre las IPP para depresión clínica es aún escasa y es necesario superar las limitaciones de las que adolece. Coincidimos en que para ofrecer a los profesionales y pacientes tratamientos completos desde esta perspectiva, es necesario realizar mayor investigación de calidad con muestras comunitarias amplias que incluyan seguimientos largos que puedan confirmar si estas intervenciones son eficaces tanto a corto como a largo plazo (Diener et al., 2016; Weiss et al., 2016).

En consecuencia, nos propusimos diseñar un estudio clínico que superase las limitaciones de los estudios previos comentados previamente y que comparase su eficacia con

la de otras intervenciones empíricamente validadas para la depresión clínica. Para ello, diseñamos un estudio clínico controlado en el que se compara un programa de IPP previamente validadas por la investigación (Chaves, López-Gómez, Hervás y Vázquez, bajo revisión editorial) con un programa de TCC (Muñoz et al., 1995), tratamiento empíricamente validado para la depresión y recomendado por las guías clínicas (p.ej., National Collaborating Centre for Mental Health, 2009).

El objetivo general de la presente tesis es analizar la eficacia en una muestra de personas con trastornos depresivos de un programa de IPP previamente validadas, compararla con la eficacia de un programa de intervención empíricamente validado como es el cognitivo-conductual, y comprobar su aceptabilidad entre los participantes.

3. Planteamiento general de la tesis

Para alcanzar el objetivo general de la tesis, se realizó el estudio clínico controlado indicado. En el artículo 1 de la tesis se detalla su diseño y los cambios en las variables clínicas y de bienestar evaluados entre el inicio y el final de los programas de intervención. En el artículo 2 de la tesis se explora el patrón de cambio durante los programas de intervención, con el fin de conocer cómo son estos cambios y si son equivalentes en los dos tipos de intervención aplicados. El artículo 3 de la tesis aborda la aceptabilidad de los programas de intervención, es decir, la adherencia y satisfacción de los participantes. Este aspecto es esencial, pues una intervención eficaz pero poco aceptable es difícilmente implementable en la práctica clínica. Adicionalmente, se incluye en el Anexo III el artículo de descripción del programa de IPP aplicado.

4. Objetivos e hipótesis específicas de los artículos incluidos en la tesis

Los objetivos específicos de cada artículo de la tesis se detallan a continuación:

- Artículo 1 *"A comparative study on the efficacy of a positive psychology intervention and a cognitive behavioral therapy for clinical depression"*

El objetivo principal es comparar la eficacia diferencial al finalizar los dos programas de intervención aplicados en una muestra de personas con trastornos depresivos.

Las hipótesis planteadas son:

1) Ambos programas de intervención reducirán los síntomas depresivos y conllevarán un cambio clínicamente significativo.

2) El programa de IPP provocará una mejora en las variables de bienestar mayor que el programa de TCC.

3) El programa de IPP será también eficaz para tratar a las personas con depresión severa produciendo un cambio clínicamente significativo.

- Artículo 2 *"Pattern of changes during treatment: A comparison between a positive psychology intervention and a cognitive behavioral treatment for clinical depression":*

El objetivo principal es examinar el patrón de cambio en síntomas depresivos y bienestar durante los programas de intervención aplicados en una muestra de personas con trastornos depresivos.

Las hipótesis planteadas son:

1) Se producirán mejoras significativas en síntomas depresivos y bienestar entre cada momento de evaluación y el siguiente en ambos programas de intervención.

2) El porcentaje de cambio producido en el primer periodo de la intervención será mayor que en periodos posteriores tanto en síntomas depresivos como en bienestar en ambos programas de intervención.

- Artículo 3 *"Comparing the acceptability of a positive psychology intervention versus a cognitive-behavioral therapy for clinical depression".*

El objetivo principal es comprobar la aceptabilidad del programa de IPP y compararla con la aceptabilidad del programa de TCC en una muestra de personas con trastornos depresivos.

Las hipótesis planteadas son:

1) El programa de IPP será más aceptable para los participantes (i.e., provocará mayor adherencia y satisfacción) que el programa de TCC.

2) La aceptabilidad de los programas de intervención no diferirá en función de la severidad de los síntomas depresivos de los participantes.

5. Aspectos metodológicos generales del estudio

Se trata de un estudio con diseño cuasi-experimental con 6 momentos de evaluación en el que se utilizaron técnicas de entrevista clínica y medidas de autoinforme. La evaluación pre-intervención tuvo lugar una semana antes del inicio de los programas de intervención y la evaluación post-intervención una semana después del fin de éstos. Se realizaron evaluaciones

cortas que incluían dos de las medidas principales del estudio durante la intervención, en concreto en la cuarta y séptima sesión, para conocer los cambios que se producían a lo largo de los programas. Se han llevado a cabo dos evaluaciones adicionales de seguimiento a los 6 y 24 meses de finalizar la intervención. Debido a que las evaluaciones de seguimiento no han finalizado para los últimos grupos de intervención llevados a cabo, los datos no se incluyen en esta tesis y serán objeto de futuras publicaciones. En la Figura 1 del presente capítulo se muestra el diagrama temporal del estudio.

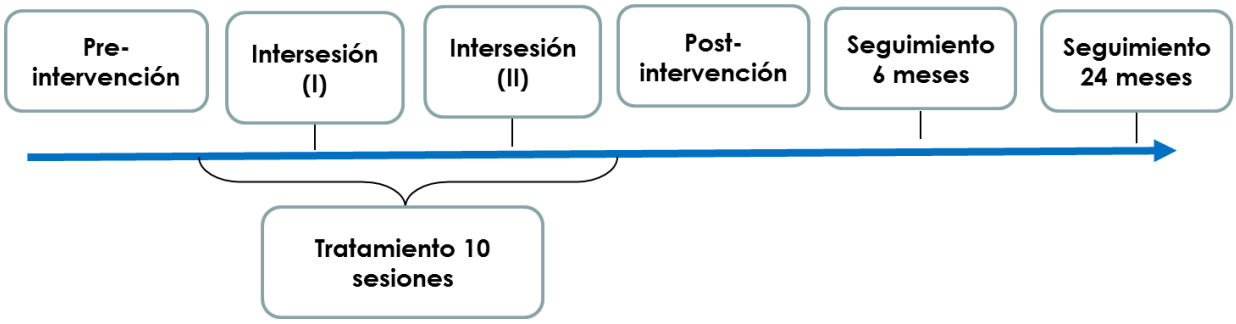

Figura 1. Diagrama temporal del estudio clínico.

5.1. Participantes

El estudio contó con una muestra de 128 mujeres adultas con un diagnóstico DSM-IV-TR (American Psychiatric Association, 2000) de depresión mayor o distimia que fueron asignadas a una de las dos intervenciones. Los criterios de exclusión fueron:

- Trastorno por abuso o dependencia de sustancias (presente)
- Episodios maniacos e hipomaniacos (pasados o presentes)
- Trastornos psicóticos (pasados o presentes)

- Estatus cognitivo que pudiese impedir el seguimiento del trabajo en grupo de las participantes (p.ej., demencia o discapacidad intelectual).

A pesar de ser conscientes de las desventajas de los sistemas de clasificación diagnóstica, que han sido objeto de numerosas críticas recientemente, estos también ofrecen ciertas ventajas (Vázquez, Sánchez y Romero, 2014). Por ello, en 2012, momento en el que se diseñó esta investigación, optamos por utilizar los criterios diagnósticos del DSM-IV-TR (American Psychiatric Association, 2000) pues era la clasificación más ampliamente utilizada, y por tanto podía facilitar la comunicación y la comparación con la literatura previa de los resultados que se extrajeran.

Cabe indicar que en el artículo 1 de la tesis, el tamaño muestral es de 96 mujeres, pues era el número de mujeres evaluadas hasta la fecha. Posteriormente se completó la muestra hasta llegar a 128 mujeres, y los análisis realizados de las muestras de 96 y 128 mujeres indican que no existen diferencias en las variables evaluadas entre la muestra incompleta y la completa. Los diagramas de participantes CONSORT (Consolidated Standards of Reporting Trials; Moher, Schulz y Altman, 2001) de ambas muestras se incluyen en la Figura 1 del artículo 1 y en la Figura 1 del artículo 3. En cada uno de los artículos de la tesis se ofrece mayor información acerca de las características de la muestra.

5.2. Procedimiento

Las participantes fueron mujeres en su totalidad, captadas en recursos de atención a la mujer vinculados a los servicios públicos de atención sanitaria y social, que ofrecen intervenciones periódicas para depresión. Las mujeres tenían una vía de acceso directa, en el periodo de apertura de matriculación para los programas por parte de la Concejalía municipal, haciendo una petición para el programa de intervención para la depresión. Asimismo, podían

ser derivadas por los profesionales sanitarios de los servicios públicos de atención sanitaria y social.

El estudio recibió el visto bueno del Comité Ético de la Facultad de Psicología de la Universidad Complutense de Madrid y las participantes completaron el consentimiento informado de manera previa al inicio de las evaluaciones. Una vez que las mujeres firmaban el consentimiento informado, respondían a una serie de preguntas demográficas y clínicas (véase Anexo I) y se aplicaba la entrevista estructurada SCID (*Structured Clinical Interview for the DSM-IV*; First, Spitzer, Gibbon y Williams, 1996) de modo individual por parte de una entrevistadora. Las entrevistadoras fueron psicólogas licenciadas[1] que permanecieron ciegas a la asignación de los participantes a cada grupo de intervención. Las entrevistas fueron grabadas en audio para evaluar la fiabilidad de las decisiones diagnósticas y una muestra del 10 % de las mismas, previas a la intervención (n = 13), fue evaluada por una experta en psicología clínica[2] con amplia experiencia en entrevistas diagnósticas estructuradas. La concordancia diagnóstica se alcanzó en 11 de las 13 entrevistas, lo que corresponde a un índice Kappa de ,70 que indica un buen acuerdo interjueces según Peat (2001). Los casos en los que no hubo acuerdo fue debido a una evaluación dispar de la gravedad clínicamente significativa (i.e., una evaluadora consideró que los síntomas depresivos alcanzaban la gravedad suficiente para diagnosticar un trastorno depresivo mayor o distímico, mientras que otra concluía que sólo se alcanzaban síntomas depresivos).

Tras la entrevista y si la persona cumplía los criterios de inclusión, recibía un bloque de medidas de autoinforme para realizar en casa antes de la primera sesión de intervención, en la que lo entregaría a la terapeuta. La evaluación post-intervención constó de una

[1] Se contó con entrevistadoras voluntarias, vinculadas al equipo de investigación, que fueron formadas en cada edición en el procedimiento de la entrevista diagnóstica.

[2] Dra. Ana Belén Calvo Calvo, psicóloga del Hospital General Universitario Gregorio Marañón Marañón (Madrid) e Investigadora en el Centro de Investigación Biomédica en Red de Salud Mental (CIBERSAM).

entrevista de idénticas características y la realización del mismo bloque de medidas de autoinforme, que en este caso era entregado por la terapeuta en la última sesión de intervención, para que las participantes lo devolvieran completo en la entrevista que tendría lugar durante la semana siguiente. Adicionalmente, se entregaba a las participantes otro bloque de instrumentos de autoinforme, en este caso anónimos, para evaluar la calidad de las intervenciones y su satisfacción con las mismas.

Las participantes fueron asignadas a una de las dos intervenciones de forma ciega si cumplían los criterios de inclusión. Debido a las características del centro donde se realizaron las intervenciones, no se pudo llevar a cabo un proceso de aleatorización puro como hubiese sido deseable, si bien es muy improbable que este proceso conlleve ningún tipo de sesgo en la recogida de información, que es el objetivo último del uso de la aleatorización. Las participantes fueron asignadas a cada grupo en función del día que preferían asistir a la intervención según su agenda personal y el día en el que se realizaba cada tipo de programa fue contrabalanceado en las sucesivas ediciones. Las participantes eran completamente ciegas al tipo de intervención que se realizaba cada día, ya que los programas de intervención se realizaban en el mismo centro, bajo la misma descripción y con el mismo horario, pero en días diferentes. La descripción de los programas que recibían las potenciales participantes incluía un mismo título (i.e., Superando la depresión), la información acerca de la duración (i.e., 10 sesiones) y las fechas y horarios en los que tenían lugar.

5.3. Criterios de calidad del diseño del estudio

En cuanto al diseño y manera de informar los resultados del estudio, se ha perseguido alcanzar los más altos criterios de calidad posibles. En los últimos años, se han consensuado ciertos criterios de calidad para diseñar los estudios controlados aleatorizados (RCTs) e

informar de los resultados extraídos. Entre ellos, los criterios CONSORT han sido los que han tenido una mayor repercusión sirviendo de guía a este tipo de estudios y facilitando así la evaluación de la validez y aplicabilidad de sus resultados. Consisten en una serie de criterios consensuados recogidos en un check list y un diagrama de participantes que permite homogeneizar cómo se presentan los resultados de los estudios. La investigación ha mostrado que el seguimiento de estos criterios se ha visto asociado con un aumento de la calidad de la presentación de los resultados de los estudios controlados (Plint et al., 2006). Por tanto, el presente estudio ha seguido como guía la extensión de los criterios CONSORT adaptada a los estudios no farmacológicos (Boutron, Moher, Altman, Schulz y Ravaud, 2008) siempre que las circunstancias lo han permitido. Una de las excepciones a los criterios CONSORT en el presente estudio fue que la asignación de los sujetos a cada grupo del estudio no pudo ser puramente aleatoria, aunque sí fue ciega. Por lo demás, en los artículos incluidos en esta tesis se han seguido los siguientes criterios CONSORT para estudios no farmacológicos (Boutron et al., 2008):

- Mostrar en la introducción el marco científico y la lógica del estudio
- Incluir en el método los criterios de elegibilidad de los participantes
- Incluir la información detallada de los tratamientos comparados y de los terapeutas que los aplicaron
- Explicitar los objetivos e hipótesis específicas de cada estudio
- Definir claramente las medidas primarias y secundarias del estudio
- Añadir la información acerca de qué personas involucradas en el estudio fueron ciegas a las hipótesis de éste (en este estudio, fueron ciegos los participantes cuando eran incluidos en una de las dos opciones de intervención y los evaluadores en todos los momentos de evaluación)

- Incluir el diagrama de participantes recomendado en los criterios CONSORT (con los participantes que se asignaron a cada grupo de intervención, los que recibieron las intervenciones, los que terminaron el protocolo de evaluación del estudio, los participantes cuyos resultados se analizaron, y las pérdidas muestrales así como las razones de ellas) que se plasma en los artículos 1 y 3.
- Describir las características de línea base de los participantes
- Utilizar la estrategia de intención al tratar, o *Intention to treat* (ITT), recomendada en dichos criterios de calidad
- En la discusión, interpretar los resultados teniendo en cuenta las hipótesis y las posibles fuentes de imprecisión o sesgo
- En la discusión, interpretar los resultados a la luz de la literatura previa
- En la discusión, comentar la validez externa de los resultados en función de las características de las intervenciones, los participantes y los terapeutas del estudio.

5.4. Programas de intervención aplicados

Los programas de IPP y TCC que se incluyen en la investigación se caracterizan por ser programas de intervención controlados que siguen sendos protocolos estructurados. Se ofrecieron 5 grupos de cada tipo de intervención en total, con 10-15 personas en cada uno. Ambos programas constan de 10 sesiones de carácter semanal, de dos horas de duración y en formato grupal. Las sesiones se apoyan en material escrito que se ofrece a las participantes, hojas de ejercicios y vídeos que ejemplifican los aspectos tratados. Ambos programas comparten la misma estructura, que es la siguiente:

- Al inicio de la sesión, se procede a revisar las tareas para casa encomendadas en la anterior sesión
- Se presenta el tema de la sesión, señalando los objetivos de ésta y aportando información psicoeducativa
- Las terapeutas fomentan la discusión entre las participantes y proponen ejercicios prácticos para promover la comprensión y aplicación de las habilidades propuestas
- Para finalizar la sesión, se realiza un resumen de las ideas y aprendizajes principales y se describe las tareas a realizar durante la siguiente semana para practicar las habilidades aprendidas

Los programas de intervención fueron aplicados por dos psicólogas expertas en intervención psicológica (I.L.G. y C.C.). Ambas contaban con 5 años de experiencia clínica y han cursado programas de máster de Intervención Psicológica desde la perspectiva cognitivo-conductual (2 años de contenidos teóricos y práctica clínica). Posteriormente, las terapeutas recibieron formación en IPP a través de cursos, congresos y seminarios a los que tuvieron acceso al formar parte de un grupo de investigación puntero en Psicología Positiva. Adicionalmente, recibieron formación extensa en la aplicación de los programas aplicados en el estudio. Cada intervención fue llevada a cabo por una de las psicólogas mencionadas junto con una coterapeuta, psicóloga alumna del Magister de Psicología Clínica basada en la evidencia de la Universidad Complutense de Madrid. La labor de la coterapeuta fue ayudar a la terapeuta en la atención a las participantes y monitorizar la adherencia al protocolo de cada sesión. Durante todo el proceso de intervención, se realizaron sesiones de supervisión dirigidas por el Dr. Carmelo Vázquez y el Dr. Gonzalo Hervás con las psicólogas que aplicaban el tratamiento para potenciar la adherencia a los protocolos y evitar la contaminación entre los programas de intervención.

5.4.1. Programa de terapia cognitivo-conductual (TCC)

El programa de TCC aplicado en este estudio es una adaptación de la versión española del Manual de Terapia Cognitivo-Conductual para Depresión Mayor de Muñoz y colaboradores (1995). Este manual parte del ampliamente utilizado *Coping with Depression Course* (Lewinsohn et al., 1984), que cuenta con apoyo empírico contrastado (Cuijpers, Muñoz, Clarke y Lewinsohn, 2009; Muñoz y Mendelson, 2005). El programa *Coping with Depression Course* tiene su origen en el libro de autoayuda *Control your Depression* que escribieron Lewinsohn, Muñoz, Youngren y Zeiss (1978) a partir de los resultados obtenidos en un estudio que realizaran previamente (Zeiss, Lewinsohn y Muñoz, 1979). En este estudio comparativo se concluyó que las intervenciones de planificación de actividades agradables, habilidades sociales y de modificación de cogniciones tenían una eficacia comparable. Así mismo, se observaron cambios en los tres tipos de variables (actividades, relaciones sociales y cogniciones) tras las intervenciones y no sólo en las variables que habían sido objeto explícito de la intervención aplicada, lo que impulsó la combinación de los tres tipos de intervenciones en un mismo programa de tratamiento.

El programa de Muñoz y colaboradores (1995) utilizado incluye contenidos psicoeducativos y ejercicios aplicados desde un enfoque cognitivo-conductual. El programa se ha aplicado siguiendo el manual de los autores, adaptándolo únicamente para que las dos intervenciones aplicadas en el estudio tuviesen diez sesiones de dos horas de duración y pudiesen ser adecuadamente comparadas sin perder ningún contenido del programa original. Los objetivos específicos de cada sesión del programa aplicado se resumen en la Tabla 1.

Durante la primera sesión se describen los objetivos de la intervención, la lógica del tratamiento y se pactan las normas del grupo con las participantes. Se dedica parte de esta

primera sesión a aportar información psicoeducativa acerca de en qué consiste la depresión desde un enfoque cognitivo-conductual. La segunda y tercera sesión incluyen contenidos de Activación Conductual (Lewinsohn y Libet, 1972) y se aplican las técnicas de planificación de actividades agradables, gestión del tiempo y establecimiento de objetivos. Las sesiones cuarta, quinta y sexta se dedican a la intervención cognitiva, haciendo uso de la reestructuración cognitiva y de habilidades provenientes de la Terapia Racional Emotiva (Ellis y Dryden, 1987) y de la Terapia Cognitiva (Beck et al., 1979). Posteriormente, las sesiones 7, 8 y 9 se centran en las habilidades sociales (Libet y Lewinsohn, 1973), los estilos de comunicación y se practican las habilidades asertivas especialmente. La última sesión se dirige a la prevención de recaídas realizando un repaso de las habilidades aprendidas, identificando dificultades así como posibles formas de afrontarlas, para finalmente proceder al cierre del grupo.

5.4.2. Programa de intervenciones psicológicas positivas para la depresión IPPI-D

El programa de IPP denominado *Integrative Positive Psychological Invervention for Depression* (IPPI-D) fue elaborado íntegramente por nuestro grupo de trabajo. En él se incluyeron IPP que han demostrado ser eficaces en la literatura científica para aumentar el bienestar y reducir los síntomas depresivos, tanto en muestras no clínicas como clínicas (Sin y Lyubomirsky, 2009; Bolier et al., 2013). Se seleccionaron intervenciones validadas que tuvieran sentido dentro del formato de la intervención y, sobre todo, que resultaran relevantes para personas que están enfrentándose a una depresión.

Se trata de un programa en el que se interviene sobre los componentes hedónicos del bienestar (i.e., las emociones positivas, el optimismo o el saboreo), así como sobre los componentes eudaimónicos (i.e., las relaciones positivas, las fortalezas personales, la

compasión, el sentido vital o el crecimiento ante la adversidad). Los objetivos específicos de cada sesión del programa de IPP aplicado se resumen en la Tabla 2 y la descripción detallada de éste ha sido objeto de un artículo científico, que se incluye en el Anexo III.

Tabla 1. *Objetivos específicos del programa de terapia cognitivo-conductual (TCC)*

Sesión 1: Bienvenida a las participantes	- Definición de objetivos, expectativas y actitudes hacia el tratamiento - Explicación de qué es la depresión desde el encuadre de la Terapia Cognitivo-Conductual - Presentación del plan de tratamiento
Sesiones de 2 a 3: ¿De qué forma nuestras actividades afectan a nuestro estado de ánimo?	- Comprensión del papel de la pasividad y el déficit de actividades agradables en el mantenimiento de la depresión - Planificación de actividades agradables e identificación de obstáculos en su realización - Priorización de objetivos y establecimiento de metas alcanzables a corto y largo plazo (Gestión del tiempo)
Sesiones de 4 a 6: ¿De qué forma nuestros pensamientos afectan a nuestro estado de ánimo?	- Comprensión de la conexión entre los pensamientos y el estado de ánimo. Análisis del papel de los pensamientos negativos en el mantenimiento de la depresión - Identificación de los pensamientos negativos - Aprendizaje de habilidades para reducir los pensamientos que nos dañan (Reestructuración cognitiva) - Aprendizaje de habilidades para aumentar los pensamientos que nos ayudan
Sesiones de 7 a 9: ¿De qué forma nuestros contactos con la gente afectan a nuestro estado de ánimo?	- Comprensión del papel de la disminución de las relaciones sociales y de los conflictos con otros en el mantenimiento de la depresión - Aprendizaje de habilidades para aumentar y mantener una red social de apoyo adecuada - Comprensión de los errores de comunicación más frecuentes y práctica de habilidades asertivas útiles en la relación con los demás
Sesión 10: Revisión de los contenidos del programa e intervención en prevención de recaídas	- Identificación de situaciones de riesgo para prevenir recaídas - Definición de las estrategias clave para mantener los cambios obtenidos - Despedida de las participantes fomentando los vínculos establecidos entre ellas

Tabla 2. *Objetivos específicos del programa de intervenciones psicológicas positivas para la depresión IPPI-D*

Sesión 1: Bienvenida a las participantes	- Definición de objetivos, expectativas y actitudes hacia el tratamiento - Explicación de qué es la depresión desde el encuadre de la Psicología Positiva - Presentación del plan de tratamiento
Sesiones 2 a 4: Emociones positivas	- Aprendizaje de la identificación de emociones positivas para equilibrar la balanza afectiva - Comprensión de las principales estrategias de regulación emocional - Práctica de las técnicas de saboreo del momento presente y las estrategias de *mindfulness* para el manejo de emociones negativas - Potenciación de las emociones positivas, como la gratitud y el optimismo
Sesión 5: Relaciones positivas	- Aprendizaje de las principales estrategias para cultivar relaciones positivas - Práctica de la amabilidad
Sesiones 6 a 9: Fortalezas, metas y crecimiento personal	- Aprendizaje de habilidades para un autocuidado basado en la aceptación y el compromiso - Identificación y puesta en marcha de las fortalezas personales - Exploración de lo que da sentido a nuestras vidas - Establecimiento de metas personales con sentido - Aprendizaje de habilidades para crecer ante la adversidad
Sesión 10: Revisión de los contenidos del programa e intervención en prevención de recaídas	- Identificación de situaciones de riesgo para prevenir recaídas - Definición de las estrategias clave para mantener los cambios obtenidos - Despedida a las participantes fomentando los vínculos establecidos entre ellas

5.4.3. Diferenciación de los programas de intervención

Parece necesario realizar una puntualización en cuanto a la diferenciación entre los dos programas de intervención. Como se explica en profundidad en el artículo 1, ambos

programas provienen de modelos explicativos diferentes y la aproximación terapéutica es completamente dispar. El foco de la intervención de TCC es la modificación de las conductas y cogniciones disfuncionales para alcanzar otras más adaptativas. Sin embargo, las IPP persiguen fomentar las emociones positivas y las características personales que se asocian a un mayor bienestar, sin poner el foco en modificar directamente ningún aspecto disfuncional. Esta diferenciación en los modelos de partida y en los objetivos, trae consigo una actitud del terapeuta y una dinámica grupal diferente.

No cabe duda de que los temas que se abordan en ambos programas de intervención son compartidos (p.ej., emociones, relaciones sociales, metas personales), ya que son los aspectos principales en la vida de las personas y por tanto donde requieren la ayuda profesional. Sin embargo el modo de abordarlos, las técnicas aplicadas y las estrategias propuestas son dispares como se evidencia en la Tabla 1 y Tabla 2, así como en el artículo que describe el programa de IPP (Anexo III).

6. Instrumentos

Las medidas principales utilizadas en el estudio han sido la gravedad de los síntomas depresivos evaluada con el Inventario de Depresión de Beck-II (BDI-II; Beck, Steer y Brown, 1996; Sanz, Navarro y Vázquez, 2003) y el diagnóstico de depresión o distimia evaluado a través de la entrevista estructurada SCID (*Structured Clinical Interview for the DSM-IV*; First et al., 1996), que es un instrumento ampliamente utilizado y fiable para realizar diagnósticos DSM (Skre, Onstad, Torgeresn y Kringlen, 1991).

Las medidas secundarias utilizadas incluyen variables cognitivas, emocionales y conductuales, tanto clínicas como de bienestar, con el objetivo de analizar cambios en todas las áreas en las que se interviene desde uno u otro de los programa de intervención. Estas

medidas han sido resumidas en la Tabla 3 junto con el resto de instrumentos validados aplicados. Adicionalmente, los instrumentos utilizados menos habituales han sido incluídos en el Anexo II.

Tabla 3. *Instrumentos validados empleados en el estudio*

Instrumento	Trabajo original Versión en castellano	Momento de aplicación
Medidas principales		
Inventario de Depresión de Beck-II (BDI-II)	Beck et al., 1996 Sanz et al., 2003	Pre, inter 1, inter 2, post, seguimiento 6 meses y 24 meses
Entrevista clínica estructurada para el DSM-IV (SCID)	First et al., 1996	Pre, post, seguimiento 6 meses y 24 meses
Medidas secundarias		
Inventario de Ansiedad de Beck (BAI)	Beck y Steer, 1990 Sanz y Navarro, 2003	Pre, post, seguimiento 6 meses
Cuestionario de Pensamientos Automáticos (ATQ-30)	Hollon y Kendall, 1980 Vázquez, 2006	Pre, post, seguimiento 6 meses
Escala de Estilos de Respuestas Rumiativas (RRS)	Nolen-Hoeksema y Morrow, 1991 Hervás, 2008	Pre, post, seguimiento 6 meses
Inventario de Supresión del Oso Blanco (WBSI)	Wegner y Zanakos, 1994 González, Avero, Rovella y Cubas, 2008	Pre, post, seguimiento 6 meses
Escalas de Afecto Positivo y Negativo (PANAS)	Watson, Clark y Tellegen, 1988 López-Gómez, Hervás y Vázquez, 2015	Pre, post, seguimiento 6 meses
Cuestionario de Respuestas al Afecto Positivo (RPA)	Feldman et al., 2008 Traducción propia	Pre, post, seguimiento 6 meses
Escala de Dificultades en la Regulación Emocional (DERS)	Gratz y Roemer, 2004 Hervás y Jodar, 2008	Pre, post, seguimiento 6 meses
Escala de Orientación al Disfrute (EOS)	Hervás y Vázquez, 2006 Hervás, Chaves, López-Gómez y Vázquez (enviado)	Pre, post, seguimiento 6 meses
Escalas de Inhibición y Activación Conductual (BIS/BAS)	Carver y White, 1994 Hervás y Vázquez, 2013a	Pre, post, seguimiento 6 meses
Life Orientation Test–Revisado (LOT-R)	Scheier, Carver y Bridges, 1994 Ferrando, Chico y Tous, 2002	Pre, post, seguimiento 6 meses

Índice de Felicidad Pemberton (PHI)	Hervás y Vázquez, 2013b	Pre, inter 1, inter 2, post, seguimiento 6 meses y 24 meses
Escalas de Bienestar Psicológico de Ryff (PWBS)	Ryff, 1989 versión de 29 ítems utilizada: Díaz et al., 2006	Pre, post, seguimiento 6 meses
Escala de Satisfacción con la Vida (SWLS)	Diener, Emmons, Larsen y Griffin, 1985 Vázquez, Duque y Hervás, 2013	Pre, post, seguimiento 6 meses

Tanto las medidas principales como las secundarias fueron administradas en la evaluación pre-intervención, post-intervención y en el seguimiento a los 6 meses. El Inventario de Depresión de Beck-II y el Índice de Felicidad Pemberton se administraron adicionalmente en dos evaluaciones inter-sesiones, con el objetivo de analizar el patrón de cambio durante los programas de intervención. Estas evaluaciones inter-sesiones tuvieron lugar antes del comienzo de las sesiones cuarta y séptima de ambos programas.

