

Research Article

An Integrative Approach to Promote Subjective Well-being and Mental Health Based on Transdiagnostic Intervention Components

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Abstract

Background: Despite the vast amount of experimental and correlational studies and the various attempts to understand the mechanisms of change of psychological interventions, researchers and practitioners are still facing unanswered questions about how intervention programs work, and which factors are those which contribute significantly to improvements in mental health and well-being. Numerous programs were developed with varying concepts and theoretical foundations: Each approach has displayed a relevant amount of empirical evidence in fostering mental health which justifies their backing within the researcher and practitioners' community. Yet, we still don't know which intervention components and specific factors are relevant to actual change. **Method:** In this study, a systematic literature review was conducted to analyze existing research related to psychological interventions. **Aim:** The aim of this study was to provide an overview of current findings on emotional support and integrate them into a comprehensive framework. **Results:** We present a unifying conceptual framework to integrate those concepts based on a transdiagnostic basis and humanistic conception of human beings. Following the ideas of transdiagnostic approaches, we propose four central components: Mindfulness (MI), Emotion Regulation (ER), Self-Reflection (SR) and Resource Activation (RA) underlying and targeting different psychological processes leading to inner change. **Limitations:** The limitation of this study is that no empirical approaches were pursued. **Conclusion:** Despite their initially different approaches, those can meaningfully be integrated into a conceptual framework. It would be desirable for the focus to be more on how different concepts can complement each other.

Keywords

Subjective Well-being, Mental Health, Psychological Intervention, Transdiagnostic Approach, Prevention Program

1. Introduction

Until today, we still know little about the optimal way to foster mental health and well-being. Since the beginnings of psychology as a research discipline, different theoretical concepts and therapeutic approaches have been developed and empirically tested. There have been discussions between

scholars and practitioners, psychoanalysts and cognitive behavioral therapists [92], between psychologists following the ideas of positive psychology and those who criticize them and their assumably too simplistic ideas [130]. In this paper, we move on from any theoretical trench warfare and focus

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on the content and empirically backed aspects of well-being interventions.

Based on a review of current empirical research on psychological interventions, the elaborated four promising conceptual components are thought to aim at different process levels of psychological change and therefore assumably complete and reinforce each other. Focusing on the enhancement of transdiagnostic processes relevant to the prevention of mental health problems, we plan to shed light on the “black box” of psychological interventions and contribute to the current research on promising prevention concepts. The components can be understood as interscholastic valuable, finding their place in diverse ways and forms in different psychotherapeutic approaches.

2. Background and Rationale

Good mental health anything than self-evident: Lifetime prevalence of mental health issues is around 35%, the 12-month prevalence within a student population is around 31% [2]. The number of depressive symptoms among teenagers in the US rose significantly from 2012 to 2018 [72], especially among girls. Around two thirds of mental disorders have their onset before 25 years of age [123]. On the other hand, loneliness and social isolation increases, representing high risk factors for mental disorders [64]. There is an elevated need for mental health services and a need for scalable, easy to implement and effective psychological treatments [139].

The so-called “third wave” of cognitive-behavioral therapies (CBT) [54, 55] emerged in recent years and with it, new forms of process-based therapies. Therapeutic approaches like mindfulness-based cognitive therapy (MBCT) or acceptance and commitment therapy (ACT) focus on core processes like emotion, sense of self and metacognition. Those transdiagnostic interventions are seen as a cost-effective way to prevent mental disorders and foster well-being [30, 84]. The transdiagnostic approach allows a bigger transfer of theoretical and practical advances between disorders [52, 62]. [54] distinguish between six transdiagnostic process levels which can be targeted through psychological interventions: Behavior, emotion, cognition, self, motivation and attention.

It is a long ongoing debate within the psychological community whether common factors and/or specific factors can be made responsible for the efficacy of psychological interventions [29, 42]. The common factors approach goes back to Saul Rosenzweig (1907–2004) who introduced the idea back in 1936. In the early 1960s, it was Jerome Frank who followed this path and described four common factors: a functioning relationship between patient and therapist, a rationale that provides credibility to the treatment being delivered, certain procedures or rituals that are provided in a structured manner, and a healing context or setting. Towards the end of the 20th century, several meta-analyses [77, 132] found no differential outcomes of different psychotherapies if the treatments were implemented bona fide. This so-called Dodo-Bird-Verdict has continued to be much-discussed until today [28, 85, 38].