Al finalizar ambos programas, se administraron de manera anónima una serie de medidas de aceptabilidad de los programas de intervención a las participantes (que pueden consultarse en el Anexo II). Se aplicó el Cuestionario de Satisfacción del Cliente (CSQ-8; Nguyen, Attkinsson y Stegner, 1983; Roberts, Attkisson y Mendias, 1984) junto con cuatro preguntas adicionales para profundizar en la satisfacción con el tratamiento, el progreso realizado y la satisfacción con las terapeutas. Así mismo, fue administrado otro cuestionario de calidad por parte del centro donde se realizaron las intervenciones. Este se compone de tres ítems acerca de la satisfacción con la duración del tratamiento, el clima y la participación grupal. Por último, se incluyó un ítem en el que se pregunta a la participante si recomendaría el tratamiento a otra persona. En los capítulos posteriores de la tesis se aporta mayor información acerca de los instrumentos de medida utilizados en cada artículo concreto.

7. Estrategia de análisis de datos

En el presente estudio se ha utilizado el método de análisis de intención al tratar o ITT (*intention to treat analysis*), debido a que se considera el método de análisis más informativo y robusto estadísticamente en el ámbito de los estudios clínicos. Consiste en incluir en los análisis todos los datos obtenidos de las personas que fueron asignadas a cada grupo de intervención, independientemente de si recibieron finalmente la intervención asignada (Streiner y Geddes, 2001). Esta aproximación permite extraer conclusiones acerca de la efectividad de las intervenciones estudiadas y por tanto aporta una información útil para aplicarlas en entornos naturales donde se puede dar una baja adherencia.

Los estudios clínicos que utilizan una estrategia de ITT cuentan inevitablemente con pérdidas de datos debidas al abandono de los participantes, ausencia en alguna sesión, falta de respuesta a ciertos ítems o instrumentos, etcétera. Es por ello que resulta esencial decidir una estrategia de tratamiento de los valores perdidos previamente a la realización de los análisis. Tradicionalmente, se ha utilizado como tratamiento de los valores perdidos el análisis de casos completos, la imputación de la media del grupo y el método LOCF (*Last Observation Carried Forward*). Tras la primera recogida de datos del presente estudio aplicamos el método LOCF pues su uso era muy habitual en los estudios clínicos (Wood, White y Thompson, 2004). Este método reemplaza el valor perdido por la última observación disponible de ese sujeto. Se trata por tanto de un método conservador, sobre todo en estudios de comparación de dos tratamientos activos como el nuestro. Asimismo, con el tiempo han ido surgiendo críticas hacia este método (p.ej., Blankers, Koeter y Schippers, 2010) que nos llevaron a replantearnos el tratamiento de los valores perdidos del estudio. Por tanto, optamos por una estrategia de tratamiento de valores perdidos más sofisticada, dentro de la cual los

métodos más habitualmente utilizados son los de imputación múltiple y máxima verosimilitud.

Los valores perdidos del presente estudio son principalmente a nivel de constructo y se ha comprobado que la pérdida ha sido completamente al azar (*missing completely at random*, MCAR) según la tipología de Rubin (1976). Se considera que la pérdida de datos es completamente al azar cuando la probabilidad de que una observación se haya perdido no depende de los datos observados y no observados. Siguiendo las recomendaciones de Newman (2014) para este tipo de datos perdidos, y teniendo en cuenta el tamaño de la muestra del estudio, elegimos la estimación por Máxima Verosimilitud (*Maximum Likelihood*, ML) a través del algoritmo EM (*expectation maximization).* Este algoritmo es un procedimiento de iteración que estima los valores perdidos a través de dos pasos que se alternan numerosas veces para alcanzar una estimación de los valores perdidos más precisa. Teniendo en cuenta que el método EM es más preciso que el LOCF, se realizó un análisis de sensibilidad con ambos métodos en la muestra del estudio, mostrándose resultados equivalentes. Este análisis de sensibilidad ha sido reflejado en el artículo 1 y permitió confirmar que el método LOCF no trajo consigo sesgos relevantes en los datos del estudio y por tanto se puede confiar en los resultados plasmados en el artículo 1. No obstante, los siguientes artículos incluidos en la tesis (artículos 2 y 3) incluyen resultados extraídos de datos producto de la imputación a través de EM, por ser la más conveniente.

La metodología utilizada en el estudio es de carácter cuantitativo, habiéndose aplicado diversas pruebas paramétricas y no paramétricas en función de los objetivos de cada artículo. En cada uno de ellos se detalla el plan de análisis de datos concreto llevado a cabo. La gestión de los datos y su análisis se ha realizado mediante el programa SPSS 20.

ARTÍCULOS INCLUIDOS EN LA TESIS DOCTORAL

ARTÍCULO 1

A comparative study on the efficacy of a positive psychology intervention and a cognitive behavioral therapy for clinical depression

[Estudio comparativo sobre la eficacia de una intervención basada en psicología positiva y una terapia cognitivo-conductual para depresión clínica]

Cognitive Therapy and Research, 41, 417–433.
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El primer artículo de la tesis es *A comparative study on the efficacy of a positive psychology intervention and a cognitive behavioral therapy for clinical depression* (*Cognitive Therapy and Research, 41*, 417–433. https://doi.org/10.1007/s10608-016-9778-9).

Su objetivo es informar de los cambios pre-post del estudio clínico objeto de esta tesis. Los resultados basados en un amplio número de medidas indican que ambos programas de intervención fueron eficaces para reducir los síntomas clínicos y aumentar el bienestar de las personas con trastornos depresivos. No se detectaron diferencias significativas en ninguna variable en función de la condición de intervención, ni siquiera en el subgrupo de participantes con síntomas depresivos graves.

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ORIGINAL ARTICLE

A Comparative Study on the Efficacy of a Positive Psychology Intervention and a Cognitive Behavioral Therapy for Clinical Depression

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Abstract Traditionally, treatments for depression have been primarily focused on reducing patients' symptoms or deficits and less concerned with building positive resources. This study aims to compare the efficacy of a manualized protocol of empirically-validated positive psychology interventions (PPI) with a cognitive-behavioral therapy (CBT) protocol. This controlled clinical trial included 96 adult women with a DSM-IV diagnosis of major depression or dysthymia. Participants were blindly allocated to a 10-session PPI ($n = 47$) or CBT ($n = 49$) group therapy condition. Intention to treat analysis showed that both interventions were effective in reducing clinical symptoms and increasing well-being. There were no significant differences between groups in either main outcomes (i.e., severity of depressive symptoms and clinical diagnosis) or secondary outcomes (e.g., positive and negative affect, and satisfaction with life). Even within the most severely depressed participants, no differences between PPI and CBT emerged. If further clinical studies confirm these results, this would widen treatment choice for both patients and professionals.

Keywords Positive psychology · Positive interventions · Cognitive-behavioral therapy · Major depression · Dysthymia · Well-being

Covadonga Chaves and Irene Lopez-Gomez have contributed equally to this work.

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Introduction

Major depression is one of the most commonly occurring clinical problems (ESEMED 2004; Kessler et al. 1994). Depressive disorders affect up to 20 % of people at some time in their lives (Wittchen et al. 2011) and depression is expected to be the disorder with the highest disease burden in high-income countries by the year 2030 (Mathers and Loncar 2006). There are many reasons that depression prevention and treatment should be considered a priority health intervention (Commission of the European Communities 2008) including its tendency to chronicity, its high comorbidity, its negative impact on mortality rates, and its considerable economic cost (Richards 2011).

In the past three decades, more than 200 controlled and comparative studies have examined the efficacy of psychological treatments for depression (Cuijpers et al. 2011a). Efficacy has been established for a range of treatments, including cognitive-behavioral therapy (CBT), problem-solving therapy, behavioral therapy, and interpersonal therapy (Barth et al. 2013; Cuijpers et al. 2011a; Hofmann et al. 2012; Hollon and Ponniah 2010). There are no large differences in efficacy between these major psychotherapies (Cuijpers et al. 2008a) and both individual and group treatment modalities have demonstrated their efficacy (Cuijpers et al. 2008b).

Specifically, CBT is one of the most widely researched treatments for depression. There is strong evidence supporting its efficacy for treating depression (Antony and Stein 2009; Barlow 2004; Cuijpers et al. 2011b; National Collaborating Centre for Mental Health, NICE 2009) and large effect sizes have been systematically found for CBT when compared to no-treatment, waiting list, or placebo controls (Butler et al. 2006). Several studies have shown that CBT is comparable to antidepressant medication for

Positive Psychology Interventions

Positive psychology interventions (PPI) are a promising approach to increasing well-being and satisfaction with life. Over the past decade, advances in the field of positive psychology (PP) have led to the development of evidence-based interventions for psychopathology and guided practitioners. The PP approach focuses its attention on the optimal functioning of individuals without denying the unpleasant aspects of life (e.g., sadness and loss) intrinsic to the human experience. The primary goal of PPI is to enhance positive variables (e.g., subjective well-being, positive emotion, life meaning) with interventions based on empirical evidence (Bolier et al. 2013; Sin and Lyubomirsky 2009).

There is a growing body of evidence to suggest that well-being-promoting exercises not only enhance well-being, but also alleviate depressive symptoms. Despite the novelty of this research area, two meta-analyses of PPI have been published including clinical and non-clinical samples. The first examined 51 PPI and found that they are effective in significantly decreasing symptoms of depression (Cohen's $d = 0.65$) and enhancing well-being (Cohen's $d = 0.61$) with moderate effect sizes (Sin and Lyubomirsky 2009). In the second meta-analysis, Bolier et al. (2013) found that PPI reduce depression (Cohen's $d = 0.23$) and enhance subjective well-being (Cohen's $d = 0.34$) with small effect sizes. At the 3–6 month follow-up, effect sizes were small, but still significant for subjective well-being and psychological well-being, indicating that the effects of PPI may be sustainable.

Although the majority of PPI have been tested using non-clinical samples (Wood and Tarrier 2010), there is preliminary evidence of their efficacy for a wide spectrum of clinical problems (Bolier et al. 2013). The efficacy of PPI has been mainly shown for treating depression (Seligman et al. 2006), but also for psychotic disorders (Meyer et al. 2012), smoking (Kahler, et al. 2014), and other clinical disorders. Even though PPI seem to be especially effective in alleviating depressive symptoms, little research has been done to test PPI programs to treat clinical depression in comparison to control groups. The few exceptions suggest that PPI are effective for treating depressive symptoms and enhancing well-being (Moeenizadeh and Salagame 2010; Seligman et al. 2006). Furthermore, these studies suggest that PPI are especially effective for treating residual symptoms (Fava et al. 1998a) and preventing future relapse (Fava et al. 1998b; Segal et al. 2002). However, these studies have some significant limitations. On one hand, the efficacy of PPI has not been systematically compared to available empirically-based treatments for depression, such as CBT. In fact, 'treatment as usual' (TAU) has been a comparison condition in several studies (Cuadra-Peralta et al. 2010; Fava et al. 1998b; Seligman et al. 2006), although this condition includes unspecific components. On the other hand, the few studies that have compared PPI to CBT have used very small samples (Asgharipoor et al. 2012), or do not report the diagnostic procedure used (Fava et al. 1998a; Moeenizadeh and Salagame 2010). In addition, there is a great need for further detailed assessments of PPI using clinically depressed samples. Likewise, there are scarce data about the efficacy of positive psychotherapy in treating severe depression (Dunn 2012).

The aim of the present study was to compare a manualized protocol of PPI with CBT, an empirically-based treatment for depression. Following NICE's recommendations for treating depression with group-based CBT, we chose the intervention developed by Muñoz et al. (1995) as the comparison intervention. A group format was chosen for delivering the interventions due to its cost-effectiveness and widespread application that allowed comparison with previous studies (Cuijpers et al. 2008b). Depressive symptoms and clinical diagnosis were the primary outcomes measured in our study. We also examined variables related to cognitive, emotional and behavioral functioning as secondary outcomes in order to have a wider understanding of the participants' functioning and in order to be able to assess the potential mediators underlying the results if they differed for each intervention.

This study was designed to address some of the limitations found in previous studies. First, the assessment protocol included multiple positive functioning and clinical measures for both interventions. Second, both interventions were manualized. Third, the PPI program was composed of empirically-validated interventions. Fourth, participants with different levels of depression severity were included in the study, since there is evidence that CBT is effective in treating severe forms of depression (Weitz et al. 2015). This study is also important because it will build upon preliminary evidence showing that various positive exercises are feasible and effective in treating suicidal patients (Huffman et al. 2014).

Based on previous research, outlined above, it was expected that (1) both interventions would reduce depressive symptoms and produce a clinically significant change (i.e., a reduction of more than 50 % of depressive symptoms following intervention). Given the scarcity of similar clinical trials, no specific predictions were able to be made about the superiority of any intervention at reducing depressive symptoms and producing a clinically significant change. Following Positive Psychology rationale it was hypothesized that: (2) PPI would be more efficacious than CBT at increasing positive functioning variables and (3) PPI would also produce a significant change for primary and secondary outcomes in those participants with severe depression.

Method

Study Design

This study was a controlled clinical trial. Subjects were blindly evaluated and then allocated to either of the two different intervention groups (i.e., CBT or PPI). The clinical assessment, which consisted of an interview and a protocol of self-report measures, was given individually at the beginning and the end of the intervention. The study protocol was approved by the Faculty Ethics Committee and it was conducted following CONSORT recommendations (Boutron et al. 2008). There was only one exception to the CONSORT recommendations during the randomization process: participants were allocated into each intervention group due to their preferences about the day of the week to attend intervention sessions. Nevertheless, participants were blind to specific contents of the two interventions offered (e.g., both were conducted in the same center, at the same starting time, and had the same title).

Participants

Participants were recruited in a women's center, linked to the community health centers system, which periodically offers group interventions for depression. Women directly applied for the intervention programs or, in some cases, were referred by a local healthcare agency. Information about the programs included the goal of the intervention (i.e., overcoming depression), length, and schedule of the sessions.

The sample included 96 adult women who had a DSM-IV diagnosis of major depression or dysthymia, using the SCID structured interview (Structured Clinical Interview for the DSM-IV; First et al. 1996). Exclusion criteria included: substance abuse or dependence disorder (present), manic or hypomanic episodes (past or present), psychotic disorder (past or present), and a cognitive status (e.g., dementia or intellectual disability) that might prevent participants to follow the interventions. The participants were blindly assigned to one of the intervention groups: 49 to the CBT group and 47 to the PPI group. Figure 1 illustrates the participants CONSORT diagram.

Procedure

All participants were seeking psychological group treatment for depression. The women signed an informed consent form to participate in the study, answered some demographic and clinical questions and were interviewed with the SCID interview. The SCID interviews were audiotaped for assessment of reliability. Interviewers were blind to treatment allocation (the decision about what

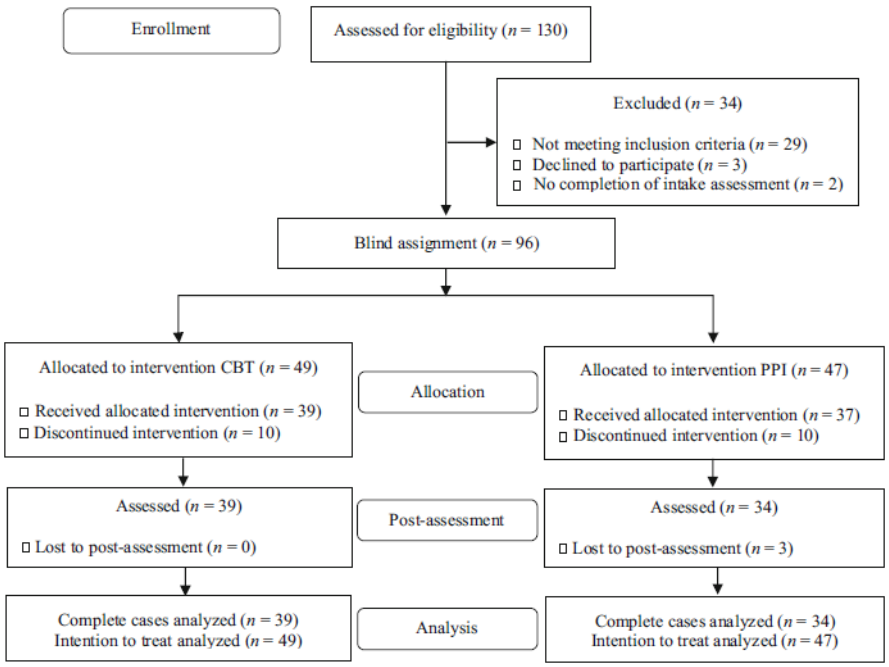

Fig. 1 CONSORT Participants flow diagram. *CBT* cognitive-behavioral therapy, *PPI* positive psychology intervention

treatment program would be given each day of the week was made after the SCID assessment). The interviewers were experienced clinicians who did not provide any of the interventions under study. A randomly selected subset of audiotaped interviews ($n = 13$, 10 % of the interviews conducted) was rated by a qualified clinician with extensive experience in structured diagnostic interviews. Diagnostic concordance was achieved in 11 of 13 cases (Kappa coefficient of .70 that represents a good agreement according to Peat 2001). The disagreements were due to different evaluation of the level of impairment (i.e., one clinician diagnosed major depression or dysthymia while the other concluded there were only depressive symptoms). All subjects who met inclusion criteria received a packet of self-report measures to be completed at home before the first intervention session, which took place less than a week after the initial interview. Post-assessment was identical to pre-assessment (i.e., interview and self-report measures).

Two licensed therapists with 5 years of clinical experience and training in the manualized interventions provided the intervention programs. Both had a postgraduate degree in CBT (2 years of study and clinical training) and were intensively trained afterwards in PPI. Additionally, these therapists (C.C. and I.L-G.) were trained in the use of intervention manuals and supervised at periodic meetings with the senior authors of the study in order to ensure adherence to the intervention protocols and avoid treatment contamination. Each therapist delivered both interventions and each was different from the interviewers who conducted the pre- and post-assessments. Along with the therapist, there was a co-therapist in each intervention group. This co-therapist was a clinical psychologist finishing her master's degree in CBT and was in charge of monitoring adherence to the protocol during each session.

Treatment Conditions

Both intervention options consisted of 10 weekly, 2-h sessions in a group format. Four groups for each condition, with a maximum 15 participants per group, were included in the study. Each session of the PPI and CBT programs had the same structure. They would begin with a review of the prior session's homework and then an introduction of the topic of the day. After that, the therapist presented session goals and a psychoeducational module and a brief discussion among participants was encouraged. Then, participants received guidance on how to carry out in-session exercises and practice new skills in the group. At the end of the session, therapists provided a summary of the key ideas and the homework assignment. Group interventions were facilitated by handouts, worksheets, and video-clips provided during each session.

Cognitive-Behavioral Intervention

The CBT program used in this study was the Spanish version of the Group Cognitive-Behavioral Therapy of Major Depression Manual (Muñoz et al. 1995), based on the widely used Coping with Depression course (Cuijpers et al. 2009; Lewinsohn et al. 1984). The program is a highly structured psychoeducational and applied cognitive-behavioral intervention. For the purposes of this study, the program's manual was adapted so that both interventions had the same number, duration and structure of sessions, and attendance norms.

In the first session, intervention goals, norms and treatment rationale were presented to attendees. It included a psychoeducational explanation of what depression is from a cognitive-behavioral point of view. Sessions 2 and 3 were dedicated to behavioral activation using pleasurable activities scheduling, time management, and goal setting. Sessions 4, 5 and 6 focused on cognitive restructuring of negative cognitions and included skills from Rational Emotive Therapy (Ellis and Dryden 1987) and Cognitive Therapy (Beck et al. 1979). Social skills were the topics of sessions 7, 8 and 9, where communication styles were analyzed and assertive skills were practiced. The last session was designed for relapse prevention, and consisted of a summary of the skills learned, the identification of potential difficulties, and a closing of the group.

Positive Psychology Intervention

A group program based on positive psychology for treating major depression was created for the purpose of this study mainly using interventions that have been shown to be effective in increasing positive functioning or alleviating depressive symptoms. The interventions included in this intervention program are presented in Table 1. Based on the idea that well-being includes components of hedonic well-being (e.g., positive affect, happiness) as well as components of eudaimonic well-being (e.g., self-acceptance, positive relations, autonomy, purpose in life, environmental mastery, personal growth; Ryan and Deci 2001; Ryff 1989), the PPI program was intentionally designed to nurture both components (see Table 1).

As in the CBT program, the first session was dedicated to establishing the intervention goals, norms, and treatment rationale. The session included a psychoeducational explanation of what depression is from a positive mental health perspective (see Keyes 2007) and emphasized the role of diminished positive emotions and cognitions in depression maintenance. Sessions 2, 3 and 4 focused on the hedonic component of well-being. Participants were presented with positive emotion enhancement, savoring

Table 1 Positive interventions included in this packaged treatment

Module	Description of the session	Previous empirically-validated studies	Well-being dimension
1	Objectives, expectations and attitudes on treatment What is depression? Rationale for treatment from a positive psychology perspective	Based on Keyes (2007), Seligman et al. (2006), Gilbert (2012), among others	
2	Positive emotions: identify and name positive emotions and learn to promote them	Seligman et al. (2006)	Hedonic
3	Savoring to amplify the intensity and duration of positive emotions Emotion regulation through mindfulness attitudes	Bryant (1989) Kabat-Zinn (1990)	Hedonic
4	Gratitude. Counting one's blessings. Optimism. Best positive self	Emmons and McCullough (2003) King (2001), Seligman et al. (2006)	Hedonic
5	Positive relationships Kindness. Counting kindnesses	Lyubomirsky et al. (2005), Boehm and Lyubomirsky (2009)	Eudaimonic: Positive relationships
6	Self-compassion	Gilbert (2012)	Eudaimonic: Self-acceptance
7	Personal strengths. Complete VIA-IS and using one's signature strengths	Seligman et al. (2005)	Eudaimonic: Autonomy; self-acceptance
8	Sense of living. Obituary/Biography Goal Setting	Seligman et al. (2005) MacLeod et al. (2008), Sheldon et al. (2002)	Eudaimonic: purpose in life, personal growth
9	Resilience	Based on Folkman and Moskowitz (2000)	Eudaimonic: environmental mastery
10	Relapse prevention	Following same rationale as CBT	

VIA-IS VIA Inventory of Strengths (Peterson and Park 2009), *CBT* cognitive-behavioral therapy

exercises, and positive emotion regulation techniques and then given time to practice them. Experience of positive emotions was enhanced in the sessions as well as in during inter-session homework. During these sessions, participants were introduced to acceptance attitudes, and practiced gratitude and optimism in order to increase well-being. The following sessions (sessions 5, 6, 7, 8 and 9) focused on the eudaimonic component of well-being. These sessions focused on promoting positive relationships and teaching kindness and self-compassion. Additionally, in this module, participants were encouraged to use their character strengths in new ways, to search for meaning in everyday life, and to start developing resilience to face difficulties. The last session dealt with relapse prevention; it consisted of a summary of the skills learned, the identification of potential difficulties, and closing the group (in the same way as the CBT).

Although both protocols shared some similarities with regard to the topics included (e.g., emotions, relationships, goal setting) and the structure of the sessions (e.g., psychoeducation, homework tasks, etc.), the PPI and traditional CBT programs had significant differences relating to their therapeutic approach and the specific contents of each session. For instance, each differed in how they explained what depression is in the initial psychoeducation modules. In the CBT approach, depression was mainly explained as a result of negative thoughts, negative emotions, cognitive biases, and behavioral withdrawal, whereas in the PPI approach depression was explained as a condition characterized by low levels of positive affect (e.g., dampening positive emotions) and diminished eudaimonic well-being (e.g., purpose in life or sense of growth).

Both frameworks also differed in how they addressed similar contents. For instance, while CBT targeted negative thoughts and activation to indirectly increase positive affect, PPI directly addressed and generated positive emotions during the sessions and homework (e.g., gratitude, love, etc.). Similarly, there were some differences between the interventions with regard to their approach to dealing with negative emotions. In PPI, the focus was less about changing the content of thoughts, but rather about encouraging participants to mindfully accept negative thoughts and feelings, such as anxiety, pain, and guilt. Likewise, although the CBT intervention addressed self-criticism, the PPI adopted self-compassion techniques that have shown to be effective both alone and when combined with standard CBT in clinical populations (Hofmann et al. 2011). As a final example, the CBT social relations module was focused on assertiveness and increasing social activity, whereas PPI was focused on ways to increase empathy, demonstrate positive affection, and strengthen emotional connections with others. Thus, despite their similarities,

both protocols had clear distinctive features and underlying conceptual differences.

Outcome Measures

Primary outcome measures were severity of depressive symptoms and clinical diagnosis. The Beck Depression Inventory-II (BDI-II; Beck et al. 1996; Sanz et al. 2003; $\alpha = .89$) was used to measure the severity of depressive symptoms. The clinical diagnosis was established through the SCID interview (Structured Clinical Interview for the DSM-IV; First et al. 1996), a widely used and reliable tool for establishing DSM-IV diagnoses (e.g., Skre et al. 1991).

Several variables related to cognitive, emotional and behavioral functioning were considered as secondary outcomes for this study. First, in order to add to the literature regarding the assessment of clinical depression, we selected measures that have been frequently included in prior depression studies. Further, we also included several questionnaires that allowed us to measure theory-related variables that would likely be sensitive to specific therapeutic changes. Following this rationale, depressive cognitive style was assessed by measures assessing different forms of automatic thoughts (The Automatic Thoughts Questionnaire, ATQ-30; Hollon and Kendall 1980; Vázquez 2006; $\alpha = .96$), rumination (Ruminative Response Style, RRS; Nolen-Hoeksema and Morrow 1991; Hervas 2008; $\alpha = .79$), and thought suppression (White Bear Supression Inventory, WBSI; Wegner and Zanakos 1994; Gonzalez et al. 2008; $\alpha = .80$). Emotional functioning was measured by assessing positive and negative affect in the last week (Positive and Negative Affect Schedule, PANAS; Watson et al. 1988; Lopez-Gomez et al. 2015; $\alpha = .87$ for positive affect, $\alpha = .85$ for negative affect), anxiety symptoms (Beck Anxiety Inventory, BAI; Beck and Steer 1990; Sanz and Navarro 2003; $\alpha = .92$), responses to positive affect (using the dampening, emotion-focus and self-focus subscales from the Responses to Positive Affect Questionnaire, RPA; Feldman et al. 2008; $\alpha = .74$ for dampening, $\alpha = .84$ for emotion-focus, $\alpha = .85$ for self-focus), and difficulties in regulating emotions (Difficulties in Emotion Regulation Scale, DERS; Gratz and Roemer 2004; Hervas and Jodar 2008; $\alpha = .90$). Behavioral functioning was assessed by a measure of behavioral activation and inhibition systems (Behavioral Inhibition System and Behavioral Approach System Scales, BIS/BAS trait version, Carver and White 1994; $\alpha = .63$ for BIS, $\alpha = .80$ for BAS). Moreover, in order to counterbalance the research bias in which recovery has been traditionally measured only by symptom reduction (Chambless and Ollendick 2001), we also examined positive functioning variables as secondary outcomes. Integrative well-being was measured with the Pemberton Happiness Index (PHI; Hervas and Vázquez 2013b; $\alpha = .84$), a brief self-report that combines hedonic, eudaimonic, and social well-being. More specific hedonic and eudaimonic components were assessed using the 29-item version of the Ryff's Psychological Well-Being Scales (PWBS) (Díaz et al. 2006; $\alpha = .86$): satisfaction with life (SWLS; Diener et al. 1985; Vázquez et al. 2013; $\alpha = .78$), optimism (Life Orientation Test–Revised, LOT-R; Scheier et al. 1994; Ferrando et al. 2002; $\alpha = .67$), and enjoyment orientation (Enjoyment Orientation Scale, EOS; Hervas and Vázquez 2006; $\alpha = .81$). Although this trial was not registered, it is important to note that all the outcome measures included in the design of the study are reported without any exception.

Statistical Methods

An analysis of variance (ANOVA) for repeated measures of severity of depression symptoms (BDI-II) was conducted and multivariate analyses of variance (MANOVAs) for repeated measures were used to analyze treatment effects in clinical and positive functioning measures. Complete case analysis was conducted with participants who completed the pre-post assessment (i.e., completers). Intention to treat analysis (ITT) was performed using two methods: last observation carried forward method (LOCF) and expectation maximization imputation (EM). To compare these procedures, a sensitivity analysis was conducted. To correct for multiple comparisons, significance tests of the differences between contrasts were performed using Holm–Bonferroni (Holm 1979) adjusted p values.

Additionally, a hierarchical regression analysis was conducted in order to confirm the effect of treatment condition on post-treatment BDI-II score when controlling for other relevant variables. A series of mixed ANOVAs was performed on all outcome measures to assess possible differences in efficacy between interventions for severe and non-severe depressed participants, as well as for participants with and without concurrent antidepressant treatment. Holm–Bonferroni correction was used for multiple comparisons (Holm 1979). Additionally, Chi square tests for independence were used to explore differences between treatment conditions in clinical diagnosis and in clinically significant change (i.e., reduction of more than 50 % on post-treatment BDI-II score) at the end of the treatments. Data were analyzed using SPSS (version 20.0).

Results

From the 130 women assessed for eligibility, 96 were blindly assigned to one of the intervention branches (see Fig. 1). The ITT sample was comprised of these 96 participants. During the 10-week intervention period, the

Table 2 Baseline characteristics

	CBT ($n = 49$)	PPI ($n = 47$)	Group differences
Demographic characteristics			
Mean age	50.73 (11.34)	52.57 (9.38)	$t = -0.86$, $p = .39$
Married or cohabitating (%)	65.3	61.7	$\chi^2 = 0.02$, $p = .88$
Primary or lower studies (%)	55.1	51.1	$\chi^2 = 0.04$, $p = .85$
Employed (%)	14.3	14.9	$\chi^2 = 0.00$, $p = 1$
Clinical characteristics			
Mean BDI-II score	35.84 (10.37)	34.35 (10.26)	$t = 0.71$, $p = .48$
Severe depressive symptoms[a] (%)	75.5	70.2	$\chi^2 = 0.12$, $p = .72$
Any other current Axis I diagnosis (%)	59.2	51.1	$\chi^2 = 0.35$, $p = .55$
Functioning[b]	58.55 (10.26)	60.86 (11.66)	$t = -1.00$, $p = .32$
Antidepressant medication (%)	61.2	60.0	$\chi^2 = 0.00$, $p = 1$
Mean no. of sessions attended	7.39 (2.55)	6.96 (2.94)	$t = 0.77$, $p = .45$

Standard deviations are shown in parenthesis; *CBT* cognitive behavioral therapy, *PPI* positive psychology intervention, *BDI-II* Beck Depression Inventory-II

[a] BDI-II $\geq$ 29

[b] Global Assessment of Functioning Scale of SCID interview

dropout rate was 20.4 % within the CBT group and 21.3 % within the PPI group. Ten subjects dropped out of each group due to an illness or accident that prevented them from attending intervention (2 in CBT group, 3 in PPI group), conflicting schedules (3 in CBT group, 5 in PPI group), lack of appropriateness of the intervention (1 in CBT group, 1 in PPI group), or for no specific reason (4 in CBT group, 1 in PPI group). There were no significant differences in dropout rates between groups, $X^2(1, n = 96) = .01$, $p = .92$, $phi = .01$.

A sensitivity analysis was performed, finding no differences between the results of the complete cases analysis, expectation maximization imputation (EM) and LOCF analysis. In this article we reported the results of the LOCF, a conservative approach based on the assumption that individuals who prematurely discontinue treatment experience no long-term changes from the beginning of treatment.

Baseline Characteristics

No differences were found at baseline in demographic and clinical characteristics between conditions in the ITT sample (see Table 2). Similarly, no differences were found at baseline between conditions in any of the main and secondary outcome measures (all $ps > .10$). Therefore, these variables were not introduced as covariates in further outcome analyses. Participants' mean age was 51.64 (SD = 10.41) and 53.1 % had completed primary school or lower education (see Table 2). In regards to clinical measures, the mean baseline depressive symptoms score measured using the BDI-II was 35.12 (SD = 10.27), indicating severe depression (Beck et al. 1996), and 21.9 % of the sample met criteria for a Dysthymic disorder. In this sample, 44.8 % of participants had an additional Axis I diagnosis, and 10.4 % had two additional Axis I diagnoses. In regards to the number of attended treatment sessions, participants in the ITT sample attended 7.2 sessions on average (SD = 2.74). In the completers sample, the mean number of attended treatment sessions rose to 8.45 (SD = 1.37). A detailed description of demographic and clinical characteristics of the groups is displayed in Table 2.

Analyses of Outcomes

Regarding the first hypothesis of the study, an ANOVA for repeated measures of the main outcome (BDI-II) was performed for all participants who entered in the study ($N = 96$). There was no significant interaction Group × Time, indicating that CBT did not differ significantly from PPI with respect to pre-post depressive symptoms, $F(1, 94) = .04$, $p = .84$, $\eta_p^2 = .05$. Additionally, there was a significant main effect for time, $F(1, 94) = 96.10$, $p < .001$, $\eta_p^2 = .51$, indicating significant pre- to post-treatment reductions in depressive symptoms.

A series of Group × Time repeated measures MANOVAs were performed for all participants who entered in the study ($N = 96$). Variables were clustered into two factors: clinical measures (BDI-II, BAI, ATQ-30, RRS, WBSI, PANAS-NA, RPA dampening subscale, DERS, and BIS) and positive functioning measures (PHI, PWBS, SWLS, PANAS-PA, RPA emotion-focus subscale, RPA self-focus subscale, EOS, LOT-R, and BAS) to test the first and second hypotheses of the study. Main effects for time were significant, indicating significant pre- to post-treatment

change in clinical measures, $F(9, 75) = 10.33$, $p < .001$, $\eta_p^2 = .55$; and in positive functioning measures, $F(14, 78) = 5.01$, $p < .001$, $\eta_p^2 = .47$. In general, symptom scores significantly decreased, and positive functioning scores significantly increased from pre- to post-treatment (see Table 3). However, there was no significant time effect for the WBSI, RPA Dampening and Emotion-focus subscales, BIS, PWBS Positive relationships, Autonomy and Environmental mastery subscale. The effects for the Group × Time interaction were not significant, indicating that CBT did not differ significantly from PPI with respect to both clinical measures, $F(9, 75) = .91, p = .52, \eta_p^2 = .10$; and positive functioning measures, $F(14,78) = .47, p = .94$, $\eta_p^2 = .08$.[1] The same results were found when the analyses were conducted including the participants' diagnosis (i.e., dysthymia vs. major depression) as a factor.

Cohen's *d* pre-post effect sizes were computed for the ITT sample. According to Cohen's guidelines (1988), effect sizes were large for BDI-II in both groups. Intermediate and small effect sizes were found in the remaining measures (see Table 3). It is worth noting that the average effect sizes for clinical variables and positive functioning variables shown in Table 3 were larger for PPI than for CBT. More specifically, the average effect size for clinical variables was 0.50 for PPI and 0.44 for CBT. For positive functioning variables, their average effect size was 0.44 for PPI and 0.26 for CBT and, interestingly, the direction of the differences favoured PPI over CBT in all these variables.

A hierarchical regression analysis was carried out, which confirmed that treatment condition did not influence post-treatment BDI-II score when controlling for pre-treatment BDI-II score and number of treatment sessions attended. Thus, pre-treatment BDI-II score and number of treatment sessions attended were entered as predictors in the first step of the regression and treatment condition in the second. The first step explained 44.7 % of the variance, $F(2, 93) = 37.62$, $p < .001$. When including treatment condition in the second step, R^2 change was .001 leading to a non-significant change, F change $(1, 92) = .17$, $p = .68$. Therefore, treatment condition was not a significant predictor of depressive symptoms at the end of treatment in this sample. The results were not affected by the inclusion of concurrent treatment with antidepressants and diagnosis comorbidity as predictors in the first step of the regression.

[1] To control for pre-post differences in the dependent variables, a series of ANCOVAS using the pre-intervention scores as covariates, was conducted. All analyses yielded nonsignificant differences between both groups of intervention with the exception of rumination as measured by the RRS ($p = .049$). This only difference also disappeared when the p value was adjusted for multiple comparisons.

The Role of Depression Severity and Medication

In order to test the third hypothesis of the study and to assess possible differences in efficacy between interventions for severe and non-severe depressed participants, a series of mixed ANOVAs on all outcome measures was conducted using the cut-off score of BDI-II ≥ 29 provided by Beck et al. (1996) to classify depression severity. This procedure allowed to group participants within each intervention into two categories, mild and moderate depression (<28) versus severe depression (≥29). More than 70 % of participants had a severe depression (see Table 2), with no statistical differences between the treatment groups. There were no significant interactions between time, treatment condition, and severity in any measure in the ITT sample (all $ps > .20$). The same analyses were conducted to assess possible differences in efficacy between treatment conditions for participants with and without concurrent antidepressant treatment. No significant interactions between time, treatment condition, and medication were found on any dependent variable (all $ps > .09$).

Response Rates and Clinically Significant Change

To assess whether there were differences between treatment conditions in response rates, the proportion of participants in each group who no longer had a diagnosis of major depression or dysthymia at the end of the treatment was analyzed. Considering only the group of completers, 71.8 % no longer met the criteria for a diagnosis in the CBT group, and 67.6 % no longer met the criteria in the PPI group. When the ITT sample was considered, these percentages decreased to 57.1 % in the CBT group and 51.1 % in the PPI group. Chi square tests for independence showed no statistically significant difference between groups in both analyses (all $ps > .69$).

A clinically significant change is defined as a reduction in BDI-II score of more than 50 % (Dimidjian et al. 2006; Strauman et al. 2006). Analyzing completers, 57.1 % of them showed a clinically significant change in the CBT group, compared to 42.9 % of the completers in the PPI group. Within the ITT sample, these percentages decreased to 40.8 % in the CBT group and 34.0 % in the PPI group. Chi square test for independence showed no statistically significant difference between groups in both analyses (all $ps > .63$).

Discussion

The main goal of this study was to compare the relative efficacy of a well-established intervention for depression (CBT) with a positive psychology intervention (PPI) in a

Table 3 Effect of time and treatment group on outcome ($N = 96$)

	Pre-treatment		Post-treatment		Cohen's *d*		Main effect (Time)			Interaction effect (Time × Treatment Group)		
	CBT M (SD)	PPI M (SD)	CBT M (SD)	PPI M (SD)	CBT	PPI	*F*	*Adj. p*	η_p^2	*F*	*Adj. p*	η_p^2
Clinical measures												
BDI-II	35.84 (10.37)	34.35 (10.26)	22.42 (14.01)	23.43 (12.39)	−1.09	−0.96	89.51	<.001***	.52	0.63	1.00	.01
BAI	32.04 (13.24)	29.04 (13.07)	23.23 (15.57)	22.04 (13.07)	−0.61	−0.54	26.45	<.001***	.24	0.76	1.00	.01
ATQ-30	89.89 (26.69)	84.82 (26.16)	71.06 (28.77)	67.07 (24.01)	−0.68	−0.71	40.20	<.001***	.33	0.04	1.00	.000
RRS	25.59 (5.61)	24.77 (6.00)	24.23 (6.27)	21.79 (5.89)	−0.23	−0.50	15.30	.002**	.16	2.11	1.00	.02
WBSI	38.24 (6.88)	39.82 (6.56)	37.69 (6.64)	38.08 (7.18)	−0.08	−0.25	2.82	.27	.03	0.76	1.00	.01
PANAS-NA	26.76 (9.46)	25.44 (6.87)	20.84 (8.94)	20.36 (7.77)	−0.64	−0.69	39.35	<.001***	.32	0.23	1.00	.003
Dampening, RPA	20.45 (4.65)	18.28 (4.97)	19.83 (5.23)	17.86 (4.10)	−0.12	−0.09	1.19	.28	.01	0.04	1.00	.001
DERS	88.21 (19.59)	84.95 (19.62)	81.12 (21.09)	74.19 (19.31)	−0.35	−0.55	21.77	<.001***	.21	0.92	1.00	.01
BIS	23.33 (2.94)	22.79 (3.50)	22.80 (3.18)	22.19 (3.73)	−.17	−0.17	6.45	.07	.07	0.03	1.00	.000
Well-being measures												
PHI	3.92 (1.65)	4.02 (1.63)	4.73 (2.18)	5.08 (1.82)	0.42	0.61	32.78	<.001***	.26	0.53	1.00	.006
Self-acceptance, PWBS	10.91 (4.20)	10.72 (4.38)	12.13 (4.26)	13.11 (5.41)	0.29	0.49	18.42	.001**	.17	1.93	1.00	.02
Positive relationships, PWBS	18.13 (6.56)	18.89 (5.10)	19.08 (6.90)	20.32 (5.49)	0.14	0.27	6.82	.07	.07	0.27	1.00	.003
Autonomy, PWBS	21.37 (6.78)	22.68 (6.09)	22.28 (6.21)	24.04 (6.13)	0.14	0.22	5.46	.10	.06	0.21	1.00	.002
Environmental mastery, PWBS	16.96 (3.56)	16.53 (2.99)	17.22 (3.85)	17.55 (3.35)	0.07	0.32	2.89	.27	.03	1.00	1.00	.01
Personal Growth, PWBS	13.48 (4.86)	13.64 (4.67)	14.57 (4.37)	15.62 (4.67)	0.24	0.42	11.67	.001**	.11	0.97	1.00	.01
Purpose in life, PWBS	15.70 (5.90)	14.32 (5.55)	16.61 (5.95)	16.37 (6.71)	0.15	0.33	8.26	.04*	.08	1.22	1.00	.01
SWLS	13.89 (6.46)	13.28 (6.11)	14.79 (5.67)	16.02 (7.22)	0.15	0.41	8.94	.03*	.09	2.30	1.00	.02
PANAS-PA	17.52 (5.24)	18.04 (5.53)	22.43 (9.77)	24.11 (9.20)	0.63	0.80	35.49	<.001***	.28	0.40	1.00	.004
Emotion-focus, RPA	9.09 (3.24)	9.08 (2.79)	9.39 (3.50)	10.49 (3.62)	0.09	0.44	5.60	.10	.06	2.35	1.00	.02
Self-focus, RPA	6.11 (2.56)	5.87 (2.05)	6.96 (3.34)	6.89 (3.05)	0.29	0.39	10.98	.01*	.11	0.09	1.00	.001
EOS	21.52 (7.74)	21.96 (7.44)	23.37 (9.30)	24.68 (7.73)	0.22	0.36	13.89	.001**	.13	0.51	1.00	.01
LOT-R	15.11 (3.94)	15.11 (4.45)	16.20 (5.27)	16.68 (4.69)	0.23	0.34	8.78	.03*	.09	0.29	1.00	.003
BAS	34.75 (7.05)	33.67 (6.05)	38.81 (7.96)	37.88 (5.46)	0.54	0.73	49.41	<.001***	.35	0.02	1.00	.000

Adj. p = Holm–Bonferroni adjusted p values for multiple comparisons

CBT cognitive behavior therapy, *PPI* positive psychology intervention, *BDI-II* Beck Depression Inventory, *BAI* Beck Anxiety Inventory, *ATQ-30* The Automatic Thoughts Questionnaire, *RRS* Ruminative Response Style, *WBSI* White Bear Suppression Inventory, *PANAS-NA* Positive and Negative Affect Schedule, Negative Affect subscale; *RPA* Responses to Positive Affect questionnaire, *DERS* Difficulties in Emotion Regulation Scale, *BIS* Behavioral Inhibition Scale, *PHI* Pemberton Happiness Index, *PWBS* Psychological Well-Being Scales, *SWLS* Satisfaction With Life Scale, *PANAS-PA* Positive and Negative Affect Schedule, Positive Affect subscale, *EOS* Enjoyment Orientation Scale, *LOT-R* Life Orientation Test Revised, *BAS* Behavioral Activation Scale

* $p < .05$; ** $p < .01$; *** $p < .001$

sample of clinically depressed participants. These interventions were evaluated using a wide array of psychological measures, which included clinical measures of psychopathology as well as a number of measures of positive functioning. The overall patterns of results showed that both interventions were effective in reducing psychopathology and increasing positive functioning, but there were no significant differences in their main outcomes (i.e., severity of depressive symptoms and clinical diagnosis) or their secondary outcomes.

The first hypothesis was that both interventions would reduce depressive symptoms and produce a clinically significant change. Our results confirmed that CBT and PPI produced a response in the expected direction. The main outcome of this study is that both intervention modalities significantly reduced symptoms of depression. Furthermore, there were also significant reductions in anxiety, negative automatic thoughts, rumination, difficulties in regulation, and negative emotions.

The results indicated that PPI and CBT did not significantly differ from each other in reducing depression and any other clinical variables under study. This lack of significant differences is a common finding when comparing modalities in well-planned and executed interventions for depression (e.g., Barth et al. 2013; Cuijpers 2016; Cuijpers et al. 2011a; Forman et al. 2007).

Following the standard criterion of clinical improvement (Dimidjian et al. 2006; Strauman et al. 2006), 40.8 % of participants in the CBT group and 34.0 % of participants in the PPI group of the ITT sample achieved a 50 % reduction of their initial BDI scores, with no significant differences between groups. These figures are similar to those found in other studies with severely depressed participants (Björgvinsson et al. 2014; Dimidjian et al. 2006).

In terms of diagnostic status following intervention, both groups in our study responded similarly to the interventions: 57.1 % of participants in the CBT group and 51.1 % in the PPI group had no formal diagnosis of MDD or dysthymia at the end of the intervention in the ITT sample. As a comparison, studies applying CBT to non-severely depressed populations showed rates of 37–77 % of participants without a depression diagnosis at post-treatment (Bodenmann et al. 2008; Gallagher-Thompson and Steffen 1994; Mohr et al. 2001). Although CBT outperformed PPI in clinical response, this difference was no statistically significant. Yet, it is interesting to note that the opposite trend occurred when the average effect sizes of pre-post differences in clinical measures were compared (Table 3).

Given the distinct focuses of both interventions and keeping previous studies in mind (Asgharipoor et al. 2012; Moeenizadeh and Salagame 2010), the second hypothesis predicted that PPI would work better than CBT in improving participants' scores on positive functioning measures. Contrary to our expectations, no significant differences were found when comparing both interventions on positive functioning measures. Yet, it is important to note that, when pre-post Cohen's *d* are compared, the average size effect for positive functioning variables for PPI (0.44) was almost twice as large as the average effect for CBT (0.26). Therefore, it is still possible that significant differences may emerge in future studies with larger samples. Our results also indicate that standard CBT likely enhances positive functioning, an interesting and understudied phenomenon. Dismantling studies that specifically examine positive and negative outcomes in parallel may shed light on this possibility in future research.

The literature on severity of depression has shown that CBT works not only for low levels of severity but also for severe depression (DeRubeis et al. 2005). However, there are very few studies regarding the efficacy of PPI in severe depression. Thus, it is important to note that our study sample was severely depressed according to the BDI-II ($M = 35.12$; severity cut-off score = 29; Beck et al. 1996). As a comparison, the average pre-treatment mean score in the BDI or BDI-II of participants included in Braun et al. (2013) meta-analysis was 25.6 (i.e., it was below the BDI-II severity cut-off score of 29). Despite the fact that our sample was severely depressed on average, we specifically hypothesized that PPI would also produce a significant change for primary and secondary outcomes in those participants with severe depression (i.e., BDI-II $\geq$ 29). Our results showed that both therapies were effective in most variables for severe cases of depression and there were no significant differences between interventions. Although there is ample evidence showing that severe depression can be effectively treated with CBT (Björgvinsson et al. 2014; Smit et al. 2006), this is the first large study to our knowledge demonstrating that PPI programs can also effectively treat severe cases of clinical depression.

Overall, this study provided further evidence that structured PPI programs should be considered a treatment option for clinical depression. Several implications can be drawn from this initial finding. First, if this result is replicated in further research on clinical depression, it will broaden the range of intervention options available to accommodate clients' preferences (Lyubomirsky and Layous 2013; Schueller 2010). Although there are few primary studies explicitly designed to explore the impact of clients' preferences on intervention outcomes, the existing evidence suggests that individual preferences may affect the decision to enter into treatment and the therapeutic alliance (Gelhorn et al. 2011). In this regard, there is some evidence that interventions exclusively focused on cognitive aspects may negatively affect the therapeutic alliance (Burns and Nolen-Hoeksema 1992; Castonguay et al.

2004), or may even increase the likelihood of treatment abandonment (Oei and Kazmierczak 1997). It is possible that, in many cases, interventions focused on positive emotions and positive traits could help to destigmatize patients' feelings towards being in psychological treatment (Rashid 2015). On the contrary, for patients who are reluctant to experience positive emotions (Gilbert et al. 2012) or for whom positive exercises are perceived as 'trivial', perhaps PPI should not be a front-line strategy. Although our PPI program presented a rationale that tried to minimize participants' possible misconceptions in this regard, this is a relevant topic for future research.

Strengths of the Study

This study has some noteworthy strengths. Firstly, regarding methodology, strict rules were followed throughout the process of conducting the study. For example, in this study, well-trained psychologists delivered the interventions and used manualized protocols, which have been found to be predictive of better psychotherapeutic outcomes (Crits-Christoph et al. 2001; Forand et al. 2011). Despite the fact that the participating therapists had a solid theoretical background in CBT, they were knowledgeable of the clinical literature in regard to positive psychology interventions. Furthermore, to avoid biases in the therapeutic delivery, the two main therapists (C.C. and I.L-G.) were assigned to lead both types of interventions and the adherence to the protocol manuals were supervised by the senior authors of the study. Secondly, participants were carefully diagnosed using a clinically structured interview. Thirdly, the study has followed conservative criteria to analyze the results (i.e., intention to treat analyses) and used multiple outcome measures that have shown to be sensitive in similar psychotherapy studies (e.g., Bolier et al. 2013; Cuijpers et al. 2011a; Sin and Lyubomirsky 2009). Fourthly, although having larger sample sizes is always desirable in comparative outcome trial (Cuijpers 2016), the sample size of this study is very close to what Barth et al. (2013) consider to be a large sample ($n = 50$ per group) in clinical trials. In fact, according to Cuijpers et al. (2013a) the mean number of participants included in comparisons between CBT and another psychotherapy is 52, ranging from 13 to 178. Fifthly, the dropout rate was relatively low (i.e., 20.4 % within the CBT group and 21.3 % within the PPI group) in comparison to other similar studies. Meta-analyses have shown a dropout rate in depression treatments between 19.2 % (Swift and Greenberg 2014) and 24 % (De Maat et al. 2006). Specifically, in CBT interventions for depression the dropout rates ranged between 20.4 % in Swift and Greenberg (2014) and 36.4 % rate in Fernandez et al. (2015) meta-analysis. Furthermore, although this study was conducted with non-hospitalized participants, they had, as a group, a severe level of depression, which adds clinical value to the study. These features allow this study to improve upon most of the limitations observed in previous studies using positive interventions.

Finally, another strength of the current study is that the protocol based on positive psychology interventions was designed using empirically-validated interventions, incorporated a balance between hedonic and eudaimonic components and also included a continuous combination of in-session exercises and homework.

Limitations

This study also has some limitations. Firstly, the study employs a quasi-experimental design where participants were blindly allocated to either of the two different interventions (i.e., CBT or PPI). It followed CONSORT recommendations except for their strict randomization procedure, due to characteristics of the center where the interventions were implemented. However, the allocation performed depended on participants' preferences about the days of the week to attend the treatment sessions, and therefore it is unlikely that the procedure followed has had any impact on the intervention effects. The fact that both groups did not differ on the studied variables at baseline supports an absence of allocation bias. Yet, it is not possible to ensure that both groups of participants did not differ on other variables that have not been measured.

Secondly, the study used a standard CBT protocol for depression that has been extensively validated in its current format or with minor variations (Cuijpers et al. 2009; Muñoz et al. 1995). In contrast, it must be acknowledged that, in the case of the PPI, there is no known "golden protocol". In the present study we included a selection of interventions that have empirical support in the literature (see Table 1). Yet, the weight of these components in relation to their contribution to clinical improvement and also the specific details of their administration (e.g., duration of the sessions, types of homework assignments, etc.) have not yet been subjected to systematic investigation. Furthermore, there are other possible positive interventions that, based on extant literature, could be used in PPI programs. For example, training on autobiographical memory (Dalgleish and Werner-Seidler 2014) or positive imagery (Holmes et al. 2009) could also fit very well within the philosophy of positive interventions.

There is a third limitation, that applies to almost all the trials comparing psychotherapies for adult depression. Due to their sample size, almost all of the studies that have been conducted to date have not had sufficient statistical power to find clinically relevant differences between therapies (Cuijpers 2016).

Another aspect that limits the conclusions that could be drawn from this article is the absence of follow-up results to analyze the sustainability of the interventions effects. A 6-month and 24-month follow-up will be reported, although data are not presented as the study is ongoing. This information may show differential long-term effects of the interventions regarding relapse and recurrence prevention.

Even though there were no significant differences between CBT and PPI in reducing symptoms and improving the clinical condition of both groups, nearly half of the participants still had a clinical diagnosis of depression or dysthymia at the end of the intervention. Therefore, the positive intervention package used in this study shares some of the limitations and ceiling effects found in the entire field of depression therapies (Björgvinsson et al. 2014; Westen and Morrison 2001), which justifies the need for research on new treatments in depression (Stirman et al. 2010). It also may be possible that a combination of both approaches (e.g., CBT plus hedonic-oriented exercises) could boost the therapeutic impact of current therapies (Dunn and Roberts 2016; Ingram and Snyder 2006). In fact, some preliminary research has shown evidence that personalizing CBT to clients' strengths leads to better results than personalizing CBT to clients' deficits (Cheavens et al. 2012).

To conclude, although there were no incremental differences per treatment for any of the measures included in the study, we think that these results are relevant. The fact that this study did not find significant differences between the two intervention modalities should not prevent researchers from replicating these findings. On the contrary, it should encourage this line of research as the outcomes, comparing a PPI with a benchmark therapeutic protocol, are very promising. If these results are replicated in future clinical studies that include larger and more diverse samples in terms of age, gender, and culture, this will add PPI to the list of empirically validated therapies for depression and will provide professionals with more therapeutic options to treat this widespread disorder.

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Compliance with Ethical Standards

Conflict of Interest Covadonga Chaves, Irene Lopez-Gomez, Gonzalo Hervas and Carmelo Vazquez declare no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the studies.

Animal Rights Statements No animal studies were carried out by the authors for this article.

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ARTÍCULO 2

Pattern of Changes During Treatment: A Comparison Between a Positive Psychology Intervention and a Cognitive Behavioral Treatment for Clinical Depression

[Patrón de cambio durante el tratamiento: Una comparación entre una intervención basada en psicología positiva y un tratamiento cognitivo-conductual para depresión clínica]

Spanish Journal of Psychology (en prensa)

El segundo artículo de la tesis es *Pattern of changes during treatment: A comparison between a positive psychology intervention and a cognitive behavioral treatment for clinical depression* (*Spanish Journal of Psychology*, en prensa).

En él se persigue mostrar el patrón de cambio de los síntomas depresivos y el bienestar durante los programas de intervención. Los resultados apuntan a la ausencia de patrones de cambio diferenciales en función del tipo de intervención aplicada. No obstante, sí muestran diferencias en cómo cambian los síntomas depresivos, el bienestar recordado y las experiencias experimentadas por las participantes durante las intervenciones.

Pattern of Changes During Treatment: A Comparison Between a Positive Psychology Intervention and a Cognitive Behavioral Treatment for Clinical Depression

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Abstract

Research on psychotherapy has traditionally focused on analyzing changes between the beginning and the end of a treatment. Few studies have addressed the pattern of therapeutic change during treatment. The aim of this study was to examine the pattern of change in clinical and well-being variables during a CBT program compared with a Positive Psychology Intervention (PPI) program for clinical depression. 128 women with a diagnosis of major depression or dysthymia were assigned to the CBT or PPI group. A measure of depressive symptoms (i.e., Beck Depression Inventory) and well-being (i.e., Pemberton Happiness Index) were administered four times: at the beginning and end of the treatment, as well as during treatment (at sessions 4 and 7). Through mixed-model repeated measures ANOVAs, both depressive symptoms ($p < .001$, partial Eta square = .52) and well-being ($p < .001$, partial Eta square = .29) showed a significant improvement through the four assessment times. No significant interactions between time and treatment modality were found ($ps > .08$). The percentage of improvement in depressive symptoms in the first treatment period was higher than in the later ones ($ps < .005$). On the contrary, well-being showed a more gradual improvement ($p = .15$). These results highlight the importance of assessing the pattern of changes in symptoms and well-being separately.

Keywords: depression, dysthymia, pattern of changes, positive psychology, well-being.

Introduction

Traditionally, psychotherapy research has been focused on analyzing changes between the start and end of the treatment, as well as the maintenance of those gains during a follow-up period. However, typical research designs do not address the change trajectory that may occur during the treatment period. Shedding light on these changes may add valuable knowledge on how treatments work (e.g., Greene, 2012; Kazdin & Nock, 2003), on how long treatments should be (e.g., Baldwin, Berkeljon, Atkins, Olsen, & Nielsen, 2009; Hansen, Lambert, & Forman, 2002), or even to personalize the treatment (e.g., Vittengl, Clark, Thase, & Jarrett, 2016; Wise, Streiner, & Gallop, 2016).

There have been some precursors of the interest in changes during treatment. The dose-effect model (Howard, Kopta, Krause, & Orlinsky, 1986) assumed that each session can be analogous to a dose of treatment and, therefore, it would be plausible to analyze patterns of change in relation to dosage levels. Additionally, the seminal study by Howard et al. (1986) revealed that different diagnostic groups responded differently to treatment. Patients grouped in the categories anxiety and depression seemed to improve earlier in treatment than those grouped in the borderline or psychotic category. Moreover, it was found that the rate of change during therapy was negatively accelerated. That means that the benefits gained at the first part of the therapy are usually bigger than the benefits later in treatment, although patients generally continue improving (e.g., Lutz, Lowry, Kopta, Einstein, & Howard, 2001).

In a similar direction, the phase model of therapy (Howard, Lueger, Maling, & Martinovich, 1993) has suggested that temporal changes can be observed in how symptoms change. More specifically, the model considers that clients, in the first place, experience remoralization and increased hope, followed by a phase of symptom relief, and finally undertake the reduction of maladaptive behaviors that interfere with adaptive life functioning.

Thus, the decelerating curve of improvement for a patient could be due to the increasing difficulty of treatment goals over the course of treatment. Another explanation for these findings is that some patients show a rapid early response (e.g., Hayes, Hope, & Hayes, 2007). Similarly, "sudden gains" (e.g., Tang & DeRubeis, 1999), which are defined as a sudden and large improvement in clinical symptoms during a single between-session interval, when they take place early in treatment, have been associated with larger changes over the course of treatment (e.g., Kelly, Roberts, & Ciesla, 2005).

More recent studies using multilevel growth curve models, and controlling for treatment duration, have confirmed this negatively accelerated curve in session-to-session change (e.g., Stulz, Lutz, Kopta, Minami, & Saunders, 2013). Yet, it is interesting to note that some authors have questioned the general finding of the negatively accelerated rate of change arguing that it might be an artefact of aggregating patients with different lengths of therapy and variable patient difficulty (Barkham et al., 2006). Specifically, it has been suggested that patients who improve more easily tend to finish their treatment early and aggregating their results to the general pool of patients, which also includes more difficult ones, could lead to a bias in the overall pattern of results related to therapeutic change.

Another relevant issue related to the analyses of patterns of change is related to the type of outcomes explored. Most of the published studies have employed the rate of change of clinical symptoms as the outcome variable. Yet, recent literature has pointed out the relevance of positive functioning and satisfaction in patients' definition of remission (Demyttenaere et al., 2015a; 2015b; Zimmerman et al., 2006). Consequently, assessing well-being and positive functioning in ongoing psychotherapy research is needed to complement the view of how patients change during psychotherapy (Joseph & Wood, 2010). In fact, unfortunately, patterns of changes in well-being and positive functioning have received much less attention in psychotherapy research. Some studies have occasionally included in their

outcome measures items about subjective well-being and life functioning along with items about psychological symptoms (e.g., Howard, Moras, Brill, Martinovich, & Lutz, 1996; Lutz et al., 2001; Stulz et al., 2013). However, some items included in the well-being and life functioning scales used in these studies were based on the idea that subjective well-being is the absence of symptoms (e.g., distress level) and life functioning is the absence of interference of psychological problems in life areas. Therefore, those attempts to include positive items or dimensions have been typically limited as they have ignored key components of current definitions of well-being (e.g., purpose in life, self-acceptance, and positive relationships).

The present study

In a controlled clinical trial, we compared a manualized protocol of empirically-validated positive psychology interventions (PPI) with a cognitive-behavioral therapy (CBT) protocol in a sample of participants with a diagnosis of major depressive disorder or dysthymic disorder (Chaves, Lopez-Gomez, Hervas, & Vazquez, 2016). Measures of both clinical and well-being indicators were included. Pre-post analyses showed that both treatments were equally efficacious in reducing clinical symptoms and increasing well-being. Furthermore, both therapies showed similar efficacy for the most severe cases of depression. These results are in line with the extensive literature that supports the equivalent efficacy of different psychological interventions in the treatment of depression (e.g., Cuijpers, van Straten, Andersson, & van Oppen, 2008). Yet, the results of that clinical trial yielded the unanswered question of how patients change during treatment and the patterns of these changes.

The aim of this paper is to provide new evidence by exploring the patterns of changes during the interventions. Examining the rate of change of two different protocols (i.e., CBT vs. PPI) is a new approach that can help to extend previous research. First, there is evidence

that the rate of change varies as a function of duration and type of clinical profile, but there is no evidence of a different pattern as a function of the therapeutic approach. Second, positive functioning was monitored in the clinical trial through an integrative measure of well-being, which will allow comparing the rate of change of well-being with clinical symptoms for the two treatment modalities.

Thus, following the dose-effect model, it was hypothesized that a significant improvement in depressive symptoms and well-being would be found across all assessment points, regardless of intervention condition. Secondly, based on results of previous studies about rate of change during psychotherapy (Lutz et al., 2001; Stulz et al., 2013), it was also hypothesized that depressive symptoms and well-being would show a higher percentage of improvement in the first period of treatment than in the following ones. Taking into account that there were no significant differences between treatments in previous analyses (Chaves et al., 2016), it was expected that there would be no significant differences between intervention conditions in this pattern of improvement.

Method

Participants

Participants were 128 women (m_{age} = 52.02; *SD* = 10.58) recruited in a women's center, linked to the community health and social services centers system. The Faculty Ethics Committee approved the study protocol and all participants gave informed consent to allow their data to be analyzed. All participants were diagnosed with major depressive disorder (MDD) or dysthymia according to DSM-IV-TR criteria (APA, 2000) by using a structured interview (Structured Clinical Interview for the DSM-IV; First, Spitzer, Gibbon, & Williams, 1996). Participants were blindly allocated to a PPI (*n* = 62) or CBT (*n* = 66) intervention

condition (for details, see Chaves et al., 2016; Lopez-Gomez, Chaves, Hervas, & Vazquez, 2017). Exclusion criteria for the study were: substance abuse or dependence disorder (present), manic or hypomanic episodes (past or present), psychotic disorder (past or present), and a cognitive status (e.g., dementia or intellectual disability) that might prevent participants to follow the interventions.

Treatment and Therapists

Participants were scheduled to attend ten 2-h weekly sessions in a group format. Each program (CBT and PPI) was offered to five groups containing 10–15 members each. Both protocols had the same session structure. Between-session homework was reviewed at the start of each session. Then, the topic of the day was introduced. Participants were encouraged to participate in brief discussions and in in-session exercises. A summary of the key ideas was provided at the end of each session and then the therapist assigned homework exercises to practice the skills learned during the session.

PPI was a manualized protocol composed of empirically-validated positive psychology interventions for depression (Bolier et al., 2013; Sin & Lyubomirsky, 2009). Sessions were thematically sequenced to facilitate the experience and generation of positive emotions as early as possible in the program (sessions 2 to 4) while sessions on eudaimonic components were incorporated into the middle of the program (sessions 5 to 9, including themes of positive relationships, compassion, personal strengths, meaning in life, personal goals and resilience). A more detailed description of the intervention conditions can be found elsewhere (Chaves et al., 2016).

The CBT program used the Group Therapy Manual for Cognitive-Behavioral Treatment of Depression (Spanish language version; Muñoz, Aguilar-Gaxiola, & Guzman, 1995), based on the Coping with Depression course (Lewinsohn, Antonuccio, Breckenridge,

& Teri, 1984), which has strong empirical support (Cuijpers, Muñoz, Clarke, & Lewinsohn, 2009; Muñoz & Mendelson, 2005).

Two licensed therapists with 5 years of clinical experience and trained in the manualized interventions provided the intervention programs. They had a postgraduate degree in CBT (2 years of study and clinical training) and received a specific training in PPI and the specific use of intervention manuals. They implemented both interventions with the aid of the co-therapists (for details, see Chaves et al., 2016).

Measures

Assessments were carried out by clinical psychologists who were blind to treatments. Eligibility for this study was assessed individually using the Structured Clinical Interview for DSM-IV (SCID-I; First et al., 1996). Participants also answered some demographic and clinical questions through a structured interview (e.g., previous psychological or pharmacological treatments, family history of mental problems). A wide protocol of self-report measures covering different aspects of cognitive and emotional components was also administered at the beginning and the end of the intervention - for details see Chaves et al. (2016).

Along with the pre- and post-assessment, participants completed two inter-session assessments of depressive symptoms and well-being in order to explore the patterns of changes during the intervention. Thus, four assessment points (pre-, first inter-sessions, second inter-sessions, and post-assessment) were used in the study. Depressive symptoms were measured with the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996; Sanz, Navarro, & Vazquez, 2003; $\alpha = .87$), and well-being was measured with the Pemberton Happiness Index (PHI; Hervas & Vazquez 2013; $\alpha = .79$). The PHI is an integrative measure of well-being that includes eleven items related to different domains of well-being. As in

most extant measures of psychological well-being, individuals are asked to make a retrospective evaluation on several domains of their life (i.e., general, emotional, eudaimonic, and social well-being). In the PHI, this retrospective or remembered well-being ($PHI_{rem)}$ is complemented with a measure of the actual well-being experienced the day before. The PHI asks participants to respond whether or not they have experienced a number of experiences with an emotional content (5 negative, 5 positive)[3] in the last 24 hours. This additional information on well-being, similar to the one gathered in instruments like the Day Reconstruction Method (Kahneman, Krueger, Schkade, Schwarz, & Stone, 2004), is less subjected to memory biases than retrospective or evaluative assessments of well-being (Hervas & Vazquez, 2013). For this study, positive (PHI_{pos}) and negative (PHI_{neg}) experiences were analyzed separately. PHI_{pos} and PHI_{neg} scores ranged from 0 to 5. Total PHI ranged from 0 to 10.

Pre-treatment assessment was conducted one week before starting the intervention and post-assessment took place one week after the end of the intervention. Inter-session assessments were conducted prior to the start of session 4 and 7 for both treatments in order to capture changes in two middle points of the therapy besides the pre- and post-treatment assessments.

Data Analysis

An Intention to treat (ITT) approach was applied to the data. Following Newman's recommendations (2014), a Maximum Likelihood (ML) estimate was performed via EM algorithm. Chi-square and *t*-tests were used to confirm that there were no significant initial

[3] Positive experiences were *"Something I did made me proud", "I did something fun with someone", "I did something I really enjoy doing", "I learned something interesting",* and *"I gave myself a treat".* Negative experiences were *"At times, I felt overwhelmed", "I was bored for a lot of the time", "I was worried about personal matters", "Things happened that made me really angry",* and *"I felt disrespected by someone".*

differences between intervention conditions in regard to demographic variables. Additionally, mixed-model repeated measures ANOVAs on the BDI-II, PHI remembered well-being subscale (PHI_{rem}), PHI Positive experiences subscale (PHI_{pos}) and PHI Negative experiences subscale (PHI_{neg}) were separately conducted to compare direct scores between the two treatments across four assessment points (pre, inter-session 1, inter-session 2, post), confidence intervals adjusted by the Bonferroni procedure. When the sphericity assumption was violated, Greenhouse-Geisser correction was applied. Finally, to analyze the pattern of improvement over time, the same analyses were performed using the percentage of improvement observed in three different time periods (i.e., T1→T2: from pre-treatment session to first inter-session assessment; T2→T3: from first to second inter-session assessment; T3→T4: from second inter-session assessment to post-treatment assessment) on outcome measures. Relative percentage of improvement was defined as the partial contribution of each of the three time periods to the total improvement observed from pre- to post-assessment. Improvement was defined, in the four different outcome variables, as the reduction in depressive symptoms (BDI-II) and negative experiences (PHI_{neg}) and the increase in remembered well-being (PHI_{rem}) and positive experiences (PHI_{pos}). Deterioration in outcome variables, from one assessment time to the next one, was coded as zero improvement. Consequently, the sum of the three relative percentages of improvement for each outcome is 100%. Arcsin transformations were applied to the variables of percentage of improvement due to their non-normality in order to conduct a series of mixed-model repeated measures ANOVAs. Data were analyzed using SPSS (version 20.0).

Results

Baseline characteristics

Table 1 displays the main baseline characteristics of participants. No significant differences were found in demographics, clinical characteristics, and primary outcomes (BDI-II and PHI) at baseline between the two intervention conditions (see Table 1).

Regarding dropouts, no significant difference was found among intervention conditions (p = .87). Eleven participants (16.7%) dropped out in the CBT condition and twelve (19.4%) in the PPI condition (for details about attendance and adherence to the interventions, see Lopez-Gomez et al., 2017). Completed data on the four assessment points were collected for 43 participants (65.1%) in the CBT condition and for 40 participants (64.5%) in the PPI condition. Following an ITT model, missing data were imputed analyzing all the assigned participants to each condition.

Table 1.
Baseline characteristics

	CBT (n = 66)	PPI (n = 62)	Group differences
Demographic characteristics			
Mean age	50.94 (10.98)	53.18 (10.10)	t = –1.20, p = .23
Married or cohabitating, %	66.7	58.1	χ^2 = .68, p = .41
Primary or lower studies, %	56.1	51.6	χ^2 = .11, p = .74
Employed, %	15.1	16.1	χ^2 = .001, p = 1
Clinical characteristics			
Mean BDI-II score	37.42 (10.68)	34.66 (10.13)	t = 1.49, p = .14
Mean PHI total score	3.63 (1.69)	3.96 (1.75)	t = –.97, p = .33
Severe depressive symptoms (BDI-II ≥ 29), %	80.03	72.6	χ^2 = .68, p = .41
Any other current Axis I diagnosis, %	65.1	48.4	χ^2 = 3.01, p = .08
Antidepressant medication, %	63.6	59.7	χ^2 = .08, p = .78
Mean number of sessions attended	7.43 (2.42)	7.13 (2.78)	t = .64, p = .52

Note. Standard deviations are shown in parenthesis; CBT = cognitive-behavioral therapy; PPI = positive psychology interventions; BDI-II = Beck Depression Inventory-II; PHI = Pemberton Happiness Index.

Analyses of outcome measures scores during interventions

Patterns of changes during interventions were firstly explored via analyses of outcome measures scores in the four assessment points to test the study's first hypothesis that expected that a significant improvement in depressive symptoms and well-being would be found across all four assessment points, regardless of intervention condition. Mean and standard deviations in outcome measures are shown in Table 2.

Table 2.
Mean and standard deviations in outcome measures

		T1 (pre)	T2 (4^{th} session)	T3 (7^{th} session)	T4 (post)
BDI-II	CBT	37.42 (10.68)	29.34 (10.87)	25.16 (10.68)	22.91 (12.89)
	PPI	34.66 (10.13)	25.91 (10.86)	21.71 (10.54)	17.89 (10.02)
PHI_{rem}	CBT	3.55 (1.76)	4.16 (1.89)	4.65 (1.88)	4.86 (2.04)
	PPI	3.83 (1.82)	4.27 (1.77)	5.10 (1.84)	5.67 (1.77)
PHI_{neg}	CBT	2.77 (1.48)	2.39 (1.20)	2.68 (1.41)	2.09 (1.36)
	PPI	2.66 (1.51)	2.47 (1.25)	2.44 (1.27)	1.93 (1.26)
PHI_{pos}	CBT	2.29 (1.67)	3.05 (1.15)	2.99 (1.49)	3.33 (1.33)
	PPI	2.66 (1.76)	2.96 (1.30)	3.30 (1.18)	3.71 (1.16)

Note. T1= pre-assessment; *T2*= first inter-sessions assessment; *T3*= second inter-sessions assessment; *T4*= post-assessment; *CBT* = cognitive-behavioral therapy; *PPI* = positive psychology interventions*; BDI-II* = Beck Depression Inventory-II; PHI_{rem} = Pemberton Happiness Index, remembered well-being; PHI_{neg} = Pemberton Happiness Index, negative experiences; PHI_{pos} = Pemberton Happiness Index, positive experiences.

A mixed-model repeated measures ANOVA of the BDI-II was performed for all participants who entered the study (N = 128). The effect for Time was significant, Greenhouse-Geisser corrected $F(3, 320) = 138.50$, $p < .001$, $\eta_p^2 = .52$, and post-hoc tests showed that depressive symptoms significantly decreased across all assessment points ($ps < .001$). A trend analysis revealed a significant linear trend, $F(1, 126) = 277.00$, $p < .001$, and a significant quadratic trend, $F(1, 126) = 19.67$, $p < .001$. Figure 1 shows how the curvature imposed by the quadratic function is superimposed on a decreasing linear trend. There was no

significant interaction Intervention condition x Time, Greenhouse-Geisser corrected $F(3, 320) = .70$, $p = .55$, $\eta_p^2 = .01$.

A series of mixed-model repeated measures ANOVAs of the subscales of PHI were performed for all participants. In the case of PHI_{rem}, the effect for Time was significant, Greenhouse-Geisser corrected $F(3, 331) = 52.40$, $p < .001$, $\eta_p^2 = .29$. Post-hoc tests for Time indicated that remembered well-being significantly increased across all assessment points (*ps* $\leq .005$). A trend analysis revealed a significant linear trend, $F(1, 126) = 113.87$, $p < .001$, that is reflected in Figure 1. No significant interaction Intervention condition x Time was found, Greenhouse-Geisser corrected $F(3, 331) = 2.38$, $p = .08$, $\eta_p^2 = .02$.

An ANOVA of the PHI_{pos} yielded a significant effect for Time, Greenhouse-Geisser corrected $F(3, 331) = 18.22$, $p < .001$, $\eta_p^2 = .13$. Post-hoc tests for Time showed that positive experiences significantly increased between T1 and T2 and between T3 and T4 (*ps* < .04). A trend analysis revealed a significant linear trend, $F(1, 126) = 48.13$, $p < .001$, that is shown in Figure 1. There was no significant interaction Intervention condition x Time, Greenhouse-Geisser corrected $F(3, 331) = 1.21$, $p = .30$, $\eta_p^2 = .01$.

An ANOVA of the PHI_{neg} showed a significant effect for Time, $F(3, 378) = 9.61$, $p < .001$, $\eta_p^2 = .07$. Post-hoc tests for Time revealed that negative experiences only decreased significantly between T3 and T4 ($p < .001$). A trend analysis yielded a significant linear trend, $F(1, 126) = 18.34$, $p < .001$, and a significant cubic trend, $F(1, 126) = 6.76$, $p = .01$. Figure 1 shows how the cubic trend (characterized by two changes in the direction of the trend) is superimposed on a decreasing linear trend. Results revealed no significant interaction Intervention condition x Time, $F(3, 378) = .50$, $p = .68$, $\eta_p^2 = .004$.

In summary, as shown in Figure 1 and in the results mentioned above, only depressive symptoms and remembered well-being followed the expected pattern in time proposed in the first hypothesis. Depressive symptoms decreased along the interventions, showing significant

differences across all assessment points and remembered well-being increased along the interventions, showing also significant differences across all assessment points. There was no significant interaction between time and intervention condition in any measure analyzed.

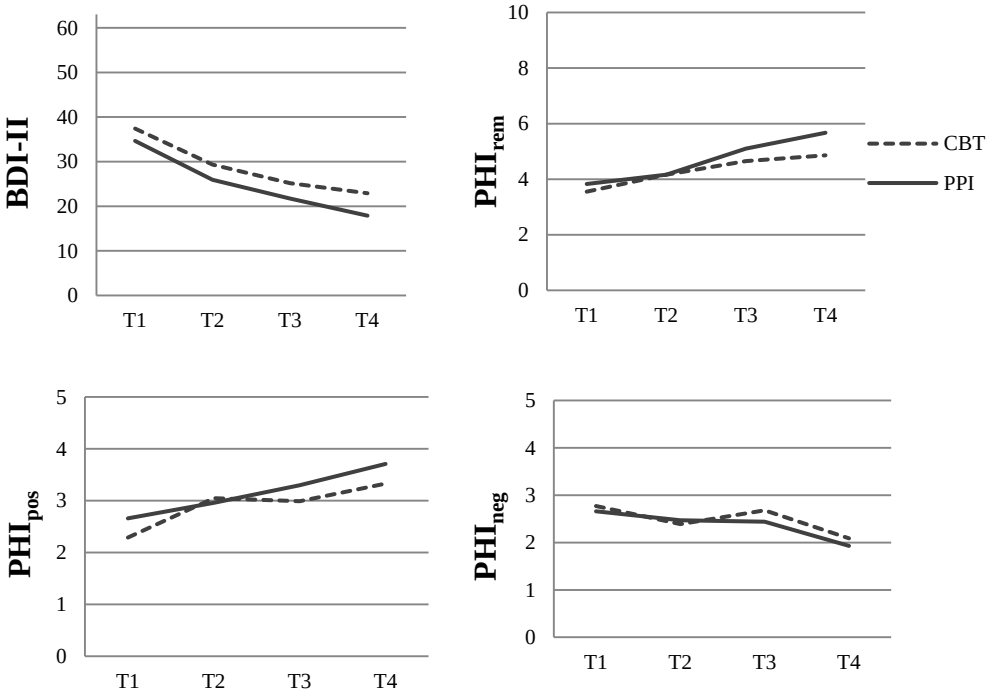

Figure 1. Changes during interventions in outcome measures (mean scores) in the four assessment points; *T1*= pre-assessment; *T2*= first inter-sessions assessment; *T3*= second inter-sessions assessment; *T4*= post-assessment; *CBT* = cognitive-behavioral therapy; *PPI* = positive psychology interventions; *BDI-II* = Beck Depression Inventory-II; PHI_{rem} = Pemberton Happiness Index, remembered well-being; PHI_{neg} = Pemberton Happiness Index, negative experiences; PHI_{pos} = Pemberton Happiness Index, positive experiences.

Analysis of percentages of improvement during interventions

The second hypothesis proposed that both depressive symptoms and well-being would show higher percentage of improvement in the first period of treatment than in the following ones, regardless of condition. Mixed-model repeated measures ANOVAs were performed on

the percentage of improvement in the outcome measures between T1→T2 period, T2→T3 period and T3→T4 period across intervention conditions.

Results of the ANOVA of the percentage of improvement in the BDI-II indicated a significant effect for Time, Greenhouse-Geisser corrected $F(2, 231) = 9.56$, $p < .001$, $\eta_p^2 = .07$. Post-hoc tests for Time showed significant differences between T1→T2 period and both T2→T3 and T3→T4 (*ps* < .005) in a way in which the percentage of improvement (i.e., decrease) in depressive symptoms in the first period of intervention was significantly higher than the percentage of improvement in the second and third period, as was hypothesized. Also, as hypothesized, no significant interaction Intervention condition x Time was found, Greenhouse-Geisser corrected $F(2, 231) = .50$, $p = .61$, $\eta_p^2 = .004$.

A series of ANOVAs of the percentage of improvement in the subscales of PHI was also performed for all participants. With regard to PHI_{rem}, no significant effects were found for Time and the interaction Intervention condition x Time, $F(2, 246) = 1.93$, $p = .15$, $\eta_p^2 = .01$ and $F(2, 246) = 1.80$, $p = .17$, $\eta_p^2 = .01$, respectively.

Results of the ANOVA of the percentage of improvement in the PHI_{pos} indicated a significant effect for Time, $F(2, 234) = 3.13$, $p = .046$, $\eta_p^2 = .03$, although specific post-hoc tests for Time did not reveal significant differences between periods of intervention (*ps* > .08). These results indicated that positive experiences increased differently along the three periods of the intervention, although these differences did not reach statistical significance when comparing specific periods of time. The interaction Intervention condition x Time was not significant, $F(2, 234) = .96$, $p = .38$, $\eta_p^2 = .01$.

The ANOVA of the percentage of improvement in the PHI_{neg} showed a significant effect for Time, $F(2, 234) = 3.86$, $p = .02$, $\eta_p^2 = .03$ and post-hoc tests revealed that the decrease of negative experiences in the T3→T4 was significantly higher than in the T1→T2

period (p = .04). The Intervention condition x Time interaction was not significant, $F(2, 234) = .36$, $p = .70$, $\eta_p^2 = .003$.

Results (see Figure 2) indicated that BDI-II showed the expected pattern proposed in the second hypothesis. Post-hoc analyses revealed that, in the first period, the percentage of improvement over the total improvement was significantly higher than in the following periods. The improvement over time for Positive experiences followed a similar significant pattern although post-hoc tests did not reach statistical significance. Contrary to our hypothesis, the percentage of improvement in remembered well-being was not significantly different in the first period of interventions compared to the following ones. Thus, the percentage of improvement across treatment was homogeneous for both intervention conditions. Interestingly, time-related changes in experiencing negative emotions was significant but in an opposite direction to which it was expected. Post-hoc tests revealed that negative experiences decreased significantly more in the third period of the intervention than in the first one.

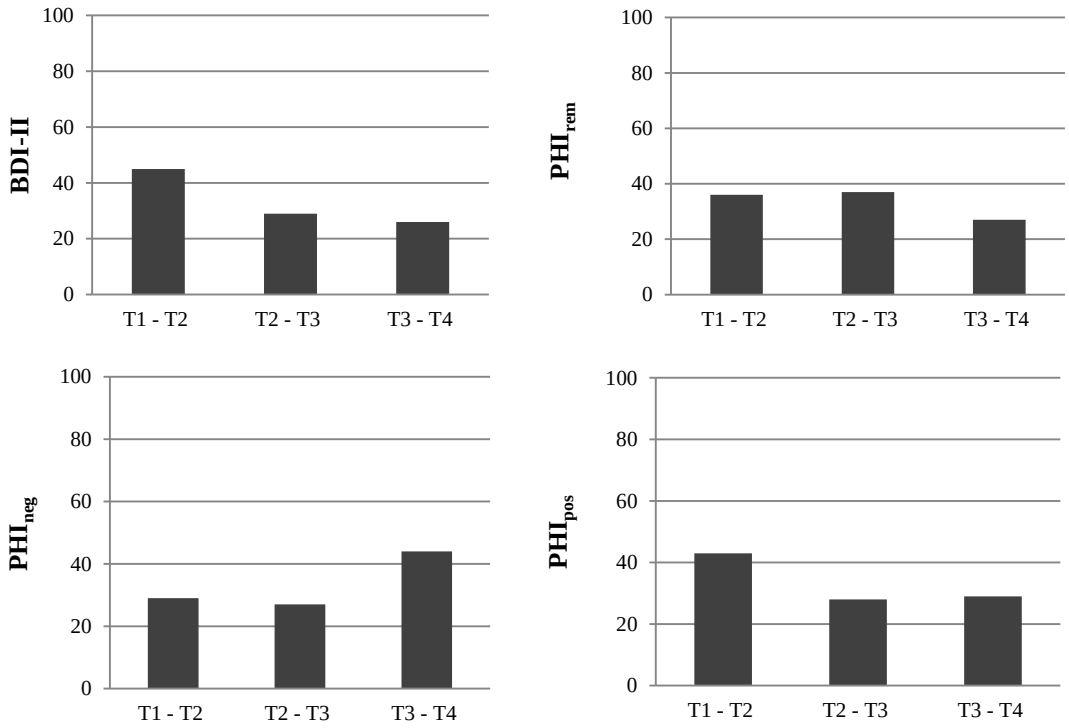

Figure 2. Percentage of improvement in outcome measures in the three time periods; *T1→T2* = period from pre- to first inter-sessions assessment, *T2→T3* = period from first to second inter-sessions assessment, *T3→T4* = period from second inter-sessions- to post- assessment. Data presented in this figure correspond to the total sample (*N* = 128). *BDI-II* = Beck Depression Inventory-II; PHI_{rem} = Pemberton Happiness Index, remembered well-being; PHI_{neg} = Pemberton Happiness Index, negative experiences; PHI_{pos} = Pemberton Happiness Index, positive experiences.

Discussion

The study's first hypothesis was that significant improvement in depressive symptoms and well-being would be found across all four assessment points, regardless of intervention condition. Results have confirmed this pattern in the case of depressive symptoms and in remembered well-being, coherently with the dose-effect model (Howard et al., 1986). However, changes in positive and negative experiences across assessment points did not follow this pattern. Changes in positive experiences in the 24 hours before the assessment

were significant in the first period of intervention (T1→T2) and the third one (T3→T4), whereas in the case of negative experiences a significant change was found only in the third period of intervention (T3→T4). It is possible that the unstable nature of these measures related to emotional experiences happening the day before may help to explain why positive and negative experiences change in a less uniform way across treatment in both intervention conditions, compared to the other measures. The differential results found between the remembered well-being and the experienced well-being subscales emphasize the importance of using both kinds of measures that provide relevant information and help to understand better the complexity of well-being. As expected, the results of the study confirmed that there were no significant differences in terms of change during intervention among CBT and PPI on the measures analyzed. Depressive symptoms decreased and well-being increased similarly during both interventions.

The second hypothesis proposed that depressive symptoms and well-being would show higher percentage of improvement in the first period of treatment than in the following ones, regardless of intervention condition. The results on the BDI-II fully confirmed this hypothesis. This improvement in symptoms at the very beginning of the therapy could be explained by the content of the first modules of both intervention protocols, which were mainly focused on hedonic components in both approaches. This initial emphasis on hedonic elements could also explain that the same pattern of improvement was found in relation to positive experiences lived the 24 hours before the assessment although, in this case, the post-hoc tests did not reach statistical significance for this measure. Interestingly, these results suggest that positive experiences are relatively easy to increase during a hedonic module, compared with decreasing negative experiences. In fact, literature has shown the importance of positive emotions and experiences in depression. For example, studies have suggested that the ability of experiencing positive emotions in daily life is related to a reduced risk of

becoming depressed in individuals with a genetic risk and an early change in positive emotions predicts better the response to antidepressants than changes in negative emotions (Geschwind et al., 2011; Wichers et al., 2007). In the case of negative experiences, the percentage of improvement in negative experiences in the last period of intervention was significantly higher than in the first period. This result is in line with the previous one about mean scores; the difference in negative experiences mean score between T3 and T4 was the only significant change during intervention in this measure. It is also interesting to note that a reduction in depressive symptoms it is not necessarily accompanied by a reduction in daily negative emotional experiences experienced by the participants, as it is showed in the results regarding depressive symptoms and negative experiences in the first period of intervention. In fact, literature has extensively shown that people with depression experience numerous stressors in their daily life (Hammen, 2005). Therefore, these kinds of negative experiences lived by the participants may need more time to decrease, compared with the increase in positive experiences, as they may require difficult changes to be made in the participants' lives and, to some extent, these circumstances do not entirely depend upon the individual. Additionally, remembered well-being showed no significant differences between the percentages of improvement which occurred during the different time periods. As it has been mentioned before, this result may be due to the nature of the measure. PHI remembered well-being subscale assesses each participant's judgment of general well-being and the cognitive nature of this type of well-being measures could explain a slower and more gradual change compared with the changes in experiences and symptoms.

In sum, the second hypothesis was confirmed in the case of depressive symptoms, with a higher percentage of improvement in the first period of the interventions than in the following ones. This result supports the idea of a negatively accelerated rate of change stated by recent literature in the field (Lutz et al., 2001; Stulz et al., 2013). The same pattern of

initial accelerated change was also found in regard to positive experiences, although differences did not reach the statistical significance in the post-hoc tests. However, the patterns of improvement in negative experiences and remembered well-being did not support our hypothesis.

According to what was expected, no significant differences were found in the pattern of improvement between treatments. Despite having different therapeutic goals, PPI and CBT led to improvements in symptoms and well-being to a similar extent during treatment, although the mechanisms of action need to be studied further. This fact supports the relevance of hedonic ingredients in CBT (i.e., increasing pleasant activities).

One key limitation of the study is that data were only available for four assessment points. It must be taken into account that progress of participants was not measured session-by-session as in other studies (Falkenström, Josefsson, Berggren, & Holmqvist, 2016; Stulz et al., 2013).

Secondly, the measure of well-being applied is a relatively new one that includes two subscales of experienced well-being, the positive experiences subscale and the negative experiences subscale (Hervas & Vazquez, 2013). They include a selection of positive and negative experiences that were chosen from a total of 16 items related to specific experiences that can generally happen the day before in the general population. The final list of items included in the scale were those that were more related to participant's overall well-being experienced the day before across countries (see Hervas & Vazquez, 2013). Consequently, it could be possible that a different pattern of results might emerge if a different set of experiences were assessed.

Several implications can be drawn from the results presented. Firstly, differences found between measures of depressive symptoms and well-being point out the need to carry out assessments that include clinical measures, as well as measures of well-being, satisfaction

and good functioning. It is not usual in clinical trials of depression to include both clinical and positive mental health measures. Yet, both from a theoretical point of view (e.g., Diaz, Blanco, Horcajo, & Valle, 2007; Keyes, 2005) and a practical perspective (e.g., Demyttenaere et al., 2015a; 2015b; Zimmerman et al., 2006) it seems clear that changes in clinical symptoms and well-being do not run in parallel and both should be monitored separately. Consequently, one of the strengths of this study is the inclusion of measures of depression and well-being, covering the complexity of what mental health consists of.

The use of a well-being measure (i.e., the PHI) that covers both experiences as well as general judgements has helped to highlight their differential pattern of change. Being more satisfied in general does not necessarily imply having less negative experiences as it is possible that these experiences are to some extent out of the control of the individual (e.g., being ignored by another person). It is also interesting that symptoms and positive experiences showed a similar pattern of change, which may reflect an intrinsic relationship between them. Once again, these results highlight the importance of positive functioning in recovery and remission for depression (Demyttenaere et al., 2015a; 2015b; Zimmerman et al., 2006).

A key point that can be inferred from the results at the end of treatment is the absence of floor effects. In other words, given the observed trajectories of change, it seems plausible that if the treatments had included more sessions or had been longer in time, the improvements might have steadily continued. Additionally, studying a sample of clinically depressed participants constitutes a strength of the study since it helps to analyze how changes occur during treatment in a clinical sample and how long treatments should be for them (Hansen et al., 2002).

Discovering patterns of change is an area that deserves future attention in therapy research. Also, new perspectives from network theory (Borsboom & Cramer, 2013) may also

contribute to shed light on the dynamics of change. It is likely that changes in certain symptoms (or subset of symptoms) may initiate a cascade of changes in other connected symptoms. Although our results reflect that both treatments work similarly, it could be possible that chains of changes in symptoms could be different between different therapeutic modalities. Network analyses of dynamics of symptom or emotion changes might also provide valuable information on tipping points (i.e., moments that predict an immediate and to some extent unavoidable change of state) – Hofmann, Curtiss, & McNally (2016). For instance, van de Leemput et al. (2014) found that a critical slowing down in negative and positive mood dynamics can predict immediate transitions into and out of depression. Therefore, future research should explore the field of the dynamics of change using perspectives that may enhance our current limited knowledge on the underlying processes of change.

This study focused on the pattern of change of well-being and depressive symptoms during psychological treatment. Although the pattern of change for depressive symptoms confirmed previous results (i.e., decelerating curve of improvement), well-being progress showed a different pattern, more gradual. It will be important to explore how these discrepancies in the patterns of change may affect the therapeutic outcomes and the psychological functioning of the individuals in the long term. Thus, exploring not only symptom trajectories but also well-being can shed light on how treatments work and how to improve their outcomes.

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ARTÍCULO 3

Comparing the acceptability of a positive psychology intervention versus a cognitive-behavioral therapy for clinical depression

[Comparación de la aceptabilidad de una intervención basada en psicología positiva frente a una terapia cognitivo-conductual para depresión clínica]

Clinical Psychology & Psychotherapy
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El tercer artículo de la tesis es *Comparing the acceptability of a positive psychology intervention versus a cognitive-behavioral therapy for clinical depression* (*Clinical Psychology & Psychotherapy*, en prensa, https://doi.org/10.1002/cpp.2129).

En él se aborda la aceptabilidad de los programas de intervención, es decir, la adherencia y satisfacción que generaron entre las participantes. Los resultados confirmaron que los programas de intervención promovieron una alta adherencia, sin diferencias significativas entre ambos. En cuanto a la satisfacción, las participantes del programa de IPP se mostraron más satisfechas que las del programa de TCC en varias medidas.

Comparing the acceptability of a positive psychology intervention versus a cognitive-behavioral therapy for clinical depression

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Abstract

There is growing evidence on the efficacy of positive psychology interventions (PPI) to treat clinical disorders. However, very few studies have addressed their acceptability. The present study aimed to analyze two key components of acceptability (i.e., client satisfaction and adherence to treatment) of a new PPI programme, the Integrative Positive Psychological Intervention for Depression (IPPI-D), in comparison to a standard CBT programme in the treatment of clinical depression. One hundred twenty-eight women with a DSM-IV diagnosis of major depression or dysthymia were allocated to a 10-session IPPI-D or CBT group intervention condition. Results showed that both interventions were highly acceptable for participants. Attendance rates were high and there were no significant differences between conditions. However, the IPPI-D condition showed significantly higher client satisfaction than the CBT condition. Moreover, acceptability did not differ based on participants' severity of symptoms, regardless of condition. These findings encourage further investigations of the applicability of PPI in clinical settings in order to broaden the range of acceptable and suitable therapies for depressed patients.

Keywords: Acceptability, Adherence, Client satisfaction, Cognitive-behavioral therapy, Major depression, Positive psychology.

Key Practitioner Message

- This study sheds light on the client satisfaction and adherence to a positive intervention.
- For participants, positive psychology interventions (PPI) may be more satisfactory than CBT as PPI are framed within a positive mental health model and, consequently, may reduce the risk of stigmatization
- Because acceptability of treatments and preferences may affect the efficacy of treatments, this study provides an excellent opportunity to offer professionals more therapeutic options to tailor treatments to clients' needs and expectations.

Introduction

New models of health care, both for physical and mental health problems, emphasize the need of finding interventions that are ‘feasible, low-cost (affordable), and appropriate to implement within the constraints of a local health system’ (WHO, 2011, p. 2). With regard to psychological treatments, the Consolidated Standards of Reporting Trials Statement (CONSORT) considered the assessment of credibility and acceptability of treatments an essential aspect in the evaluation of their quality (Moher, Schulz, & Altman, 2001). The development of new interventions based on positive psychology principles, provides an excellent opportunity to address this issue. As it has been the case in other types of interventions (Hayes, Long, Levin, & Follette, 2013), most of the research on the utility of these new positive interventions is still mainly focused on their efficacy (Bolier et al., 2013; Weiss et al., 2016). Yet, paying more attention to research on the acceptability of these interventions could provide relevant information on their applicability and utility relative to other interventions.

This general lack of research on acceptability is particularly problematic for the treatment of common mental health problems, like anxiety or depression, because available evidence-based treatments are not fully satisfactory to promote clinically significant changes in the majority of patients (Cuijpers, van Straten, Andersson, & van Oppen, 2008). The high rates of dropouts (Fernandez, Salem, Swift, & Ramtahal, 2015; Hans & Hiller, 2013) and the high number of residual symptoms after treatment (Paykel, 2008) lead some experts to consider that the overall quality of available treatments for depression is poor (McIntyre & O’Donovan, 2004). In conclusion, as the NICE guidelines for depression have emphasized, there is a need for more research about the acceptability and practicality of available treatment options (NICE, 2009).

One of the most widely used definitions of treatment acceptability was proposed by Kazdin (2000). He defined it as the extent to which consumers (e.g., clients, patients) found a particular procedure or intervention to be fair, appropriate, and consistent with their expectations of treatment. Examining acceptability allows us to determine whether treatments are satisfactory for both clients and practitioners and whether they are ready to be disseminated and implemented with success in real settings (Lennox & Miltenberger, 1990). From an applied perspective, premature discontinuation of treatment is a major concern (Cahill et al., 2003). Professionals need treatments that are not only efficacious, but also likely to be followed and completed by clients. Together, these characteristics increase the probability of full recovery, highlighting that client's perception of treatment is highly valuable. Previous research has pointed out that interventions that are acceptable are more likely to be sought out and followed by participants once they have entered into treatment (Reimers, Wacker, Cooper, & DeRaad, 1992; Kazdin, 1996). Therefore, treatment acceptability is an important topic as it could be a path for reducing the rates of therapeutic non-compliance, one of the main challenges that clinicians face (Chabrol, Teissedre, Armitage, Danel, & Walburg, 2004).

Typical indicators of treatment acceptability are adherence and client satisfaction (Andrews, Cuijpers, Craske, McEvoy, & Titov, 2010). In the case of psychotherapy for depression, dropout rates (i.e., a common proxy indicator of adherence) have ranged between 0% and 43% (Cuijpers et al., 2008; Swift & Greenberg, 2014). When comparing different psychotherapy modalities for depression (i.e., cognitive-behavioral therapy; CBT, nondirective supportive therapy, behavioral activation therapy, psychodynamic therapy, problem-solving therapy, interpersonal psychotherapy and social skills training), CBT, despite its extended use and being one of the most researched therapeutic options, has shown a significantly higher dropout rate than other psychotherapy modalities, while problem-

solving therapy has shown the lowest dropout rate (Cuijpers, van Straten, Andersson, & van Oppen, 2008). Some meta-analytic evidence has shown that, when CBT dropout rates have been compared among different diagnoses, the highest rate is found in depression (36.4%), far from the average dropout rate (26.2%) found in CBT interventions for other mental health problems (Fernandez et al., 2015). Other recent meta-analyses have suggested lower rates when establishing a difference between randomized and non-randomized clinical trials for depression. These meta-analyses have found that the dropout in CBT was 17% in randomized clinical trials (Cooper & Conklin, 2015) and 25% in non-randomized effectiveness studies (Hans & Hiller, 2013). Concerning the acceptability of group CBT for depression, a meta-analysis showed a striking result: there were no significant differences in dropout rates between group CBT and non-active control conditions (Okumura & Ichikura, 2014). The same result was obtained when comparing group CBT with middle-intensity group-based psychosocial interventions (e.g., relaxation training, psycho-education) (Okumura & Ichikura, 2014).

A more direct way to examine acceptability is exploring client satisfaction. Surprisingly, there are only a few studies comparing interventions for depression on client satisfaction. In a pioneer study, Scott & Freeman (1992) compared antidepressant medication, CBT by a psychologist, counselling and case work by a social worker and routine care by a general practitioner. At a significant level, participants reported that counselling and case work better met their needs as compared to both CBT and routine care for their problems. Additionally, counselling and case work showed a higher score on global evaluation of treatment than routine care or antidepressant medication. In another study, Ward et al. (2000) compared CBT with non-directive counseling and standard care for depressed patients. Client satisfaction scores at the 4-month follow-up were higher in both psychotherapy groups compared with standard care. However, a 12-month follow-up revealed that only patients in

the non-directive counselling condition were significantly more satisfied than the ones in the standard care condition. In general, this overall pattern of results reveals that, when compared to other psychological treatments, treatment acceptability for CBT, despite its high efficacy, is relatively lower. Given the growing popularity of evidence-based PPI, and their demonstrated efficacy (Bolier et al., 2013; Sin & Lyubormirsky, 2009), it becomes relevant to address their acceptability in order to tailor treatments to clients' needs and expectations, as the person-activity model has proposed (Layous & Lyubomirsky, 2013). In one of the few studies that has analyzed acceptability of PPI, Schueller and Parks (2012) explored the use and enjoyment of positive psychology exercises in a website intervention aimed at reducing depressive symptoms in a non-clinical sample from the general population. Even though there were no significant differences in the use of the exercises available, in 5 of the 6 exercises enjoyment was positively associated with the extent of use at the 6-week follow-up. A similar study using positive psychology online exercises in a broad non-clinical sample showed that participants liked the positive psychology exercises more than the placebo control exercises (Gander, Proyer, & Ruch, 2016). Additionally, participants also reported more personal benefit from positive psychology exercises than from the placebo control exercises. This research group has also found indicators, in line with the person-activity model (Layous & Lyubomirsky, 2013), that predicted happiness and depressive symptoms 3.5 years after completion of a positive psychology intervention in a non-clinical sample (Proyer, Wellenzohn, Gander, & Ruch, 2015). Specifically, these authors found that continued practice, preferences for some exercises, and early reactivity in happiness predicted long term changes in happiness. However, only continued practice and early reactivity in depression predicted long term changes in depression. Although PPI have also been used to treat clinical disorders (e.g., Fava et al., 2005; Johnson, Gooding, Wood, Fair, & Tarrier, 2012; Meyer, Johnson, Parks, Iwanski, & Penn, 2012; Riches, Schrank, Rashid, & Slade,

2016; Seligman, Rashid, & Parks, 2006), very few studies have assessed the acceptability of these interventions. In an interesting exception, Huffman et al. (2014) applied nine positive psychology exercises aimed at decreasing hopelessness and increasing optimism in patients hospitalized for suicidal thoughts or behaviors. Although there was no control condition, participants completed almost 90% of assigned exercises and perceived them as easy to complete, with no significant differences between exercises. Similarly, in a pilot study of positive psychotherapy for people with schizophrenia, with no control condition, Meyer et al. (2012) found that the intervention was feasible as evidenced by the high rates of attendance (similar rates to other effective interventions for schizophrenia) and the amount of practice outside the group reported by participants. Kahler et al. (2015) assessed the feasibility and acceptability of a positive smoking cessation intervention for smokers with low positive affect. Client satisfaction and enjoyment of the treatment's positive focus were very high. Attendance was also high, and although the sample was too small to draw strong conclusions, participants reported a moderate to extreme perceived usefulness of the programme.

Research comparing multicomponent programmes based in positive psychology with other programmes has yielded mixed results. A study comparing positive psychotherapy with dialectical behavior therapy (DBT) in university students with significant psychopathology (Uliaszek**,** Rashid, Williams, & Gulamani, 2016) showed that attrition was significantly higher and attendance significantly lower in the positive psychotherapy group than in the DBT group. However, another recent study comparing a combined group programme of CBT and PPI with treatment as usual (TAU) in clinically depressed participants found no differences in attrition, and preliminary findings revealed a superior efficacy of the combined programme (Carr, Finnegan, Griffin, Cotter, & Hyland, 2016). In sum, despite increasing interest in this research area, evidence on the acceptability of PPI is still limited, especially in people suffering from severe psychological disorders.

A recent study with a large sample of several hundred patients with clinical depression has shown that there is a high discrepancy between the therapeutic goals of practitioners versus clients. While doctors and psychiatrists in this study considered reducing symptoms to be the main goal of therapy, patients believed that treatment should be aimed at increasing their life satisfaction and general well-being (Demyttenaere et al., 2015a) and the magnitude of this discrepancy positively predicted a worse response to the treatment at 6 months (Demyttenaere et al., 2015b). Thus, it is possible that positive interventions improve the acceptability of therapy for depression as they may better align with patients' expectations for the key therapeutic targets. A fact that should not be ignored is that a large number of people with mental health problems do not seek help (e.g., Thompson, Hunt, & Issakidis, 2004). This is especially true in the case of people who are less prone to reveal personal thoughts and feelings or those who experience stigma associated with their psychological problems (Vogel, Wester, & Larson, 2007). It is possible that using a positive mental health framework accompanied by specific techniques focused on enhancing well-being might help reduce the treatment gap found for many psychological difficulties (e.g., Thompson et al., 2004). Some individuals may be more willing to receive help through approaches focused on increasing well-being rather than receiving treatments focused on mental symptoms and difficulties.

The study of interventions' acceptability is still a novel area and more research is needed to clarify the relationship between acceptability and efficacy of the treatments that are implemented in the clinical practice. The aim of the present study was to test the acceptability of the IPPI-D programme in comparison to a standard CBT programme in the treatment of clinical depression. Based on the previous studies just described (Carr et al., 2016; Demyttenaere et al., 2015a; 2015b), the first hypothesis was that the IPPI-D programme would be more acceptable (i.e., have greater adherence and client satisfaction) than the CBT

programme. Additionally, based on previous research showing that psychological interventions, whether CBT treatments (DeRubeis et al., 2005) or PPI (Chaves, Lopez-Gomez, Hervas, & Vazquez, 2017), are efficacious for severely depressed patients, the second hypothesis was that acceptability would not differ based on the severity of participants' symptoms.

Methods

Design and participants

One hundred twenty-eight women with a DSM-IV-TR (APA, 2000) diagnosis of major depressive disorder or dysthymia were blindly allocated to the IPPI-D (n = 62) or CBT (n = 66) intervention condition (for details, see Chaves et al., 2017; Lopez-Gomez, Chaves, Hervas, & Vazquez, 2017). Figure 1 illustrates the participants CONSORT diagram[4].

Participants were adults (mean age = 52.02; *SD* = 10.58) recruited in a women's center, linked to the community health system. Women directly applied for the intervention programmes or were referred by a local healthcare agency. The Faculty Ethics Committee approved the study protocol and participants signed an informed consent document in order to participate in the study. Exclusion criteria for the study were: substance abuse or dependence disorder (present), manic or hypomanic episodes (past or present), psychotic disorder (past or present), and a cognitive status (e.g., dementia or intellectual disability) that might prevent participants to follow the interventions.

[4] The previous article of this study (Chaves et al., 2017) analyzed 96 participants, which was the sample size of the study at that time.

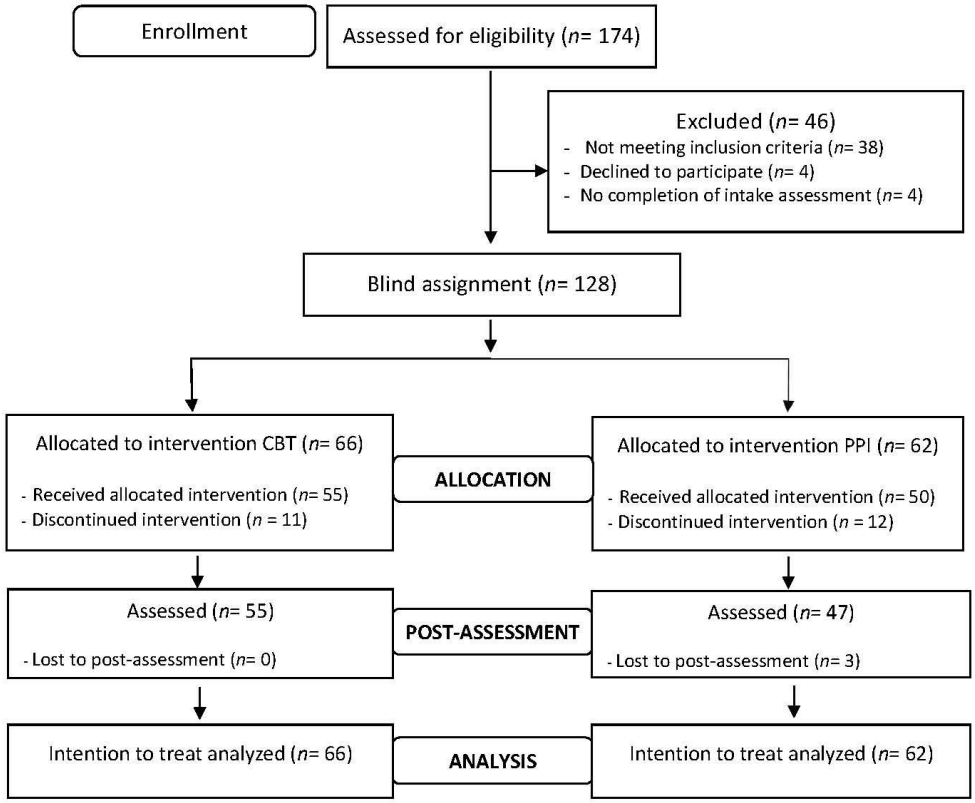

Figure 1. Participants CONSORT diagram. CBT = cognitive-behavioral therapy; IPPI-D = integrative positive psychological intervention for depression.

Intervention Conditions

Both intervention programmes (CBT and IPPI-D) consisted of 10 weekly, 2 hour sessions in a group format. Five groups for each condition were included in this study. Each session of the IPPI-D and CBT programmes had the same structure (i.e., a review of the prior session's homework, an introduction to the topic of the day, a presentation of the session goals, a brief discussion among participants, in-session exercises, a summary of the key ideas, and a homework assignment).

The CBT programme used in this study was an adaptation of the Spanish version of the Group Cognitive-Behavioral Therapy of Major Depression Manual (Muñoz, Aguilar-Gaxiola, & Guzman, 1995), based on the widely used Coping with Depression course (Lewinsohn et al., 1984). The programme is a highly structured psychoeducational and applied cognitive-behavioral intervention that has been shown to be efficacious for depression (Cuijpers, Muñoz, Clarke, & Lewinsohn, 2009). The programme starts with a session that is dedicated to establishing the intervention goals, norms, and treatment rationale. Next, a module of two sessions of behavioral activation is included, that consists of pleasurable activities scheduling, time management, and goal setting. The next three sessions are focused on cognitive restructuring of negative cognitions and include skills from Rational Emotive Therapy (Ellis & Dryden 1987) and Cognitive Therapy (Beck et al., 1979). The last part of the programme is dedicated to social skills, where communication styles are analyzed and assertive skills are practiced. The final session focuses on relapse prevention and includes a closing activity for the group.

A group programme based on positive psychology for treating major depression was created for the purpose of this study mainly using interventions that have been shown to be effective in increasing positive functioning or alleviating depressive symptoms (Bolier et al. 2013; Sin & Lyubomirsky, 2009). The Integrative Positive Psychological Intervention for

Depression (IPPI-D) protocol included hedonic interventions (aimed at increasing positive affect, savoring, emotion regulation, gratitude and optimism) as well as eudaimonic interventions (i.e., promoting positive relationships, compassion, personal strengths, purpose in life and resilience). The programme includes a first session that is dedicated to establishing the intervention goals, norms, and treatment rationale. The following three sessions are focused on the hedonic component of well-being. Positive emotion enhancement, savoring exercises, and positive emotion regulation techniques are practiced. Additionally, participants were introduced to acceptance attitudes, and practiced gratitude and optimism exercises during these sessions in order to increase well-being. The following five sessions of the programme are focused on the eudaimonic component of well-being. These sessions are dedicated to promote positive relationships and teaching kindness and self-compassion. Furthermore, in this module, participants were encouraged to use their character strengths in new ways, to search for meaning in everyday life, and to start developing resilience to face difficulties. The last session dealt with relapse prevention and includes a closing activity for the group, as in the CBT programme. A more detailed description of the IPPI-D programme can be found elsewhere (Chaves, Lopez-Gomez, Hervas, & Vazquez, submitted).

Measures

Clinical and psychological functioning

At the beginning and the end of the intervention, participants were clinically assessed using a structured interview (Structured Clinical Interview for the DSM-IV, SCID-I; First, Spitzer, Gibbon, & Williams, 1996) and a protocol of self-report measures. The main measure to assess the efficacy of the treatments was the Beck Depression Inventory-II, which evaluates severity of depressive symptoms (BDI-II; Beck et al., 1996; Sanz, Navarro, Vazquez, 2003; $\alpha = .87$). Participants also completed a wide array of psychological measures covering relevant aspects of cognitive, emotional and behavioral functioning in depression.

Depressive cognitive style was measured by assessing automatic thoughts (Automatic Thoughts Questionnaire, ATQ-30; Hollon & Kendall 1980; Vazquez, 2006; α = .96), rumination (Ruminative Response Style, RRS; Nolen-Hoeksema & Morrow 1991; Hervas, 2008; α = .76), and thought suppression (White Bear Suppression Inventory, WBSI; Wegner & Zanakos 1994; Gonzalez et al. 2008; α = .75). Emotional functioning was assessed with measures of positive and negative affect (Positive and Negative Affect Schedule, PANAS; Watson, Clark, & Tellegen, 1988; Lopez-Gomez, Hervas, &Vazquez, 2015; α = .82 for positive affect, α = .83 for negative affect), anxiety symptoms (Beck Anxiety Inventory, BAI; Beck & Steer, 1990; Sanz & Navarro, 2003; α = .91), responses to positive affect (Responses to Positive Affect Questionnaire, RPA; Feldman et al. 2008; α = .75 for dampening, α = .82 for emotion-focus, α = .78 for self-focus), and emotion regulation difficulties (Difficulties in Emotion Regulation Scale, DERS; Gratz & Roemer, 2004; Hervas & Jodar 2008; α = .89). Additionally, reward and punishment systems were assessed by the Behavioral Inhibition System and Behavioral Approach System Scales (BIS/BAS trait version; Carver & White 1994; Hervas & Vazquez 2013a; α = .58 for BIS, α = .74 for BAS). Furthermore, using a comprehensive perspective of recovery, positive functioning measures were also included in the study. Thus, optimism (Life Orientation Test-Revised, LOT-R; Scheier et al. 1994; Ferrando et al. 2002; α = .62), psychological well-being (29-item version of the Ryff's Psychological Well-Being Scales, PWBS; Diaz et al. 2006; α = .84), life satisfaction (Satisfaction With Life Scale, SWLS; Diener et al. 1985; Vazquez, Duque, & Hervas, 2013; α = .81), enjoyment (Enjoyment Orientation Scale, EOS; Hervas & Vazquez 2006; α = .79), and hedonic and eudaimonic well-being (Pemberton Happiness Index, PHI; Hervas & Vazquez 2013b; α = .79) were assessed -for details, see Chaves et al. (2017).

Treatment acceptability

Client satisfaction with treatment was assessed with the Client Satisfaction Questionnaire (CSQ-8; Nguyen, Attkinsson, & Stegner, 1983; Roberts, Attkisson, & Mendias, 1984). The CSQ-8 contains 8 items concerning treatment quality, expectations and needs reached, satisfaction and help received (e.g., 'How would you rate the quality of the counseling you received?', 'To what extent has the programme met your needs?') rated with a 4-point scale where 1 reflects 'very low satisfaction' and 4 reflects 'very high satisfaction' ($\alpha = .73$). Four additional questions were included in order to have a broader picture of client satisfaction (i.e., 'To what extent do you think you have made progress in solving your problem with this treatment?', 'How would you rate the treatment?', 'To what extent have your therapists shown competence about the topic?', 'To what extent have your therapists been understanding and thoughtful with you?') rated with a 11-point Likert scale where 0 shows 'very low satisfaction' and 10 shows 'very high satisfaction'.

As part of the institutional assessment of the quality of the intervention, a 3-item client satisfaction questionnaire was included covering length of the intervention, group atmosphere, and group participation using a 5-point response scale where 1 reflects 'very low satisfaction' and 5 reflects 'very high satisfaction'. There was also one final item, rated in a dichotomous way, asking participants whether they would or would not recommend the treatment to another person. Besides client satisfaction questionnaires, dropout rates were also analyzed as a proxy indicator of acceptability.

Statistical Methods

An Intention to treat (ITT) approach was applied to the data. Following Newman's recommendations (Newman, 2014), a Maximum Likelihood (ML) estimate was performed via EM algorithm. With the ITT sample, chi-square and t-tests were used to confirm that there were no significant initial differences between groups in regards to demographic

variables. A series of t-test analyses were performed to assess possible differences in adherence and client satisfaction between intervention conditions. Likewise, possible differences in dropout rates between intervention conditions and between levels of depression severity at baseline were analyzed via chi-square tests. Additionally, two-factor ANOVAs were conducted to explore the interaction between intervention condition and depression severity at baseline. In the first one, attendance was the dependent variable. In the second one, client satisfaction (i.e., CSQ-8) was the dependent variable. The same analysis was used to explore the interaction between intervention condition and experiencing a clinically significant change at the end of the intervention on client satisfaction. Associations between CSQ-8 and baseline characteristics were explored using bivariate correlations in both intervention conditions. Chi-square tests were used to explore differences between conditions in clinical diagnosis and clinically significant change (i.e., reduction of more than 50% on post-treatment BDI-II score) at the end of the interventions. Data were analyzed using SPSS (version 20.0).

Table 1. Baseline characteristics

	CBT (n = 66)	IPPI-D (n = 62)	Group differences
Demographic characteristics			
Mean age	50.94 (10.98)	53.18 (10.10)	t = -1.20, p = .23
Married or cohabitating, %	66.7	58.1	χ^2 = .68, p = .41
Primary or lower studies, %	56.1	51.6	χ^2 = .11, p = .74
Employed, %	15.1	16.1	χ^2 = .001, p = 1
Clinical characteristics			
Mean BDI-II score	37.42 (10.68)	34.66 (10.13)	t = 1.49, p = .14
Severe depressive symptoms (BDI-II ≥ 29), %	80.03	72.6	χ^2 = .68, p = .41
Any other current Axis I diagnosis, %	65.1	48.4	χ^2 = 3.01, p = .08
Antidepressant medication, %	63.6	59.7	χ^2 = .08, p = .78
Mean number of sessions attended	7.43 (2.42)	7.13 (2.78)	t = .64, p = .52

Note. Standard deviations are shown in parenthesis; BDI-II = Beck Depression Inventory-II; CBT = cognitive-behavioral therapy; IPPI-D = integrative positive psychological intervention for depression.

Results

Baseline characteristics and adherence to the interventions

Table 1 displays the baseline characteristics of the participants. Eleven participants (16.7%) dropped out in the CBT condition and twelve (19.4%) in the IPPI-D condition. No significant difference was found in dropout rates between conditions (p = .87). Reasons cited by participants for discontinuing their participation in the intervention were having an illness

or accident that prevented them from attending intervention (2 in CBT group, 3 in IPPI-D group), conflicting schedules (3 in CBT group, 6 in IPPI-D group), lack of appropriateness of the intervention (2 in CBT group, 2 in IPPI-D group), or no specific reason (4 in CBT group, 1 in IPPI-D group).

No significant differences in baseline characteristics were found in the dropout rates between the two intervention conditions (all *ps* > .05). However, regardless of intervention condition, participants who completed the interventions did differ at baseline from those who dropped out on the LOT-R pessimism subscale, $t(125) = -2.34$, $p = .02$, Cohen's $d = 0.54$, 95% CI [.08, .99], and the BAS sensitivity to reward subscale, $t(125) = -2.42$, $p = .02$, Cohen's $d = 0.56$, 95% CI [.10, 1.02]. Participants with higher scores in pessimism and sensitivity to reward were significantly more likely to discontinue the interventions.

Pre- and post-assessments were collected for 55 participants (83.3%) in the CBT condition and 47 participants (75.8%) in the IPPI-D condition, the difference in number of participants being a nonsignificant difference ($p = .40$). Following an ITT model, missing data were imputed analyzing all the assigned participants to each condition.

The mean number of sessions attended was 7.42 ($SD = 2.42$) and 7.13 ($SD = 2.78$) in the CBT and IPPI-D conditions respectively. Among completers of the interventions, these means reached 8.29 ($SD = 1.46$) sessions in the CBT group, and 8.24 ($SD = 1.61$) sessions in the IPPI-D group. Analyzing only the participants who dropped out, the mean number of sessions attended was 3.09 ($SD = 1.3$) and 2.5 ($SD = 1.51$) respectively. None of these differences between intervention conditions reached statistical significance (all *ps* > .33). Additionally, number of sessions attended was not related to depression symptoms (BDI-II), neither at baseline nor at the end of the interventions (all *ps* > .34).

Client satisfaction

Table 2 displays the results for client satisfaction. T-test analyses showed significant differences between intervention conditions in CSQ-8 (that includes items concerning treatment quality, expectations and needs reached, satisfaction and help received), and progress made during the intervention. Participants in the IPPI-D condition showed significantly higher mean scores in both variables (i.e. CSQ-8 and progress made) than participants in the CBT condition.

For both interventions, the lowest mean in client satisfaction was found in the desirable length of the intervention. When asked whether they would recommend the intervention to others, all participants from both groups reported that they would.

Table 2. Client satisfaction for the intervention conditions

	CBT (n = 66)	IPPI-D (n = 62)	Group differences
CSQ-8[a]	28.42 (2.17)	29.48 (1.87)	t = -2.95, p = .004** d = .52 95% IC: .17-.87
Progress made[b]	7.15 (1.44)	7.75 (1.42)	t = -2.38, p = .02* d= .42 95% IC: .06-.77
Quality of the intervention[b]	8.76 (1.12)	8.94 (.92)	t = -.99, p = .32
Therapists' competence[b]	9.73 (.49)	9.75 (.56)	t = -.21, p = .83
Therapists' understanding[b]	9.83 (.41)	9.85 (.41)	t = -.22, p = .83
Length of the intervention[c]	2.83 (1.05)	2.88 (1.17)	t = -.26, p = .80
Group atmosphere[c]	4.08 (.88)	4.32 (.72)	t = -1.69, p = .09
Group participation[c]	3.89 (1.02)	3.86 (1.25)	t = .14, p = .89
Recommendation of the intervention (Yes/No)	100%	100%	No difference

Note. Standard deviations are shown in parenthesis; CBT = cognitive-behavioral therapy; CSQ-8= Client Satisfaction Questionnaire 8; IPPI-D = integrative positive psychological intervention for depression; d = Cohen´s *d;* *p < .05; **p < .01; [a] CSQ-8 total score range from 4 to 32; [b] ratings based on 11-point Likert scales; [c] ratings based on 5-point Likert scales.

Acceptability, baseline severity and improvement

A two-factor ANOVA was conducted to explore the interaction between depression severity at baseline and intervention condition on attendance. The sample was divided in two categories, mild and moderate depression (BDI-II < 28) versus severe depression (BDI-II ≥ 29) –see cut-off scores in Beck, Steer and Brown (1996). The analyses revealed neither a significant interaction nor a main effect of depression severity or intervention condition on

attendance (all *ps* > .50). Likewise, a two-factor ANOVA showed that there was no significant interaction between intervention condition and depression severity at baseline on client satisfaction, measured with CSQ-8, as well as no significant main effects of depression severity or intervention condition (all *ps* > .60).

Results related to dropout (i.e. discontinuation of the intervention) did not reveal a significant difference between intervention conditions among severely depressed participants (p = .90). The same result was found among non-severely depressed participants (p = 1). In addition, no significant differences in dropout based on participants severity were found in any intervention condition (all *ps* = 1).

Analysing the whole sample (N = 128), 53% of the participants in the CBT condition and 54.8% of the participants in the IPPI-D condition no longer had a diagnosis of major depression or dysthymia at the end of the treatment. In line with this, 43.9% of the participants in the CBT condition showed a clinically significant change (i.e., a reduction in BDI-II score of more than 50%; see Dimidjian et al. 2006; Strauman et al. 2006). In the IPPI-D condition, 45.2% experienced a clinically significant change. Differences between conditions did not reach statistical significance (all *ps* > .95)[5].

A two-factor ANOVA was conducted to analyze the interaction between experiencing a clinically significant change during the intervention and intervention condition on the CSQ-8. No significant interaction was found (p = .66), but there was a significant main effect of experiencing a clinically significant change on CSQ-8, $F(1,124) = 7.54$, p = .007, Cohen´s d = .49, 95% CI [.13, .84]. Participants who had experienced a clinically significant change had

[5] A series of repeated measures group x time MANOVAs on clinical measures and positive functioning measures showed an identical pattern of results reported in Chaves et al. (2017) with the sample of 96 participants that was then recruited.

higher scores on CSQ-8 (M = 29.50, SD = 1.79) than those who did not (M = 28.50, SD = 2.22).

Client satisfaction and baseline characteristics

Possible associations between client satisfaction, measured with CSQ-8, and baseline characteristics were also explored. CSQ-8 was significantly associated with the mean number of sessions attended, regardless of condition. In the CBT condition, the CSQ-8 was significantly associated with the SWLS (r = .30, p = .01) and the PWBS Positive relationships scale (r = .39, p = .001). In the IPPI-D condition, significant associations between CSQ-8 and ATQ-30 (r = .32, p = .01), RRS brooding subscale (r = .37, p = .003) and BAS (r = −.29, p = .02) were found. CSQ-8 was not significantly associated with any other outcome measure assessed regardless of intervention condition, including baseline BDI-II (all ps > .07).

Discussion

Results indicated that both IPPI-D and CBT programmes were highly acceptable for participants. Attendance rates were high and less than 20% of participants dropped out from the study, with no significant differences between intervention conditions. This figure is lower than the ones reported by several meta-analyses about depression treatments (Cuijpers et al., 2008; Fernandez et al., 2015 Hans & Hiller, 2013). When compared to other studies that have implemented PPI programmes for clinical depression, the attrition rate of the present study is lower than the one reported in Carr et al. (2016) study but higher than the one reported in Seligman et al. (2006) although in the latter case the sample size was small (N = 13).

Among completers, session attendance was very high. Participants attended on average more than 80% of the sessions, with no significant differences between intervention conditions, and around 20% percent of the sample attended all 10 sessions. This attendance rate was very similar to the attendance reported in the depression study by Carr et al. (2016) and in the smoking cessation study by Kahler et al. (2015), which was 79.1% and 78% respectively.

The first hypothesis, which predicted that PPI would be more acceptable than CBT in our depression intervention, received partial support. While there was no significant difference in terms of adherence, there were some significant differences in terms of client satisfaction. Outcomes revealed some significant differences in favor of the IPPI-D programme on the main measure of client satisfaction (i.e., the CSQ-8). It is worth noting that CSQ-8 average scores in many different health care settings, samples and services have indicated a lower client satisfaction than our study's outcome (Attkisson & Greenfield, 2004). Moreover, despite the scarcity of data about client satisfaction for psychological interventions measured with the CSQ-8, the figures found are also lower than the ones of the present study (Houghton & Saxon, 2007; Richards et al., 2013; Sabourin et al., 1989).

Along with the CSQ-8, this study included some complementary aspects of client satisfaction (see Table 2). Participants were extremely satisfied with the quality of the intervention, and the therapists' competence and understanding, with no significant differences between intervention conditions. These results reveal that the therapist's attitude in the IPPI-D programme in terms of their focus on the nurturing of positive emotions and psychological strengths (and lack of focus placed on negative cognitions or dysfunctional behaviors) was as satisfactory as the CBT therapist's focus on correcting negative thoughts and difficulties. Furthermore, participants in the IPPI-D group were more likely to report higher satisfaction with the progress made during the intervention than participants in the

CBT group. All participants from the two groups would recommend the intervention they received to someone else, which is coherent with participants' high levels of satisfaction with the interventions and perception of their utility.

In sum, both programmes were highly acceptable for participants and there were only significant differences between intervention conditions in terms of client satisfaction. Results regarding the efficacy of both interventions (IPPI-D and CBT) in this sample of patients revealed no significant differences between conditions. Yet, interestingly, the average effect sizes of change in clinical variables and positive functioning variables were always in favor of the IPPI-D programme (Chaves et al., 2017). Future research is needed to test whether this overall tendency in favor of the IPPI-D programme reaches statistical significance when increasing statistical power by using larger sample sizes.

The second hypothesis was fully confirmed. Participants with severe depression found the intervention just as acceptable as participants with mild or moderate depression, regardless of the assigned intervention condition. Additionally, no intervention was more acceptable for participants with severe depression than the other. These findings are in line with the finding that IPPI-D is at least as efficacious as CBT to treat severely depressed participants (Chaves et al., 2017). This is a promising result as it suggests, if future research supports it, the extended applicability of PPI toward the treatment of a wide range of depression severity. It seems plausible that creating intervention programmes specifically tailored to the specific needs of clinical populations (e.g., Chaves et al., 2017; Carr et al., 2016) may increase their acceptability as reflected, for instance, by low dropout rates. Positive interventions where these adjustments are not taken into account may face problems related to the credibility of the intervention and, consequently, lead to high dropout rates (Uliaszek et al., 2016).

Regarding the exploratory analyses on associations between variables and treatment satisfaction, some interesting results emerged. Within the CBT group, higher pre-intervention levels of life satisfaction and positive relationships, predicted higher treatment satisfaction. Within the IPPI-D group, pre-intervention levels of brooding, automatic negative thoughts, and sensitivity to reward were related to later treatment satisfaction. Although, a positive association between an initial negative cognitive set (i.e., brooding and repetitive negative contents) and later satisfaction with therapy is unexpected, it opens new ways to consider the viability of positive interventions based on empirical predictions. Parallel results have been found in large clinical trials of depression where CBT unexpectedly works better for those participants with less negative cognitions (i.e., dysfunctional attitudes) – Sotsky et al. (1991). Some preliminary evidence shows that in fact IPPI-D could work better for those participants with more comorbidity and negative thoughts (Lopez-Gomez, Chaves, Hervas, & Vazquez, 2016), but the precise mechanisms that operate to achieve a good therapeutic response are still ignored.

The present study has some limitations. The sample of participants is socio-demographically homogeneous (i.e., middle aged women with a low educational level) and the acceptability of the treatments might be different in other type of samples. In regard to the sample size, although it would be desirable to have included more participants, it could be considered a large sample according to the average size of standard clinical trials (Barth et al., 2013). Additionally, there was a sort of ceiling effect found in most of the measures of client satisfaction which reduces sensitivity to detect subtle changes that could exist between both interventions. It could be possible that scales with wider ranges of responses might provide better measures of change. Finally, at this initial stage of the development of PPI, qualitative studies on all the involved actors (i.e., patients and therapists) would be a valuable resource to detect further differences in acceptability among therapeutic modalities.

Future research should also analyze the acceptability of PPI in more heterogeneous and larger samples of people with depression. Moreover, the acceptability of PPI for other clinical disorders should also be examined. In recent years, studies applying PPI to treat severe mental disorders such as schizophrenia (Johnson et al., 2012; Meyer et al., 2012; Riches et al., 2016) and generalized anxiety disorder (Fava et al., 2005) have been developed. Systematic assessment of acceptability may shed light on the plausibility of extending the use of these techniques to wider audiences.

Research on the acceptability of different treatment programmes might also focus on each of the components or modules of the programmes rather than on the acceptability of the programmes as a whole. Although in the field of CBT there has been research showing the acceptability of different components of the therapeutic packages (e.g., imaginary vs in vivo exposure) in problems like obsessive compulsive disorders (Sookman & Steketee, 2007) or panic disorders (Cox, Fergus, & Swinson, 1994), the acceptability of components of CBT for depression has comparatively received much less attention. Therefore, research focused on more fine-grained analyses of the acceptability of programme's components is needed for available evidence-based therapies for depression.

The present study adds some relevant information to the psychotherapy field. It provides support for the high and comparable adherence to CBT and PPI programmes for clinical depression in a large clinical trial. Furthermore, it shows participants' severity of depression did not affect the overall acceptability of the programmes, which is particularly relevant to novel positive psychology interventions. The study also indicates that, although participants' satisfaction was very high in both conditions, whenever differences between conditions emerged they were always in favor of the PPI condition.

These results have relevant clinical implications. Firstly, the study of acceptability of interventions for depression is especially important for professionals as therapeutic non-

compliance is one of the main obstacles in their daily practice (Chabrol et al., 2004). Finding interventions that are satisfactory for clients may help to increase attendance and therefore increase the likelihood of recovery. Also, it could be possible that some individuals may be more willing to receive help through approaches focused on increasing well-being rather than through approaches focused on symptoms and difficulties. For example, people who are less prone to reveal personal thoughts and feelings or those who experience stigma are reluctant to seek professional help (Vogel et al., 2007). In these cases, well-being approaches may be more acceptable. Secondly, finding acceptable treatments may also help to reduce the treatment gap found for many psychological problems (Thompson et al., 2004).

Overall, the study's findings encourage further investigations of the applicability of PPI in clinical settings in order to make progress toward being able to offer a more diverse range of acceptable and suitable therapies for depressed patients.

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Informed Consent: Informed consent was obtained from all individual participants included in the study.

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DISCUSIÓN Y CONCLUSIONES GENERALES

DISCUSIÓN GENERAL

Los objetivos de la presente tesis fueron: a) conocer la eficacia de un programa de intervención de IPP para la depresión, b) analizar los cambios producidos en diversas variables clínicas y de bienestar, y c) comprobar su aceptabilidad para las participantes. Para ello realizamos un estudio comparativo con el tratamiento más estudiado y avalado por la investigación hasta la fecha, la TCC. Los resultados hallados se recapitulan a continuación, discutiéndose sus implicaciones y proponiendo líneas de investigación futura.

1. Comparación de la eficacia pre-post de los programas de intervención (Artículo 1)

Los resultados del artículo 1 de la tesis nos permiten concluir que las dos intervenciones aplicadas en este estudio han sido eficaces y no se presentaron diferencias significativas entre ellas en el momento de su finalización. Esta ausencia de diferencias significativas en eficacia se ha mostrado en los diversos indicadores utilizados como son el amplio espectro de medidas de autoinforme, que abarcan tanto variables clínicas como de bienestar, el cambio clínicamente significativo evaluado a través del BDI-II y la presencia o ausencia de diagnóstico clínico al finalizar los programas de intervención. Así mismo, ambos programas de intervención se han mostrado eficaces para personas con sintomatología severa, reiterándose la ausencia de diferencias significativas entre las condiciones de intervención. De igual manera, estos resultados se han repetido con la muestra completa de 128 mujeres y han sido reportados en el artículo 2 de la tesis.

La similitud en los cambios encontrados tras ambos programas de intervención contradice la asunción de especificidad de las intervenciones psicológicas, pues por ejemplo

no se ha registrado un mayor cambio en variables cognitivas disfuncionales (p.ej., en ATQ, RRS o WBSI) tras el programa de TCC o, por el contrario, un mayor cambio en bienestar tras el programa de IPP, como de hecho se hipotetizaba. No obstante, la especificidad de las intervenciones psicológicas ya ha sido puesta en duda a raíz de los resultados de estudios previos, como ha mostrado el metaanálisis de Ahn y Wampold (2001).

Podemos concluir, por tanto, que en este estudio y con la muestra utilizada, no existieron diferencias relevantes en la eficacia pre-post de ambos programas de intervención. Estos resultados están en línea con amplia literatura que avala la equivalente eficacia de diversas intervenciones psicológicas para la depresión (p.ej., Barth et al., 2013; Cuijpers, 2016; Cuijpers et al., 2011a; Forman, Herbert, Moitra, Yeomans y Geller, 2007). En su conjunto, dichos resultados ponen en evidencia la incógnita acerca de cómo y por qué funcionan las diferentes intervenciones, esto es, cuáles son sus mecanismos de acción. Muchos autores han aludido a los factores comunes o no específicos de las intervenciones psicológicas para explicar su similar eficacia (Lambert y Barley, 2001; Wampold, 2001). No obstante, sigue existiendo controversia en cuanto a su rol específico (Budd y Hughes, 2009). Los factores comunes que parecen tener cierto peso en la similar eficacia de las diferentes intervenciones son la alianza terapéutica (Horvath y Symonds, 1991; Martin, Garske y Davis, 2000), algunas variables del terapeuta (Baldwin y Imel, 2013; Wampold, 2001), condiciones facilitadoras como la empatía, la congruencia y la calidez (Lambert y Barley, 2001) y factores del paciente, especialmente de personalidad (Blatt y Zuroff, 2005). Otra explicación plausible de la similitud de resultados de diversos tratamientos para la depresión podría ser que existan mecanismos diferentes de acción que traigan consigo resultados semejantes. Este aspecto ya se ha demostrado en el caso de la medicación antidepresiva y la terapia cognitiva, que muestran resultados similares a corto plazo aunque difieren en los cambios a nivel cerebral que producen (DeRubeis, Siegle y Hollon, 2008). A pesar de que en las últimas décadas la

investigación sobre el proceso psicoterapéutico ha experimentado un gran avance (Moldovan y Pintea, 2015), todavía queda por clarificar de qué manera y por qué se produce el cambio en psicoterapia (Kazdin, 2007).

Dicha ausencia de diferencias en la eficacia de ambas intervenciones puede tener su explicación en el hecho de que los resultados obtenidos en este estudio se refieren a la eficacia media de ambas intervenciones. En los estudios clínicos se analizan habitualmente los resultados a nivel de la media de la muestra, pero cabe preguntarse si existen diferencias en la eficacia de las intervenciones a nivel individual. Esta es una pregunta extraordinariamente relevante, pues lo que nos interesa desde un punto de vista aplicado es qué tratamiento es más beneficioso para una persona en concreto (Paul, 1967). Tanto los datos procedentes de multitud de estudios y metaanálisis como la experiencia clínica directa demuestran que ni siquiera el mejor tratamiento empíricamente validado es eficaz para todos los pacientes. Además, parecen existir diferentes tipos de pacientes que pueden responder de manera dispar a diferentes aspectos del proceso de intervención, así como diferentes tipos de pacientes que pueden responder de manera diferente a un mismo tratamiento (Blatt y Zuroff, 2005).

La pregunta de qué tratamiento es más beneficioso para cada persona ha intentado ser respondida en el campo de la medicina desde el marco de la medicina personalizada y en los últimos años se está comenzando aplicar en el campo de la psicología clínica (Simon y Perlis, 2010). El objetivo de las intervenciones personalizadas consiste en estudiar características en la línea base que sean factores predictivos de la respuesta diferencial de una persona a diferentes intervenciones (Cuijpers, Reynolds, Donker, Li, Andersson y Beekman, 2012). Esta información permitiría desarrollar herramientas de selección de tratamientos óptimos para cada individuo, en función de sus características y circunstancias personales. En el caso de la depresión, ésta parece ser una línea de futuro muy prometedora dado que, en

concordancia con nuestros resultados, los metaanálisis recientes suelen reportar la ausencia de diferencias en la eficacia media de diversas intervenciones psicológicas para la depresión (p.ej., Barth et al., 2013; Cuijpers, 2016; Cuijpers et al., 2011a; Forman et al., 2007). Por otra parte, se evidencia gran heterogeneidad dentro del cuadro clínico que denominamos depresión (Lorenzo-Luaces, 2015) y las tasas de remisión y recuperación tras las intervenciones psicológicas que se aplican actualmente no son totalmente satisfactorias (p.ej., Cuijpers, Karyotaki, Weitz, Andersson, Hollon y van Straten, 2014). Parece que la personalización de las intervenciones para las personas con depresión puede mejorar la eficacia del tratamiento individualmente y por tanto aumentar las tasas de remisión y recuperación (Simon y Perlis, 2010). Muy recientemente han aparecido revisiones y metaanálisis señalando algunos moderadores de la eficacia diferencial de las intervenciones psicológicas para la depresión (Cuijpers et al., 2012; Cuijpers, 2016; Kessler et al., 2016). Sin embargo es un campo todavía muy poco explorado y que requiere mayor investigación para alcanzar la personalización de los tratamientos que ofrecemos desde la psicología clínica (Cuijpers, 2016). Desde la psicología positiva, también ha habido autores que han abogado por adaptar las intervenciones a las características personales, variables contextuales y culturales (Schueller, 2012). El modelo del *Person-activity fit* de Lyubomirsky y Layous (2013) es el que ha recibido mayor atención. En línea con estas aportaciones, algunos estudios han analizado predictores de la eficacia de las intervenciones positivas, pero por ahora se trata de ejemplos aislados y que tienen en cuenta sólo variables individuales (Proyer, Gander, Wellenzohn y Ruch, 2015; Schueller, 2011; 2012).

A la vista de estos datos y tras concluir el estudio de la presente tesis, nuestro objetivo ha sido aplicar de modo riguroso las herramientas metodológicas necesarias para encontrar moderadores de la eficacia diferencial de las dos intervenciones aplicadas en el estudio. La investigación previa se ha centrado principalmente en el efecto de moderadores individuales.

Esta estrategia resulta insuficiente pues cada moderador individual tendrá un efecto pequeño y por tanto lo idóneo es analizar combinaciones de moderadores (Cuijpers et al., 2012; Kraemer, 2013). En consecuencia, hemos optado por aplicar los índices combinados de moderadores desarrollados por los equipos de DeRubeis y de Kraemer (DeRubeis et al., 2014; Kraemer, 2013) en una serie de análisis iniciales para identificar el tratamiento óptimo para cada persona en función de sus variables previas al tratamiento. Además de ahondar en el papel de los moderadores que se conocen hasta la fecha en el tratamiento de la depresión, nuestro estudio incluye variables de funcionamiento positivo que son relevantes en la depresión clínica (Dunn y Roberts, 2016). Estas variables no han sido analizadas hasta la fecha como potenciales moderadores de la eficacia diferencial de las intervenciones psicológicas. Cabe añadir que su inclusión permitirá analizar moderadores de la eficacia diferencial entre una intervención de TCC y otra de IPP, por lo que esta metodología permitirá abrir nuevos cauces en el conocimiento existente. Hasta ahora hemos realizado análisis preliminares y requerimos mayor profundización en los aspectos metodológicos de la creación de índices combinados de moderadores para extraer conclusiones fiables. En consecuencia, los resultados no se recogen en esta tesis y serán objeto de futuras publicaciones científicas, aunque los resultados exploratorios han sido ya mostrados en congresos internacionales (López-Gómez, Chaves, Hervás y Vázquez, 2016; 2017).

2. Comparación de los cambios durante los programas de intervención (Artículo 2)

Tras analizar los cambios producidos entre el inicio y el fin de los programas de intervención, el objetivo del artículo 2 fue explorar los patrones de cambio durante dichos programas. Para ello, contamos con dos medidas de síntomas depresivos y bienestar aplicadas

en la cuarta y séptima sesión, además de antes y después de los programas de intervención. Un aspecto a subrayar es que la medida de bienestar utilizada (PHI) nos permitió diferenciar entre el bienestar recordado (i.e., la evaluación retrospectiva del bienestar general), que es la forma habitual de evaluación a través de las medidas de autoinforme, y el bienestar experimentado (i.e., las experiencias concretas, positivas o negativas, vividas por la persona en las 24 horas previas).

Los resultados indican que los síntomas depresivos y el bienestar recordado manifiestaron una mejoría significativa en cada tramo temporal evaluado. Sin embargo, este patrón difiere del encontrado en las medidas de experiencias, mostrándose cambios significativos en las experiencias positivas vividas en el primer y tercer periodo temporal y, en el caso de las experiencias negativas, sólo en el tercer periodo. En base a la idea de la aceleración negativa de la tasa de cambio durante la intervención (Lutz, Lowry, Kopta, Einstein y Howard, 2001; Stulz, Lutz, Kopta, Minami y Saunders, 2013), se hipotetizó que el porcentaje de mejora en las variables evaluadas sería mayor en el primer periodo de intervención que en los sucesivos. Dicho patrón sólo fue confirmado totalmente en el caso de los síntomas depresivos, aunque también se mostró una tendencia en la misma dirección en relación a las experiencias positivas. Estos resultados son interesantes, ya que indican que la mejora en síntomas clínicos es continua durante las intervenciones, pero más rápida que otras mejoras que en principio pudieran considerarse más sencillas de lograr (i.e., aumento del bienestar o satisfacción). Por otra parte, parece que el aumento de experiencias positivas es posible de forma más temprana (en base a los incrementos significativos observados en nuestro estudio en el primer y tercer periodo de intervención), y que reducir las experiencias negativas que sufren las personas con depresión requiere mayor intervención y/o tiempo (en base a los incrementos significativos en el tercer periodo de intervención hallados en nuestro estudio). Otro aspecto a destacar es que los síntomas disminuyeron antes de que lo hicieran

las experiencias negativas de la vida de las participantes. Este dato apoya la importancia de la intervención y la capacidad de mejora de las personas aunque sus circunstancias sean adversas. Por último, el bienestar recordado no presentó cambios significativos en el porcentaje de mejora en cada tramo temporal y mejoró significativa y continuamente a lo largo de la intervención, lo que concuerda con la naturaleza de la medida. Al ser una medida basada en la evaluación general retrospectiva, el cambio se produce de forma más paulatina que en las medidas de experiencias, mucho más volubles.

Una vez más no se encontraron patrones diferenciales en función del tipo de intervención, pero sí en función del tipo de variable evaluada (i.e., síntomas depresivos, bienestar recordado, experiencias positivas y negativas). Esto refuerza nuestra convicción en la necesidad de hacer uso de medidas que evalúen tanto síntomas clínicos como variables de funcionamiento positivo, así como la necesidad de aplicar medidas que vayan más allá de un juicio retrospectivo.

Estos datos preliminares acerca de los patrones de cambio durante la intervención son novedosos y generan diversas preguntas muy relevantes en el campo de la investigación del proceso psicoterapéutico. Por ejemplo, interesa conocer de qué manera se interrelacionan los cambios en unas variables y en otras, o qué cambios son fruto de cada intervención específica aplicada. Se requiere mayor investigación para avanzar en su respuesta y conviene que ésta se sustente en diseños más sofisticados como son los multinivel (p.ej., Tasca y Gallop, 2009). En el presente estudio, los modelos multinivel no pudieron ser aplicados pues sólo se contaba con cuatro momentos temporales. Por ello, sería recomendable que futuras investigaciones analizasen los patrones de cambio durante este tipo de intervenciones psicológicas con evaluaciones como las realizadas a través del método del muestreo de la experiencia (ESM; Csikszentmihalyi y Larson, 2014). Ello permitiría evaluar de forma más continua los cambios

en variables clínicas y de bienestar que en estos resultados se esbozan, y aplicar modelos multinivel que clarificasen cómo son los patrones de cambio durante las intervenciones.

3. Comparación de la aceptabilidad de los programas de intervención (Artículo 3)

Un objetivo principal de este estudio consistió en analizar aspectos relevantes para la práctica clínica, más allá del estudio de la eficacia de las intervenciones que continúa siendo el foco de la mayoría de estudios clínicos (Bolier et al., 2013; Weiss et al., 2016). Las prestigiosas recomendaciones de NICE y CONSORT subrayan la necesidad de evaluar la aceptabilidad y aplicabilidad de los tratamientos psicológicos a la hora de valorar su calidad (Moher et al., 2001; National Collaborating Centre for Mental Health, 2009). Por consiguiente, el objetivo de este tercer artículo fue plasmar los resultados de la aceptabilidad de los programas de intervención aplicados. Los resultados confirmaron que los dos programas de intervención fueron altamente aceptables para las participantes. Se alcanzaron tasas de abandono menores que las mostradas en metaanálisis previos sobre intervenciones para la depresión (Cuijpers, van Straten, Andersson y van Oppen, 2008; Fernández et al., 2015; Hans y Hiller, 2013) y tasas de asistencia elevadas (asistencia media a más del 70% de las sesiones). Sin embargo, no se encontraron diferencias significativas en adherencia en función de la condición de intervención. En cuanto a la satisfacción con las intervenciones, los resultados sí revelaron diferencias significativas. En concreto, las participantes en el programa de IPP mostraron mayores puntuaciones en el cuestionario de satisfacción CSQ-8 y en la valoración del progreso realizado durante la intervención. Esto no impidió que se alcanzasen en ambas condiciones de intervención puntuaciones de satisfacción muy elevadas e incluso mayores a las de estudios similares (Houghton y Saxon, 2007; Richards et al., 2013;

Sabourin et al., 1989). Así mismo, los programas de intervención aplicados fueron muy eficaces en personas con síntomas depresivos severos, sin diferencias significativas entre ambos, y tampoco hubo diferencias significativas en aceptabilidad en función de la severidad de los síntomas depresivos.

Estos resultados complementan los presentados previamente acerca de la eficacia de ambos programas de intervención. Muestran que el programa de IPP fue muy satisfactorio, y superior en algunos aspectos al de TCC, que es de por sí un ejemplo de tratamiento empíricamente validado y satisfactorio. De confirmarse este dato en posteriores estudios, estaríamos ante un importante hallazgo pues el grado de satisfacción medio de los participantes puede ser un factor relevante a la hora de elegir aplicar una intervención entre varias disponibles.

Estos hallazgos alientan la investigación futura acerca de la aceptabilidad y aplicabilidad de las IPP y de las intervenciones psicológicas en general, pues su implementación no será exitosa si no son aceptables y viables para los usuarios y profesionales. En este sentido, la investigación acerca de la aceptabilidad de las intervenciones para los propios profesionales que las han de utilizar es aún más escasa, a pesar de ser uno de los factores que explican la baja implementación de los tratamientos psicológicos eficaces en la práctica clínica habitual (Tortella-Feliu et al., 2016b).

Adicionalmente, consideramos que este tipo de datos cuantitativos pueden enriquecerse al complementarse con otros de origen cualitativo. El uso de metodologías cualitativas permitiría conocer en mayor profundidad la opinión de las participantes de los programas de intervención y los efectos de éstos, más allá de los resultados de autoinforme. Esta información también haría posible la personalización de las intervenciones en función de las preferencias y necesidades de las personas, que podrían constituir moderadores de la eficacia diferencial de las distintas opciones terapéuticas. Estudios previos han comenzado a

analizar la relación entre las preferencias de los destinatarios de las terapias y la eficacia de éstas y sus resultados respaldan que cuando la persona muestra preferencia por un tipo de intervención, tiende a beneficiarse más de ella (Chilvers et al., 2001; Schueller, 2011).

Un aspecto relevante que no se aborda en este estudio y que supondría el siguiente paso a realizar es conocer cuáles son los componentes más eficaces dentro de cada programa de intervención. Los estudios de componentes, de desmantelamiento o aditivos, pueden clarificar el efecto de las técnicas y estrategias que se incluyen en los programas multicomponente como los aplicados en este estudio. Una vez que se conozcan estos ingredientes activos provenientes de cada enfoque de intervención, sería interesante analizar la eficacia de la combinación de las técnicas que hayan resultado más eficaces de la TCC y de las IPP. Estas dos orientaciones, aunque distintas, pueden ser compatibles como ya han señalado otros autores (Dunn, 2017; Ingram y Snyder, 2006). Desde un enfoque integrador y basado en la personalización de los tratamientos, en el futuro podríamos aplicar los índices combinados de moderadores de la eficacia diferencial a cada persona para crear tratamientos que combinen técnicas provenientes de distintos enfoques teóricos que permitan alcanzar una mayor eficacia y satisfacción para esa persona en concreto. Por ahora esto resulta lejano, pero esperamos que llegue el momento en el que diseñemos intervenciones a medida de las necesidades de cada persona en base a técnicas y estrategias empíricamente validadas.

4. Limitaciones del estudio

El presente estudio supera muchas de las limitaciones de las que adolecen los estudios previos sobre los efectos de programas de IPP en personas con trastornos depresivos. No obstante, tiene algunas limitaciones que conviene tener presente a la hora de extraer conclusiones de sus resultados y que se han comentado en extenso en los correspondientes

artículos de la tesis. En primer lugar, la asignación de las participantes en el estudio no cumplió con una estricta aleatorización, aunque fue totalmente ciega. La ausencia de diferencias en la línea base entre ambas condiciones de intervención apoya la ausencia de sesgos debidos al método de asignación utilizado.

Cabe resaltar que el programa de intervención cognitivo-conductual aplicado ha sido respaldado por la investigación (Cuijpers et al., 2009). En cambio, el programa de IPP utilizado es un programa multicomponente diseñado por el equipo de investigación y no ha sido validado previamente, de hecho este es el primer estudio en el que se ha aplicado. Sin duda, las IPP que lo componen se han mostrado eficaces previamente en la investigación, pero desconocemos si la combinación concreta de intervenciones, el orden o el número de sesiones dedicadas a cada componente son los idóneos. Así mismo, podrían añadirse otras IPP que han mostrado ser eficaces posteriormente al diseño del programa, como la imaginación positiva (Holmes, Lang y Shah, 2009) o el entrenamiento en memoria autobiográfica (Dalgleish y Werner-Seidler, 2014). Por supuesto, resulta imprescindible que el programa de IPP diseñado para este estudio pueda ser aplicado en otros grupos de investigación, por parte de otros terapeutas, para disipar posibles dudas acerca de que sean las terapeutas concretas que lo aplicaron o incluso un posible sesgo a favor de las IPP a la hora de aplicar ambos programas, lo que explique los resultados encontrados.

En cuanto a la muestra, el presente estudio se encuentra con una limitación compartida con prácticamente todos los estudios en los que se comparan diferentes intervenciones psicológicas. Tal y como señala Cuijpers (2016), los tamaños muestrales necesarios para alcanzar un poder estadístico adecuado en este tipo de investigaciones exceden con creces los tamaños muestrales habituales. En el caso de este estudio, a pesar de que la muestra obtenida puede ser calificada como grande en comparación con las muestras medias de los estudios clínicos (Barth et al., 2013), hubiese sido deseable ampliarla. La razón

para no hacerlo fue principalmente la escasez de recursos, al no contar con financiación directa ni recursos personales de apoyo en el desarrollo del estudio. De este hecho, también se deriva otra limitación, que consiste en la homogeneidad de la muestra. La muestra con la que se contó es homogénea en cuanto al género, la edad y las características psicosociales. Por ello, se postula necesario corroborar los resultados obtenidos con muestras clínicas heterogéneas.

Otra limitación importante, pero que será solventada en próximas publicaciones, es la falta de resultados de las evaluaciones de seguimiento. Esto es debido a que resta llevar a cabo varias evaluaciones para finalizar el seguimiento de todas las ediciones del programa y poder analizar así los datos en conjunto. Con ellos, será posible dilucidar los efectos a largo plazo del programa de IPP y compararlos con los del programa de TCC. La ausencia de evaluaciones de seguimiento ha sido una de las limitaciones habituales en los estudios sobre IPP (Weiss et al., 2016), por lo que estamos muy interesados en conocer si los efectos informados en esta tesis se mantienen a los 6 meses y a los 24 meses de haber realizado la intervención.

Las medidas de evaluación utilizadas en este estudio son la entrevista clínica diagnóstica y numerosas medidas de autoinforme. Como hemos mencionado previamente, hemos contado con un número de momentos de evaluación limitados, lo que limita la riqueza de los datos obtenidos. Por ejemplo, para el análisis de los patrones de cambio durante las intervenciones se contó con cuatro momentos de evaluación. Esto ha limitado las posibilidades de análisis de dichos patrones impidiendo el seguimiento sesión a sesión de dichos cambios que ha sido posible en otros estudios (Falkenström, Josefsson, Berggren y Holmqvist, 2016; Stulz et al., 2013). Además, algunas de las medidas de autoinforme aplicadas son novedosas y por consiguiente poco utilizadas hasta la fecha (p.ej., PHI, RPA).

Ello conlleva la escasez de investigación con la que comparar los resultados y cabe la posibilidad de que dichas medidas experimenten mejoras en el futuro.

Por último, no podemos eludir el dato de que cerca de la mitad de las participantes continuaron teniendo un diagnóstico clínico de depresión mayor o distimia al finalizar las intervenciones. Esto indica que el programa aplicado de IPP comparte probablemente las limitaciones y el efecto techo de las intervenciones psicológicas para los trastornos depresivos en general (Björgvinsson et al., 2014; Westen y Morrison, 2001). Se requiere evaluar la influencia del formato utilizado al aplicar los programas (i.e., formato grupal, duración total de 10 sesiones) en los resultados obtenidos. Es posible que los resultados varíen aumentando la duración de la intervención y/o aplicándola de forma individual. Consideramos que la creación de tratamientos personalizados combinando técnicas y estrategias de diversas orientaciones terapéuticas en el formato más adecuado para cada persona es una alternativa muy prometedora para aumentar las tasas de recuperación y los niveles de bienestar de las personas con trastornos depresivos.

CONCLUSIONES GENERALES

Tras cinco años de desarrollo del estudio, y restando todavía la finalización de las evaluaciones de seguimiento para conocer los resultados a largo plazo de los programas de intervención comparados, podemos concluir que los resultados obtenidos hasta ahora son coherentes entre sí y con la literatura previa. En esta tesis hemos demostrado que el programa de intervención de IPP diseñado por nuestro equipo fue eficaz al finalizar el tratamiento, inclusive en los casos con sintomatología más severa, y que no existieron diferencias con un tratamiento tan ampliamente utilizado como es el de TCC. Además, hemos explorado de forma preliminar los cambios durante los programas de intervención, detectando diferencias en cómo cambian los síntomas depresivos y el bienestar durante la intervención, independientemente del enfoque de ésta. Por último, se ha comprobado que el programa de IPP fue muy satisfactorio para las participantes y, de hecho, superior al de TCC en algunas medidas de satisfacción.

Sin obviar las limitaciones del estudio (p.ej., ausencia de aleatorización pura, homogeneidad de la muestra, uso de medidas de autoinforme), consideramos que representa una importante aportación en el ámbito de los estudios clínicos de IPP y, en general, de las intervenciones psicológicas para la depresión. Esperamos que los resultados plasmados supongan un incentivo para seguir investigando acerca de estas intervenciones psicológicas o de cualquier otra que pueda suponer una alternativa contrastada y eficaz que ofrecer a las personas con depresión. La innovación y la experimentación son parte indispensable del proceso científico (Karwoski, Garratt e Ilardi, 2006) y por tanto es imprescindible seguir planteándonos preguntas y respuestas alternativas a lo establecido. La investigación acerca de las intervenciones psicológicas es joven todavía y es necesario superar el denominado “parón terapéutico” de los últimos años (McNally, 2007), en el que apenas se han aumentado los

niveles de eficacia de los tratamientos ya existentes ni se han establecido nuevos tratamientos no basados en otros previos (Tortella-Feliu et al., 2016b). Consideramos que la personalización de los tratamientos en función de las características de las personas será una pieza clave para aumentar la eficacia de nuestras intervenciones. Esto entronca con la opinión extendida recientemente en el campo de la investigación de huir de las etiquetas diagnósticas amplias y analizar los perfiles personales y patrones de síntomas concretos. En este sentido, los modelos de redes (Borsboom y Cramer, 2013) pueden ser herramientas de incalculable valor para evaluar a la persona concreta que deseamos ayudar y personalizar su tratamiento *ad hoc*.

En resumen, creemos que hemos de mantener el compromiso ético con la reducción del sufrimiento de las personas con problemas mentales y el aumento de su bienestar. A pesar de que ya en 1948 la OMS definiese la salud no sólo como la ausencia de enfermedades sino como la presencia de bienestar (Organización Mundial de la Salud, 1948), resta un largo camino por recorrer hasta conseguir que esta definición sea un hecho a nivel poblacional.

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ANEXOS

ANEXO I. PREGUNTAS INICIALES DE LA EVALUACIÓN DE LAS PARTICIPANTES

DATOS DEMOGRÁFICOS

NOMBRE PACIENTE: _____

Nº DE HISTORIA: _____ **EVALUADOR:** _____

ESTADO CIVIL:
1. Soltera
2. Casada o conviviendo con pareja
3. Separada o divorciada
4. Viuda

EDAD: _____

EDUCACIÓN:
0. Sin estudios
1. Estudios primarios o Educación obligatoria
2. Estudios Secundarios o Bachillerato
3. Estudios Universitarios

EMPLEO:
0. No trabaja
1. En paro
2. Trabaja
3. Ama/o de casa
4. Jubilada o pensionista

DATOS CLÍNICOS

¿Sigue algún tratamiento farmacológico actualmente? 0. No 1. Sí

¿Qué tipo de fármacos?_____

¿Ha tenido problemas psicológicos anteriormente? 0. No 1. Sí

¿De qué tipo? _____

¿Ha tenido otros tratamientos farmacológicos o psicológicos anteriores? 0. No 1. Sí

¿Cuántas veces?_____

¿De qué tipo? _____

¿Hay antecedentes familiares de problemas psicológicos? 0. No 1. Sí

¿De qué tipo? _____

_____

ANEXO II. INSTRUMENTOS SELECCIONADOS

Escala de Orientación al Disfrute (EOS)

Hervás y Vázquez (2006); Hervás, Chaves, López-Gómez y Vázquez (enviado)

Marque con una cruz la opción de respuesta más adecuada:

	Muy en desacuerdo	Bastante en desacuerdo	Un poco en desacuerdo	Ni de acuerdo ni en desacuerdo	Un poco de acuerdo	Bastante de acuerdo	Muy de acuerdo
1. Me considero una persona que busca siempre disfrutar de cualquier cosa por pequeña que sea							
2. Suelo pararme a disfrutar intensamente de experiencias cotidianas como ver un paisaje bonito, degustar una comida sabrosa o cosas similares							
3. No suelo buscar muchas satisfacciones en mi rutina diaria							
4. Intento no dejar pasar ni una sola oportunidad de disfrutar de las cosas del día a día							
5. Casi siempre estoy buscando disfrutar de cosas nuevas cada día aunque sean pequeñas							
6. Intento siempre disfrutar al máximo de los pequeños placeres de cada día							

Cuestionario de Respuestas al Afecto Positivo (RPA)

Feldman, Joormann y Johnson (2008); Traducción propia

La gente piensa y hace muchas cosas diferentes cuando se siente feliz. Por favor, lea cada uno de los siguientes elementos e indique en qué medida hace o piensa esas cosas cuando se siente feliz o entusiasmada. Por favor, indique lo que generalmente hace, no lo que cree que debe hacer.

	Casi nunca	A veces	Frecuentemente	Casi siempre
1. Pienso sobre lo feliz que me siento	1	2	3	4
2. Pienso sobre lo fuerte que me siento	1	2	3	4
3. Pienso que me siento capaz de hacer todo	1	2	3	4
4. Observo cómo me siento llena de energía	1	2	3	4
5. Saboreo el momento	1	2	3	4
6. Pienso ''Mi racha de suerte se va a acabar pronto''	1	2	3	4
7. Pienso ''No merezco esto''	1	2	3	4
8. Pienso en las cosas que podrían salir mal	1	2	3	4
9. Pienso en las cosas que no han ido bien para mí	1	2	3	4
10. Recuerdo que estos sentimientos no durarán	1	2	3	4
11. Pienso ''Esto es demasiado bueno para ser verdad''	1	2	3	4
12. Pienso en lo difícil que es concentrarse	1	2	3	4

13. Pienso ''La gente va a pensar que estoy presumiendo''	1	2	3	4
14. Pienso'' Yo estoy logrando todo''	1	2	3	4
15. Pienso'' Estoy a la altura de mi potencial''	1	2	3	4
16. Pienso en lo orgullosa que estoy de mi misma	1	2	3	4
17. Pienso ''Estoy consiguiendo terminar todo"	1	2	3	4

Índice de Felicidad Pemberton (PHI)

Hervás y Vázquez (2013b)

Marque con una cruz la opción de respuesta más adecuada:

	Totalmente en desacuerdo 0	1	2	3	4	5	6	7	8	9	Totalmente de acuerdo 10
1. Me siento muy satisfecha con mi vida											
2. Me siento con la energía necesaria para cumplir bien mis tareas cotidianas											
3. Siento que mi vida es útil y valiosa											
4. Me siento satisfecha con mi forma de ser											
5. Mi vida está llena de aprendizajes y desafíos que me hacen crecer											
6. Me siento muy unida a las personas que me rodean											
7. Me siento capaz de resolver la mayoría de los problemas de mi día a día											
8. Siento que en lo importante puedo ser yo misma											
9. Disfruto cada día de muchas pequeñas cosas											

	Totalmente en desacuerdo 0	1	2	3	4	5	6	7	8	9	Totalmente de acuerdo 10
10. En mi día a día tengo muchos ratos en los que me siento mal											
11. Siento que vivo en una sociedad que me permite desarrollarme plenamente											

Valore si son ciertas estas afirmaciones centrándose en su día de **AYER**:

	SI	**NO**
12. Me sentí satisfecha por algo que hice		
13. En algunos momentos me sentí desbordada		
14. Pasé un rato divertido con alguien		
15. Me aburrí durante bastante tiempo		
16. Hice algo que realmente disfruto haciendo		
17. Estuve preocupada por temas personales		
18. Aprendí algo interesante		
19. Pasaron cosas que me enfadaron mucho		

	SI	NO
20. Me permití un capricho		
21. Me sentí menospreciada por alguien		

Cuestionario de Satisfacción del Cliente (CSQ-8)

Nguyen, Attkinsson, y Stegner, (1983); versión en castellano: Roberts, Attkisson, y Mendias (1984)

El objetivo de este cuestionario es mejorar la atención dada a lo largo del tratamiento clínico. Las respuestas que nos dé usted serán tratadas de modo anónimo y confidencial. Contestando de modo sincero a las siguientes preguntas nos ayudará a perfeccionar nuestro servicio. Muchas gracias.

Nombre de las terapeutas.....

1. ¿Cómo evalúa la calidad del tratamiento que ha recibido?

4 Excelente
3 Buena
2 Regular
1 Mala

2. ¿Recibió el tipo de tratamiento que quería (cubrió sus expectativas)?

1 Definitivamente no
2 No, no mucho
3 Sí, generalmente
4 Definitivamente sí

3. ¿Hasta qué punto este tratamiento ha cubierto sus necesidades?

4 Casi todas
3 La mayoría
2 Solamente unas pocas
1 Ninguna

4. Si un amigo/a necesita una ayuda parecida, ¿podría recomendar este tratamiento a él o a ella?

1 Definitivamente no
2 Probablemente no
3 Probablemente sí
4 Definitivamente sí

5. ¿Está satisfecha con la ayuda que ha recibido?

1 Estoy muy insatisfecha
2 Me es indiferente o estoy levemente insatisfecha
3 Estoy levemente satisfecha
4 Estoy muy satisfecha

6. ¿La ayuda que ha recibido le ha ayudado a manejar mejor su problema?

4 Sí me ha ayudado mucho
3 Sí, me ha ayudado más o menos
2 No, realmente no me ha ayudado
1 No, ha empeorado mi problema

7. En general, ¿está satisfecha con el servicio recibido (material entregado, tiempo dedicado a las sesiones, etc.)?

4 Estoy muy satisfecha
3 Estoy levemente satisfecha
2 Me es indiferente o estoy levemente insatisfecha
1 Estoy muy insatisfecha

8. Si fuera a buscar ayuda otra vez, ¿volvería a utilizar este servicio?

1 Definitivamente no
2 Probablemente no
3 Probablemente sí
4 Definitivamente sí

Preguntas adicionales sobre calidad asistencial

Por favor, rodee con un círculo sus respuestas a cada una de las siguientes preguntas:

1. De 0 a 10, siendo 0 muy poco y 10 mucho, ¿en qué medida cree que ha hecho algún avance en la solución de sus problemas con este tratamiento?

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

2. En una escala de 0 a 10, ¿qué calificación pondría al tratamiento?

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

3. En una escala de 0 a 10, ¿en qué medida las terapeutas se han mostrado competentes y conocedoras del tema a tratar?

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

4. En una escala de 0 a 10, ¿en qué medida las terapeutas se han mostrado comprensivas y atentas con usted?

0	1	2	3	4	5	6	7	8	9	10

Preguntas institucionales de calidad

Por favor, indique su opinión acerca de:

	Mal	Regular	Bien	Muy Bien	Excelente
La duración de la actividad					
El clima del grupo					
La participación en el grupo (dudas, comentarios…)					

¿Recomendaría a alguien esta actividad? Sí ☐ No ☐

ANEXO III. ARTÍCULO DESCRIPTIVO DEL PROGRAMA THE INTEGRATIVE POSITIVE PSYCHOLOGICAL INTERVENTION FOR DEPRESSION (IPPI- D)

The Integrative Positive Psychological Intervention for Depression (IPPI- D)

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Abstract

Despite the variety of empirically supported treatments for depression, many available evidence-based treatments do not satisfactorily promote or maintain clinically significant changes in patients. Moreover, treatments for depression have been primarily focused on reducing patients' symptoms or deficits and less concerned with building positive resources that seem to be of interest to depressed individuals. This paper describes a manualized protocol of a new empirically-validated positive psychological intervention for depression, which incorporates a balance between hedonic and eudaimonic components and a combination of in-session exercises and homework. The protocol is a 10-session program, in a group format, and includes interventions that have been shown to be effective in increasing well-being or alleviating depressive symptoms. The rationale for developing this protocol, the underlying theoretical framework and some general guidelines for its application are presented. Furthermore, the implications of this protocol are discussed, demonstrating how it overcomes some of the limitations of current, evidence-based psychological treatments for depression.

Keywords: Positive psychological interventions; Major depression; Well-being; Positive emotions; Personal strengths.

Major depression is one of the most prevalent and seriously impairing psychological problems (ESEMED, 2004; Kessler & Bromet, 2013). Lifetime prevalence estimates of major depressive disorder (MDD) range from 4 to 10% (Kessler et al., 2009). Moreover, recent predictions estimate that by 2030 depression will be the leading cause of disease burden in high-income countries (Mathers, Fat, Boerma, & World Health Organization, 2008), and compared to other mental disorders, depression entails a significant reduction in happiness (Bergsma, Veenhoven, Have, & Graaf, 2010) and life satisfaction (Vazquez et al., 2015). Taking all of these findings into consideration, the accessibility of validated interventions for depression is as necessary as ever before (WHO, 2012).

Current treatments for depression and their limitations

Recent meta-analyses have shown the efficacy of a range of treatments for depression (e.g., cognitive-behavioral therapy, problem-solving therapy, interpersonal therapy) with comparable benefits (Barth et al., 2013; Cuijpers, Andersson, Donker, & van Straten, 2011; Linde et al., 2015). These are promising findings. However, despite the variety of empirically supported treatments for depression, many available evidence-based treatments do not fully promote clinically significant changes in the majority of patients (Cuijpers, van Straten, Andersson, & van Oppen, 2008). The high number of residual symptoms after treatment (Paykel, 2008), the high relapse and recurrence rates (Vittengl, Clark, Dunn, & Jarrett, 2007) and the high dropout rates (Fernandez, Salem, Swift, & Ramtahal, 2015; Hans & Hiller, 2013) lead some experts to consider that the overall quality of available treatments for depression is unacceptably poor (McIntyre & O'Donovan, 2004). Thus, although some authors believe that extant treatments are sufficient alleviate depression (Cuijpers, 2015), the limitations of current treatments

shed light on the importance of conducting research on new modalities of treatment (Stirman, Toder, & Crits-Christoph, 2010) or on improvements of current treatments based on advancements in the understanding of the science underlying depression (e.g., Beck & Bredemeier, 2016).

One way to improve treatments relates to shifting the focus of the intervention itself. Existing depression treatments have been primarily focused on alleviating symptoms and deficits while paying less attention to building positive resources (Dunn, 2012). Yet, this classical, clinical focus seems to be at odds with patients' beliefs about the goals of therapy. For instance, it has been found that patients with major depression believe that what best defines 'remission' is the presence of positive mental health characteristics (i.e., optimism, general sense of well-being) (Zimmerman et al., 2006). Consequently, depressed patients consider that the main goal of therapy should be aimed at increasing their life satisfaction and general well-being (Demyttenaere et al., 2015a). However, doctors and psychiatrists' main aim has traditionally been reducing symptoms (Demyttenaere et al., 2015a). This discrepancy between professionals and patients has some practical effects. As Demyttenaere et al. (2015b) found in their study with a large sample of patients with major depression, the magnitude of that difference (i.e., the discrepancy between clinicians and their patients) positively predicts a worse response to treatment at 6 months. Taking into account aspects of positive mental health in the treatment of mental disorders is important, as the absence of mental illness does not necessarily imply the presence of well-being (Keyes & Simoes, 2012). This model of positive mental health (Jahoda, 1958) also has profound implications for the treatment of depression. In fact, the efficacy of psychotherapy is typically assessed by symptom reduction, while variables such as quality of life or well-being are not

commonly considered as core components of recovery in the scientific literature (Chambless & Ollendick, 2001).

Another way to improve treatments relates to optimizing the fit between treatment characteristics and patients' preferences. Recent evidence suggests that individual preferences may affect one's decision to enter into treatment and the therapeutic alliance generated (Gelhorn, Sexton, & Classi, 2011). For some clients with depression, pointing out deficits in their thinking as an exclusive focus of therapy may be counterproductive and may disrupt the therapeutic alliance (Burns & Nolen-Hoeksema, 1992; Castonguay et al., 2004) or may even increase treatment abandonment (Oei & Kazmierczak, 1997). Therefore, the integration of positive aspects may improve the acceptability of therapy for some patients as these aspects may better align with their expectations of the key therapeutic targets and may help them realize that psychotherapy is not only about reducing symptoms, but also about learning to use one's personal strengths, skills, and abilities to face challenges. Thus, new treatment alternatives should strive to cultivate individuals' well-being, along with ameliorating depressive symptoms. In doing so, these new empirically-validated options may extend the variety of intervention options available to accommodate clients' preferences (Lyubomirsky & Layous, 2013; Schueller, 2010)

Are positive variables relevant targets for depression treatment?

Classic psychological research on depression has been focused on negative emotions and cognitions (Gotlib & Hammen, 2010). However, in recent years, the substantial role of positive emotions and cognitions in different disorders is becoming increasingly recognized (Carl, Soskin, Kerns, & Barlow, 2013; Garland et al., 2010; Vazquez, 2017). Specifically, low positive affect has been found to characterize

depression as compared to other emotional disorders like anxiety (Clark & Watson, 1991; Watson & Naragon-Gainey, 2010). Also, low positive affect is associated with a maladaptive regulation of positive emotions that seems to be persistent in recovery from depression and unique to symptoms of mood disorders (Werner-Seidler, Banks, Dunn, & Moulds, 2013; Edge et al., 2013). Particularly, some studies have revealed that depressed individuals show difficulties to maintain, or amplify, positive emotions once they appear and have a greater tendency to dampen positive experiences (McMakin, Santiago, & Shirk, 2009; Werner-Seidler et al., 2013). In line with these results, both naturalistic and experimental studies have shown that depressive mood is consistently associated with a reduction in reward sensitivity rather than to increases in sensitivity to punishment (Hervas & Vazquez, 2013).

To develop more integrative models of vulnerability to depression, a dual perspective on depression (i.e., taking into account positive and negative aspects of functioning separately) may be relevant. For instance, in a longitudinal study, Wood and Tarrier (2010) showed that people who had low scores on characteristics related to psychological well-being (Ryff, 1989) such as self-acceptance, autonomy, purpose in life, positive relationships with others, environmental mastery, and personal growth were up to seven times more likely to meet the cut-off for clinical depression 10 years later.

In summary, these conceptual and empirical arguments highlight the importance of targeting positive emotional and cognitive functioning when designing new interventions for depressed patients.

Bases for Positive psychological interventions' programs

Although interest in developing specific interventions to enhance psychological well-being is not new (e.g., Fordyce, 1977, 1983), there has been a recent upsurge of research aimed at increasing specific variables (e.g. subjective well-being, positive emotion, life meaning) that are intrinsically related to psychological well-being (Bolier et al., 2013; Sin & Lyubomirsky, 2009).

Over the past decade, research in this field has provided a growing body of evidence that supports the efficacy of well-being-promoting exercises not only to enhance well-being, but also to alleviate symptoms of depression. Although the majority of positive psychological interventions (PPI) have been tested using non-clinical samples (Wood & Tarrier, 2010), there is preliminary evidence of their efficacy for a wide spectrum of clinical problems (Bolier et al., 2013), mainly for depression (Seligman, Rashid, & Parks, 2006), but also for psychotic disorders (Meyer, Johnson, Parks, Iwanski, & Penn, 2012) or smoking (Kahler, et al., 2014), among others. These positive psychological interventions have shown high rates of client satisfaction (Kahler et al., 2014; Lopez-Gomez, Chaves, Hervas, & Vazquez, 2017b), attendance (Meyer et al., 2012), exercise completion (Huffman et al., 2014), and practice outside the session (Meyer et al., 2012). Moreover, positive exercises were perceived as easy to complete (Huffman et al., 2014) and enjoyable (Kahler et al., 2014), two important variables that have been positively associated with the extent of use of exercises during the follow-up period (Schueller & Parks, 2012).

With regard specifically to depression, two meta-analyses of PPI have been published including clinical and non-clinical samples, concluding that these interventions are effective in significantly decreasing symptoms of depression and enhancing well-being (Bolier et al, 2013; Sin & Lyubomirsky, 2009). Furthermore, the

efficacy of the interventions seems to be long-lasting. In their meta-analysis, Bolier et al. (2013) found that at the three to six month follow-up, effect sizes were small, but still significant for subjective well-being and psychological well-being, indicating that effects may be sustainable.

Even though PPI seem to be especially effective in improving depressive symptoms, very little research has been done to test PPI packages to treat clinical depression in comparison to appropriate control groups. There are few studies that have shown PPI to be effective for reducing depressive symptoms and enhancing well-being (Carr, Finnegan, Griffin, Cotter, & Hyland, 2016; Moeenizadeh & Salagame, 2010; Seligman et al., 2006), treating residual symptoms (Fava, Rafanelli, Cazzaro, Conti, & Grandi, 1998a) or preventing future relapse (Fava, Rafanelli, Grandi, Conti, & Belluardo, 1998b). However, some of these studies present substantial limitations discussed elsewhere (*see* Chaves, Lopez-Gomez, Hervas, & Vazquez, 2017). Taking into account the need for designing a study that addresses these limitations, a comparative study of the present intervention protocol with a well-validated treatment for depression, a cognitive-behavioral protocol (Muñoz, Aguilar-Gaxiola y Guzman, 1995; Cuijpers, Muñoz, Clarke, & Lewinsohn, 2009), was conducted with an appropriate sample size of clinically depressed patients (Chaves et al., 2017; Lopez-Gomez, Chaves, Hervas, & Vazquez, 2017a). Both treatments were effective and no significant differences were found between them (see Chaves et al., 2017; Lopez-Gomez et al., 2017a).

A manualized protocol: The Integrative Positive Psychological Intervention for Depression (IPPI- D)

The aim of this paper is to describe a manualized protocol which includes a structured combination of empirically-validated positive psychological interventions (see Table 1) that have been proved to be effective in increasing well-being or alleviating depressive symptoms (Bolier et al., 2013; Sin & Lyubomirsky, 2009).

The study protocol was approved by the Faculty Ethics Committee. This program consists of 10 weekly, two-hour sessions in a group format. We recommend a maximum of 15 participants per group. Therapists should follow a manualized protocol in which all sessions have the same general structure. Positive results from this program have already been published (Chaves et al., 2017; Lopez-Gomez et al., 2017a).

Table 1. *Positive psychological interventions included in this packaged treatment*

Module	Description of the session	Previous empirically-validated studies	Well-being dimension
1	Objectives, expectations and attitudes on treatment What is depression? Rationale for treatment from a positive psychology perspective	Based on Keyes (2007), Seligman et al. (2006), Gilbert (2012), among others.	
2	Positive emotions: identify and name positive emotions and learn to promote them.	Seligman et al. (2006)	Hedonic
3	Savoring to amplify the intensity and duration of positive emotions	Bryant (1989)	Hedonic
	Emotion regulation through mindfulness attitudes	Kabat-Zinn (1990)	
4	Gratitude. Counting one's blessings. Optimism. Best positive self.	Emmons & McCullough (2003) King (2001), Seligman et al. (2006)	Hedonic
5	Positive relationships Kindness. Counting kindnesses	Lyubomirsky et al. (2005), Boehm & Lyubomirsky (2009)	Eudaimonic: Positive relationships
6	Self-compassion	Gilbert (2012)	Eudaimonic: Self-acceptance
7	Personal strengths. Complete VIA-IS and using one's signature strengths	Seligman et al. (2005)	Eudaimonic: Autonomy, Self-acceptance
8	Sense of living. Obituary/Biography Goal Setting	Seligman et al. (2005) MacLeod et al., (2008), Sheldon et al. (2002)	Eudaimonic: Purpose in life, Personal growth
9	Resilience	Based on Folkman & Moskowitz (2000)	Eudaimonic: Environmental mastery
10	Relapse prevention	Following same rationale as CBT	

Note. VIA-IS = VIA Inventory of Strengths (Peterson & Park, 2009). CBT = cognitive-behavioral therapy.

Conceptual framework

The current conceptualization of positive mental health challenges the extended notion that mental health is merely the opposite of mental disorder. Based on this idea, Keyes (2007) proposed a "complete state of mental health model" in which psychological well-being (i.e., positive emotions, coping resources, life satisfaction, strengths, etc.) may coexist with psychological difficulties (i.e., symptoms, deficits, disorders), and both aspects should be evaluated separately (Vazquez & Hervas, 2008).

Following current consensus on the nature of well-being (Ryff, 2014; Diener et al., 2016), the conceptual framework of the IPPI-D program considered well-being as a combination of hedonic components (e.g., positive affect) and eudaimonic components (e.g., self-acceptance, positive relations, autonomy, purpose in life, environmental mastery, personal growth; Ryan & Deci, 2001; Ryff, 1989). The IPPI-D program was intentionally designed to nurture both components (see Table 1) that, despite being intrinsically interrelated (Ryan & Deci, 2001; Waterman, 2008), need to be independently targeted in interventions aimed at improving well-being.

Moreover, although hedonic well-being may be considered transient, the broaden-and-build theory of positive emotions (Fredrickson, 1998; 2001) suggests that positive emotions may have a rather long-term effect on increasing or maintaining people's subsequent psychological well-being by building more durable physical, intellectual, and social resources that are essential to promoting adaptive coping responses (Tugade & Fredrickson, 2002). In turn, these enabling resources (e.g., personal strengths, positive emotions, positive cognitions, resilience) feed back into one's experience and cognitive judgments about life (Cohn, Fredrickson, Brown, Mikels, & Conway, 2009).

This framework guided the design of the protocol where sessions were thematically sequenced to facilitate the experience and generation of positive emotions as early as possible in the program (sessions 2 to 4) while eudaimonic components were incorporated in the following sessions (sessions 5 to 9). In any case, they were not entirely separate sequences since patients were encouraged to continue practicing hedonic exercises throughout the whole program.

General structure of a session

Sessions start with a revision of previously assigned homework followed by an introduction to the topic of the day. Metaphors, poems, songs, and video-clips help to introduce the central topic of the session. After that, session goals and a brief psychoeducational module are presented and a brief discussion among participants is encouraged. Selected results from scientific studies are presented in an understandable manner to explain and counteract the effect of biased ideas and misconceptions about well-being and related topics. Then, participants receive guidance on how to carry out in-session exercises and practice new skills in the group. In-session exercises are relevant since this program tends to emphasize contextual and experiential change strategies in addition to more narrative and didactic ones. At the end of each session, therapists provide a summary of the key ideas and the goals of the homework assignments. Exercises are facilitated by handouts and worksheets provided during each session. There is a continuous effort by the therapist to generate a warm and supportive atmosphere during each session, trying to make participants feel welcomed and accepted. Session facilitators acknowledge any concerns from participants.

Description of Sessions Content

First session: Orientation to Treatment. The first session is dedicated to establishing the intervention goals, the ground rules for each session, and the treatment rationale. First, therapists welcome participants and highlight how important it is to attend treatment in order to help live a better life. The importance of committing to the program in order to get better results is highlighted. As in similar group intervention programs (Muñoz et al., 1995), participants accept some rules to ensure that the group functions well and is productive, as well as to reinforce what is expected of participants. These ground rules include elements such as punctuality, regular attendance, active participation, confidentiality, and completion of between-session assignments. Then, participants are guided to introduce themselves focusing on positive aspects (e.g., talking about their preferences, hobbies, skills, etc.). This first session is focused mainly on generating a warm and open atmosphere to help participants feel comfortable. Consequently, active listening and kindness with and between participants are constantly promoted. After this exercise, to formally start the meeting, therapists provide an outline and rationale for treatment, which includes a psychoeducational explanation of what depression is from a positive mental health perspective (*see* previous conceptual framework description) and emphasize the role of diminished positive emotions, cognitions and other resources (e.g., personal strengths, positive relationships, resilience or meaning) in depression maintenance (Seligman et al., 2006). At this point, therapists begin to explore the participants' opinion about the model and whether it fits their personal experience. Therapists also assess participants' expectations and establish general therapy goals within the group. To close the session, participants are asked to become aware of the positive events, and the positive emotions they may experience during the next week. A list of positive emotions is provided (e.g.

joy, gratitude, hope, admiration, serenity, love). To help them become aware of these events and emotions, participants are encouraged to record them on a daily basis. A worksheet is provided for this exercise.

Second session: Positive Emotions. First, therapists explore how participants feel after the first session and they congratulate participants for their effort of coming to the treatment and trying to look at things in their daily lives differently and paying attention to positive experiences. This session is focused on learning to identify and name positive emotions (Seligman et al., 2006). Key ideas about positive emotions and their benefits based on Fredrickson's theory (Fredrickson, 1998, 2001) are presented and discussed in the group. For example, the difficulties of detecting positive emotions against negative emotions or the functions and benefits of both are discussed. Then, participants identify and name the positive emotions they feel when seeing different short emotional video-clips, with an emphasis on the low intensity emotions (to improve their ability to discriminate each emotion). Participants explore in which daily situations they feel a certain emotion, what are the physical sensations associated with it and what is the utility of it. Research has shown that the ability to name and differentiate positive emotions is related to higher well-being and resilience (Tugade, Fredrickson, & Barrett, 2004). Thus, the ultimate goal of this session is to increase participants' ability to identify their positive emotions, broaden their emotional vocabulary and promote the experience of positive emotions during the session. The need of identifying, naming and promoting positive emotions in daily life is discussed and therapists help participants find examples of when they experienced positive emotions during the previous week. This strategy aims to show participants that, although it may be difficult at first to detect positive emotions in their daily lives, they can train themselves to become aware of positive emotions and to not take them for granted or dampen them. As homework,

participants are asked to start this training by identifying and recording any small pleasures they experience in the following week. When identifying the experience, participants are asked to take a moment to name the emotion (they can use the positive emotion list provided in session 1) and actively experience it.

Third session: Savoring and Being Aware. This session was designed based on the idea that positive emotions can be maintained and even increased both in the short- and longer-term through attentional deployment (Quoidbach, Mikolajczak, & Gross, 2015). Attentional deployment is a deliberate attempt to make emotions last and minimize hedonic treadmill (Seligman et al., 2006). Savoring, mindfulness and emotion regulation are the topics of this session. Mindfulness may foster both savoring and emotion regulation. For example, simple mindfulness abilities may help patients become aware of emotions and learn how to manage them without judgement and without pushing them away. Participants also learn and practice mindfulness attitudes in order to change their relationship to their emotional experiences and thoughts (Segal, Vincent, & Levitt, 2002; Williams, Russell, & Russell, 2008) and prevent the experiential avoidance that characterizes depression (Cribb, Moulds, & Carter, 2006). These attitudes are 'non-judging', 'patience', 'beginner's mind', 'trust', 'non-striving',' acceptance' and 'letting go' (Kabat-Zinn, 2004). In order to facilitate positive and negative emotion regulation processes, these attitudes are illustrated in the session through different exercises, such as brief practices of mindful breathing, body scan, and savoring. For instance, participants are given a piece of chocolate and are asked to savor it following the therapist's guidance. After the exercise, they are encouraged to comment on their experience. After this practice, participants follow the same guidance savoring a raisin, as a way to cultivate mindful awareness and openness. This exercise helps introduce the topic of negative emotion regulation strategies. Participants explore

different negative emotions and their adaptive functions, as well as the possible emotion regulation strategies that may help to manage them. The goal is that participants learn the importance of embracing the whole emotional experience (Kabat-Zinn, 2004).

As part of their homework, participants are instructed to purposefully notice pleasurable features of their environment and practice attitudes of mindfulness in their daily lives. For example, they could take an attentive walk, noticing as many positive things around them as possible (e.g., flowers, sunshine), or they could take a few minutes a day to fully focus their attention on pleasant activities that they typically rush through (e.g., a mindful meal or shower) (Kabat-Zinn, 1994). Participants are encouraged to use savoring techniques before, during, and after positive emotional events (Bryant & Veroff, 2007). Handouts with specific savoring exercises are provided.

Fourth session: Gratitude and Optimism. Benefits of expressing gratitude and optimism have been broadly tested (e.g., Emmons & McCullough, 2003; Carver, Scheier, & Segerstrom, 2010). Firstly in the session, gratitude and its benefits are explained. Participants explore the effects of giving thanks for things that they feel grateful for and discuss their benefits on well-being and health. Participants write individually about three good things (small or big) for which they want to express gratitude and are then encouraged to share them aloud, noticing the effect on themselves (Seligman et al., 2006). To focus on interpersonal gratitude, participants are invited to write a gratitude letter in a mindful and open way to a person who has helped them, and to whom they have never properly thanked. The effects of writing these letters are discussed and attendants are encouraged to think about whether or not they would like to actually send or give the letter to the intended recipient. In case they ultimately decide to send the letter, expectations of the recipient's reaction are analyzed,

emphasizing that when we express true gratitude we do not expect anything from the other person in return. After this activity on gratitude, the topic of optimism is introduced. Participants think about optimistic people that they know and explore the benefits of thinking in a more optimistic way (Seligman, 1998). Key concepts of locus of control and characteristics of an optimistic explanatory style are illustrated with examples from public figures that the participants know well. Video-clips and interviews of these well-known people are shown to further discuss how to practice a more optimistic way of thinking. Reframing things in a more positive way (e.g., finding silver linings) is often challenging for depressed people. This session helps participants perceive benefits from even negative situations (Sergeant & Mongrain, 2014). While the exercises discussed and practiced in this session can be applied to significant life events and traumas, we explicitly try to start by practicing the concept of reappraisal to help participants reframe smaller events from daily life (e.g., even though you missed the bus, you at least got some good exercise when you were running to catch it). Once participants are used to seeing things not only in black and white, it will be easier – or even come naturally – to also find meaning or "look on the bright side" of more important negative life events. As part of their homework, participants start a gratitude journal in which they write down three good things that happened during the day. Participants also complete a journal of silver linings. Worksheets for these exercises are provided. As an optional exercise, participants are invited to complete the 'Best possible self' writing exercise which consists of imagining your life in the future and describing what the best possible life you can imagine for yourself would look like, considering all of the relevant areas of life, such as your family, career, relationships, hobbies, and/or health (King, 2001; Sheldon & Lyubomirsky, 2006).

Fifth session: Positive Relationships. The characteristics and benefits of nurturing positive relationships (Lyubomirsky, 2007) are discussed based on scientific literature, participants' examples, and video-clips about lessons learned by people who have suffered difficult events and have learned the importance of positive relationships. Then, participants individually write their current strategies for cultivating positive relationships and share their ideas in the group to learn from others' experiences. Key strategies highlighted during the session are expressing frequent positive affect to others, offering sincere compliments, mindful listening, expressing gratitude, making a conscious effort to stay connected, seeking out happy people, investing in quality time with the people you care about, responding actively and constructively to good news from others, or practicing acts of kindness. For instance, the benefits of practicing kindness are analyzed based on participants' experiences of being kind or being treated kindly; all together participants make a list of possible random acts of kindness. As part of their homework, participants are asked to put into practice the acts of kindness in the list that they committed to performing (Boehm & Lyubomirsky, 2009). Two journals, one aimed at nurturing positive relationships and another focusing on kindness, are provided where personal and interpersonal consequences of the performed actions are recorded.

Sixth session: *Compassion.* This session focuses on the importance of cultivating a compassionate mind, and it is especially useful for people with high shame and self-criticism. Key characteristics of a compassionate mind are presented through imagined situations (e.g., conscientiousness, nonjudgmental nature, centered on personal strengths, perspective, desire to reduce suffering, warmth, and soothing) (Gilbert, 2012). These examples introduce the importance of compassion, the difficulties of being compassionate with oneself and the common experience of self-criticizing. The adaptive

function of self-criticism (e.g., sense of constructive shame) is also analyzed and compared with the benefits of a compassionate approach. First, participants identify and explore these characteristics when relating to others. Later, participants are invited to write a self-compassionate letter during the session (Neff & Germer, 2013; Shapira & Mongrain, 2010). This exercise asks participants to write a letter to themselves expressing compassion for their own suffering while depressed. While participants write these letters, a mindfulness attitude, a feeling of common humanity, and self-kindness are promoted (Gilbert, 2012). Participants are asked to write to themselves from the perspective of a loving friend that accepts them unconditionally for who they are. They are guided to feel the compassion as it soothes and comforts them. As homework, participants complete a journal where their self-critical inner 'thinker' is analyzed in terms of its adaptive function (Gilbert, 2012) and it is reframed as a more compassionate and warm voice. Soothing feelings of warmth after reframing are also recorded in the journal.

Also, as a link to the next session, participants are asked to complete the VIA-IS (VIA Inventory of Strengths; Peterson, Park, & Seligman, 2005) for homework, which identifies participants' signature strengths.

Seventh session: Personal Strengths. This session focuses on personal strengths and how people often give their weaknesses and limitations more attention than their strengths. Participants explore how thinking about their personal strengths can increase happiness and reduce depression (Seligman et al., 2006). Firstly, VIA classification and the definition of character strengths are presented (handouts are provided). Participants receive individualized feedback about their top five strengths (Peterson & Park, 2009) and are provided with comments regarding their results. Attendants analyze whether or not these results reflect some of their signature strengths. Working in pairs, participants

are instructed to engage in an interview about their strengths (Tarragona, 2012). Participants share stories that illustrate their strengths in action, the impact that these strengths have had in their lives and what they do to nurture them. Participants complete the exercise 'at my best' (Seligman et al. 2006) where they are invited to share with their conversational partner a story that reflects a time that they were "at their best" – a time when they felt proud of themselves. Therapists help clarify the idea further by giving a personal example of an experience from a time when they were "at their best" to guide participants about the types of things they could think about (e.g., an excellent performance during a job interview). Partners are asked to listen carefully in order to identify the personal strengths in the story. Finally, participants are guided to formulate specific, concrete and achievable behaviors that promote the cultivation of signature strengths. As homework, participants are asked to use one of these top strengths in a new and different way every day for one week following a guide provided (Seligman, Steen, Park, & Peterson, 2005).

Eighth session: Personal Goals and Purpose in Life. In this session, the significance of defining one's purpose in life is discussed. Purpose in life represents a stable and generalized intention to accomplish something that is both meaningful to the self and leads to productive engagement with some aspect of the world beyond the self (Damon, 2009). Firstly, participants complete the 110-year old you in a time machine activity (Ben-Shahar, 2007). Participants are asked to think what they would say to their today 'you' if they could call he/she when they were 110 years old. During this exercise, participants begin to reflect upon the essence of living a fruitful and satisfying life and projecting them into the future is considered an antidepressant technique (Lazarus, 1989). Secondly, participants are told to imagine that they need to write their own biography from a realistic perspective. They are asked to write down what the title

of that biography would be (e.g., *Mother Teresa of Calcutta: A Life of Love*). After writing, participants are encouraged to share their titles with the entire group. They are asked to describe what the biography tells about themselves in terms of purpose (e.g., what you would like to be remembered for the most) and personal strengths. Awareness of one's purpose and making conclusions about oneself in terms of personal strengths encourage individuals to take steps so that their actions and relationships will be more aligned and congruent with their purposes in life (Kashdan & McKnight, 2009). The second part of this session is focused on setting goals, guided by purpose in life, but more specific and feasible than one's greater purpose in life. Purpose is a larger construct that motivates people to have goals and it organizes those goals (Steger, 2009). Key aspects of goal-setting are discussed (e.g., setting specific, challenging, and realistic goals, getting feedback, committing to the goal) and barriers to achieving them (Locke & Latham, 1990). Participants are provided with a worksheet to start defining their goals in different areas (e.g., health, family, work, friends, etc.) and strategies to face the difficulties in achieving goals are discussed (MacLeod, Coates, & Hetherton, 2008; Sheldon, Kasser, Smith, & Share, 2002). As homework, participants are encouraged to select one or two goals and plan the steps they must take to achieve them.

Ninth session: Resilience. The goal of the session is to describe key aspects of resilience and the factors that enable individuals to cope with life's adversities. Resilience has been described as a key concept in the prevention of the onset and maintenance of depression (Waugh & Koster, 2015). In the beginning of the session, some testimonial video-clips of resilient people facing adversity (e.g., severe illness, natural disasters) are displayed. Characteristics of these resilient people are subsequently explored following what research has revealed about those attributes and trajectories (Bonnano, 2004). Then, participants are asked to write about a personal past

adverse situation where they utilized a resilient coping mechanism. Working in pairs initially, and then sharing their reflections on the exercise with the group, participants are asked to identify the factors that probably helped them to overcome these challenges. These factors typically include cognitive, emotional, social and behavioral skills. External or internal resources such as personal strengths, optimism, and spirituality are also discussed (Folkman & Moskowitz, 2000). Facing adversity as a challenge, managing emotions and finding meaning in adversity are also important elements of resilience that are specifically tackled during this session. Finally, therapists conclude that recognizing and exercising personal strengths can make participants stronger and better prepared to meet life's challenges. Participants are encouraged to remember these stories and the resources (e.g., personal strengths) that will probably help them cope with new adversities. A well-known song with lyrics about resilience that provides a feeling of hope and empowerment is played to close the session. As homework, participants are invited to write a letter to future participants of this PPI workshop. They are asked to share how they felt when they first began therapy, what their emotions were, what they have learnt, what helped them the most, what difficulties they had during the past three months and how they overcame them.

Tenth session: relapse prevention. Therapists introduce the last session focusing on how participants have changed and the importance of maintaining those improvements in order to continue to live better lives. Characteristics of relapse are discussed and ways of maintaining the gains achieved during the program are explored. A review of learned techniques is presented, focusing on the broad repertoire of positive techniques that the participants have learnt. To enhance the use of positive psychological interventions, participants are also reminded that a variety of exercises usually minimizes hedonic adaptation. Searching for an optimal person-activity fit (i.e.,

the overlap between activity and person features) is also encouraged (Lyubomirsky & Layous, 2013). Therapists emphasize the importance of continuing to practice the activities that work better for each person in order to achieve sustainable results. To close the session participants are invited to read out their letters for future participants to the entire group. The ultimate goal is to help participants retrospectively analyze the changes they have undergone during this treatment and the main strategies that help them recover from depression. It is important to highlight learned skills and identify potential difficulties. Feedback from the group is encouraged, reinforcing their achievements and strengths and promoting a sense of mutual help and belonging. At this point in the session, therapists reveal that the recipients of these letters are not other future participants, but rather are themselves. They tell participants that they should keep their letters in case they ever need them. At the end of the session participants celebrate graduation, a time to recognize and celebrate their achievements.

Underlying philosophy and general guidelines for therapists

Addressing problems and symptoms is the most widespread conception of the role of psychotherapy among clinicians but also among some clients. Any perceived failure to take clients' troubles seriously may violate their expectations and can undermine the establishment of a good therapeutic alliance (Seligman et al., 2006). Therapists doing PPI interventions should keep this in mind, seeking a balance between nurturing positive resources and attending to and validating suffering. When clients report negative emotions or clinical symptoms, they should be empathically attended to within the context of a holistic well-being framework. Difficulties, frustrations or obstacles in achieving the therapeutic goals are embraced and normalized. In addition to this attitude of acceptance and openness, therapists working from this positive approach

spend substantial time during the sessions reeducating patients' attention and memory to help them focus on what is good in their lives and new ways to increase well-being. This strategy fosters a transformation of the conventional language used during therapy towards a more positive and constructive dialogue and, over time, provides a more balanced context in which clients can cope with their problems. Another relevant aspect of the PPI framework that is rather unique is the group atmosphere generated. Although not easy to assess, the positive affect that arises when individuals reveal or (re)discover key intrinsic valuable aspects of their selves is far from something frivolous or light. Although this positive climate often greatly benefits patients, it is also relevant for explaining therapist engagement.

Handling PPI programs requires a deep understanding of therapy and, in this particular case, the theoretical models of positive mental health and depression. Although many PPI techniques have been tested to modify healthy participants' mood (Sin & Lyubomirsky, 2009), their use in clinical samples requires a solid background in clinical psychology and psychotherapy and skills that allow them to foster a positive group atmosphere.

Although the PPI protocol could share some formal similarities with other psychotherapies (e.g., CBT) in regard to its structure, general therapeutic targets (e.g., emotions, relationships, goal setting) or sequential strategies (e.g., psychoeducation, relapse prevention), PPI differ fundamentally in terms of their theoretical underpinnings and other relevant aspects, such as the framework, the therapist's approach, and the specific contents of the therapy and exercises. For instance, in terms of initial psychoeducation, while CBT frames depression as a result of behavioral inhibition, negative emotions and cognitive biases related to the processing of negative information (e.g., Beck & Bredemeier, 2016), the PPI approach frames depression by focusing on

low levels of positive affect (e.g., dampening positive emotions) and psychological well-being (e.g., a diminished purpose in life or sense of growth) which are also well supported by the literature (e.g., Dunn, 2012; Admon & Pizzagili, 2015).

On the other hand, PPI also differ from other therapeutic frameworks in the way they address similar dimensions. For instance, while CBT is targeted at identifying and modifying negative thoughts and behaviors to indirectly increase positive affect, PPI directly identify and generate positive emotions during the sessions and homework assignments (e.g., gratitude, love) and help participants manage these emotions more effectively (Holmes, Lang, & Shah, 2009). Furthermore, the underlying philosophy and methods used in PPI are often more experiential than didactic. Moreover, whereas CBT promotes an intensification of positive experiences in general, PPI emphasizes the importance of investing in activities linked to intrinsic values and well-being dimensions (Ryff, 2014). Although some problem-solving and discussion of clinical symptoms does occasionally take place in the course of PPI, the goal is to strengthen already existing positive aspects or build psychological resources, rather than teaching the reinterpretation of negative aspects (Rashid, 2015). Similarly, although negative emotions are addressed in both treatments, there are some differences with regard to their approach to negative emotions. Whereas in traditional CBT the focus is aimed at changing the content of emotions, in the current PPI program the focus is on encouraging patients to embrace negative thoughts and feelings, such as anxiety, pain, and guilt. This approach is also applied to address self-criticism. In the PPI context, promoting self-compassion is less about eliminating self-criticism, and more about developing loving-kindness toward others and oneself. Although self-compassion and self-criticism could be seen as two sides of the same coin, self-compassion is a positive outcome in its own right and not just the reduction of self-criticism (Gilbert, 2012).

Discussion and conclusions

There is emerging evidence on the adequacy of structured PPI programs in the treatment of clinical depression (Carr et al., 2016; Seligman et al., 2006). If the efficacy of PPI is supported by further research, it would add PPI to the list of empirically validated therapies for depression and extend the range of intervention options available to accommodate clients' needs and preferences (Lyubomirsky & Layous, 2013). Since acceptability of treatments is an essential aspect of their effectiveness (Moher, Schulz, & Altman, 2001) and preference may affect the efficacy of treatments (Schueller, 2010), the development of new interventions based on positive psychology principles is an excellent opportunity to provide professionals with a wider range of effective therapeutic options. Although there are few primary studies that are explicitly designed to explore the impact of clients' preferences on intervention outcomes (Proyer, Wellenzohn, Gander, & Ruch, 2015; Schueller, 2011), it is plausible that, in many cases, interventions focused on positive emotions and positive traits could help to destigmatize patients' feelings towards being in psychological treatment (Rashid, 2015). Results from a trial using this protocol have shown that it was highly acceptable for participants and more satisfactory than CBT in some parameters (Lopez-Gomez et al., 2017b). On the contrary, for patients who are reluctant to experience positive emotions (Gilbert et al., 2012) or for those whom positive exercises are perceived as 'trivial', perhaps PPI should not be a front-line strategy or should be adapted. Otherwise, the credibility of the intervention could be compromised which, consequently, would lead to high dropout rates (Uliaszek, Rashid, Williams, & Gulamani, 2016). To minimize participants' possible misconceptions in this regard, our PPI program made sure to present a credible rationale for its aims and strategies in its first module.

It is worth mentioning that this protocol was designed to treat patients with clinical depression on an outpatient basis, excluding some comorbid conditions such as present substance abuse or dependence disorder, manic or hypomanic episodes (past or present), psychotic disorder (past or present), and/or a cognitive status that might prevent participants from following the intervention (e.g., dementia or intellectual disability). Future research should address the feasibility of using these positive psychological interventions in populations with comorbid conditions associated with depression.

This protocol was applied in a group setting since the group format has been shown to be a cost-effective alternative to individual treatment (Tucker & Oei, 2007) and it provides some advantages in terms of promoting cohesion and a therapeutic context for recovery (Thimm & Antonsen, 2014; Whitfield, 2010). To achieve better results, it is important to include an introduction to the group program and a list of rules during early sessions, fostering group cohesion and enhancing emotional expression of all participants (Burlingame & Woodland, 2013; Kleinberg, 2012).

It is important that the design of the assessment protocol to evaluate the efficacy of the intervention also maintains a balance between clinical and well-being variables. There are enough theoretical and empirical reasons to assert that positive and negative affect, distress and well-being or, even more generally, illness and health, are relatively independent of each other (Keyes & Waterman, 2003) (for details, see Chaves et al., 2017).

Potential future research should consider the weight of the program components in relation to their contribution to clinical improvement, the specific details of their administration (e.g., order of components, duration of the sessions) or the combination of this program with other types of psychotherapy. It is possible that a combination of

PPI with other approaches (e.g., CBT plus hedonic-oriented exercises) could boost the therapeutic impact of known therapies (Dunn & Roberts, 2016; Ingram & Snyder, 2006). In this line of reasoning, some preliminary research has shown evidence that personalizing treatments to clients' strengths led to better results than personalizing treatments to clients' deficits (Cheavens, Strunk, Lazarus, & Goldstein, 2012). Another option could be tailoring treatments according to patients' depression presentations, applying CBT, PPI or a personalized combination of both. Personalizing treatments for specific clients is an area of research that awaits further exploration. It seems plausible that creating intervention programs specifically tailored to the specific needs of clinical populations (e.g., Lopez-Gomez et al., 2017b; Carr et al., 2016) may increase their acceptability.

Finally, it should be emphasized that the current PPI program was based on techniques and interventions that have been successfully used to improve mood in patients and healthy individuals. It would be useful if future developments of PPI in depression, and other disorders, took into account other techniques inspired by basic research on emotions and psychopathology. For instance, based on current research on cognition and emotion in depression, it is possible that in the near future interventions may include modules targeting, for instance, positive components of imagery (Holmes, Blackwell, Burnett Heyes, Renner, & Raes, 2016), future directed thinking (Vilhauer et al., 2013), positive specific memories (Romero, Vazquez, & Sanchez, 2014; Vrijsen, Hertel, & Becker, 2016), or benign interpretation biases (Yiend et al., 2013). The field of positive psychological interventions is a promising new area. Yet, it will allow advancements in the treatment of depression and other mental disorders only as long as it is deeply rooted in sound findings from basic and applied research and the design of the interventions follows the strictest rules required to validate psychological treatments

(Vázquez, 2017; Dunn, 2017). To sum up, we believe that PPI will favor the emergence of ideal therapeutic settings where therapists will integrate the handling of symptoms and strengths, vulnerabilities and resources. This will allow therapists to better understand the inherent complexities of human experience in a more comprehensive and balanced way, leading to better treatment

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ANEXO IV. AUTORIZACIÓN DE LOS COAUTORES DE LOS ARTÍCULOS INCLUIDOS EN LA TESIS

Facultad de Psicología
Universidad Complutense de Madrid
Vicedecanato de Investigación, Doctorado e Infraestructuras

Autorización para utilizar una publicación en la tesis

Programa de Doctorado en Psicología – RD 99/2011

Doctorando/a: Irene López Gómez

Título de tesis: Eficacia y aceptabilidad de un programa de intervenciones psicológicas positivas versus un programa cognitivo-conductual para el tratamiento de los trastornos depresivos

Director 1 y tutor: Carmelo Vázquez

Director 2:

Director 3:

Los abajo firmantes, en calidad de coautores del trabajo A comparative study on the efficacy of a positive psychology intervention and a cognitive behavioral therapy for clinical depression publicado en 2017 (i) autorizan que este trabajo sea presentado por el doctorando/a para su tesis doctoral, (ii) declaran que el trabajo no ha sido presentado en ninguna otra tesis doctoral en la que los firmantes estén involucrados y (iii) se comprometen a no utilizarlo en ninguna otra tesis doctoral en la que estén involucrados.

Deberán firmar todos los co-autores del trabajo, consignando debajo su nombre completo y fecha de firma.

Fdo: Gonzalo Haro
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Carmelo Vázquez
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Programa de Doctorado en Psicología – RD 99/2011

Doctorando/a: Irene López Gómez

Título de tesis: Eficacia y aceptabilidad de un programa de intervenciones psicológicas positivas versus un programa cognitivo-conductual para el tratamiento de los trastornos depresivos

Director 1 y tutor: Carmelo Vázquez

Director 2:

Director 3:

Los abajo firmantes, en calidad de coautores del trabajo Pattern of changes during treatment: A comparison between a positive psychology intervention and a cognitive behavioral treatment for clinical depression publicado en 2017 (i) autorizan que este trabajo sea presentado por el doctorando/a para su tesis doctoral, (ii) declaran que el trabajo no ha sido presentado en ninguna otra tesis doctoral en la que los firmantes estén involucrados y (iii) se comprometen a no utilizarlo en ninguna otra tesis doctoral en la que estén involucrados.

Deberán firmar todos los co-autores del trabajo, consignando debajo su nombre completo y fecha de firma.

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Director 3:

Los abajo firmantes, en calidad de coautores del trabajo Comparing the acceptability of a positive psychology intervention versus a cognitive-behavioral therapy for clinical depression publicado en 2017 (i) autorizan que este trabajo sea presentado por el doctorando/a para su tesis doctoral, (ii) declaran que el trabajo no ha sido presentado en ninguna otra tesis doctoral en la que los firmantes estén involucrados y (iii) se comprometen a no utilizarlo en ninguna otra tesis doctoral en la que estén involucrados.

Deberán firmar todos los co-autores del trabajo, consignando debajo su nombre completo y fecha de firma.

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Director 1 y tutor: Carmelo Vázquez

Director 2:

Director 3:

Los abajo firmantes, en calidad de coautores del trabajo The Integrative Positive Psychological Intervention Program for Depression (IPPIP- D) publicado en 2017 (i) autorizan que este trabajo sea presentado por el doctorando/a para su tesis doctoral, (ii) declaran que el trabajo no ha sido presentado en ninguna otra tesis doctoral en la que los firmantes estén involucrados y (iii) se comprometen a no utilizarlo en ninguna otra tesis doctoral en la que estén involucrados.

Deberán firmar todos los co-autores del trabajo, consignando debajo su nombre completo y fecha de firma.

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