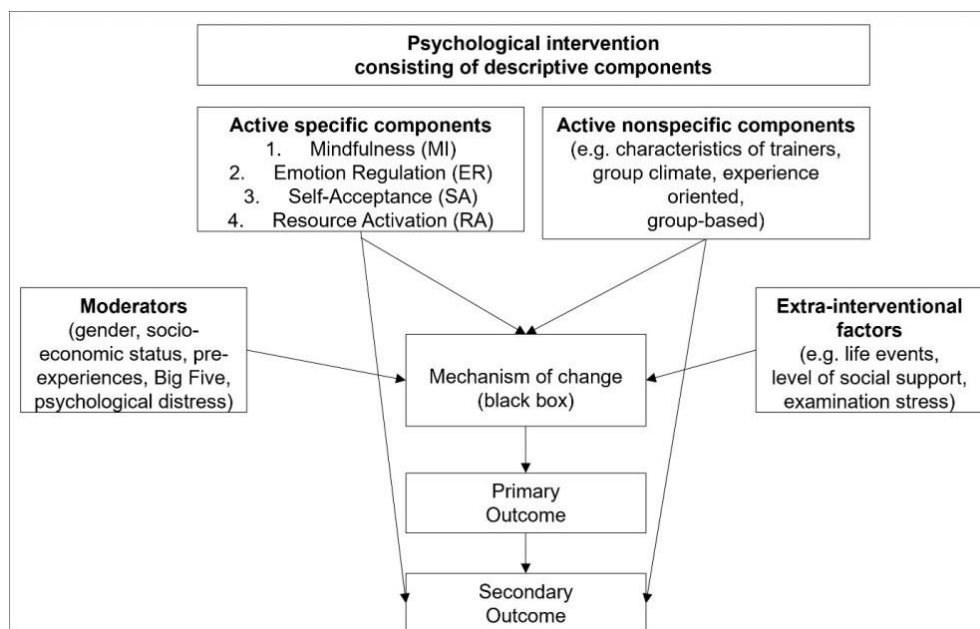


Figure 1. Model of Inner Change through Psychological Interventions.

In Figure 1, we present a model of inner change through psychological interventions, with the four specific compo-

nents being active components. Those are being evolved in chapter 3, being the key aspects in the framework. Active

nonspecific components are characteristics of the trainers, e.g., their personality and professional background, and the group specific climate and atmosphere. Some common characteristics lie within the concept of the training, like strong experience orientation and group-based exchange. They are not tied to any specific interventional school but are active in any intervention. Besides that, we must consider that extra-interventional factors like any positive or negative life events or level of social support influence the outcome. Those lie beyond our control. Furthermore, you can think of some potential moderators such as gender, pre-experiences and state of psychological distress which affect the participants and the mechanism of change.

3. Conceptual Framework

As can be seen in [Figure 1](#), the four components target at least two psychological processes and through implementing all four components, a comprehensive, holistic approach and pattern of change is induced. Behavioral, emotional, motivational, cognitive, attentive, and self-focused level of inner processes can be distinguished as transdiagnostic levels.

3.1. Component 1 – Mindfulness

3.1.1. MI as a Transdiagnostic Factor

Mindfulness (MI) has received huge attention from the research community during the past years and has become one of the most studied transdiagnostic factors within mental health and well-being [\[19, 26, 46, 69\]](#). [\[12\]](#) proposed an operational definition of mindfulness consisting of two facets: (1) attention to the present moment and (2) an openness to and acceptance of experience. Another widespread definition of mindfulness is paying attention to the present moment in a state of nonjudgment [\[70\]](#). A correlated concept is the one of compassion, which means a feeling of care in response to someone suffering with the wish to improve their well-being [\[121\]](#). According to Kristin Neff [\[87, 88\]](#), self-compassion is closely intertwined with mindfulness but expands the view further with an alternative, healthy attitude toward oneself. She describes it as a balanced view of oneself as well as one's (negative) emotional experience [\[87\]](#), consisting of three main bipolar components: (a) self-kindness (vs. self-judgment); (b) common humanity (vs. isolation); and (c) mindfulness (vs. overidentification) [\[86\]](#). The ethical-motivational mechanism is seen to be critical for mindfulness improving mental health and well-being [\[32\]](#).

3.1.2. Relationship to Mental Well-being and Mental Health

The ability to be aware and attentive for the present moment has been shown to have a relevant impact on several outcomes and markers of mental health and well-being. [\[145\]](#) report a significant correlation of $r = .47$ between mindfulness

and well-being. [\[73\]](#) showed that the distracted states are associated with lower levels of mental wellbeing – even during the least enjoyable activities throughout the day, mind-wandering people were unhappier than the people in a more aware stadium. Less awareness and higher distraction in unintentional mind wandering are associated with higher stress and anxiety [\[111\]](#). Depressive patients show significantly higher levels of mind wandering and rumination, especially reporting anxious and stressful thoughts [\[61\]](#).

Up to this point, different theoretical assumptions can be distinguished on how mindfulness could enhance mental health and well-being [\[99\]](#). One well-studied mechanism is the association of mindfulness to adaptive emotion regulation [\[95\]](#): Mindfulness may improve the ability to perceive all relevant aspects of the situation and of one's own emotional reaction. It could help with amplifying the focus of concentration, moving away from a fight-flight reaction, opening to a range of different behavioral responses. Beyond that, being more mindful could come with less distracting thought, it decreases rumination and mind wandering, while improving an accepting attitude towards one's own self. Mindfulness is said to “regulate the maladaptive thoughts, emotional responses, and automatic behaviors that underlie mental health problems” [\[26\]](#). Mindfulness could decrease subjective perceived stress and decrease symptoms of anxiety and depression [\[18, 31, 79\]](#). [\[65\]](#) proposes five different mechanism which explain the efficacy of mindfulness: Attention regulation, body awareness, increased cognitive reappraisal as part of emotion regulation and intensified exposure, extinction and reconsolidation as part of emotion regulation, and changes in the perspective of on the self, leading to less identification with a static sense of self.

Mindfulness shares common facets with emotion regulation. Emotional intelligence as described by [\[81, 82\]](#) includes the perceptual clarity about one's emotional states. If someone is more aware of their current emotions, needs and wishes, he or she will be better able to choose adaptive emotion strategies. MI could be important for someone to disengage from unhealth and maladaptive behavior and habits, so it could enhance self-regulation [\[59\]](#). Apart from that, it could enhance the experience of positive states and emotions and lead to higher quality of moment-to-moment experiences, so directly enhancing well-being. People experiencing flow [\[27\]](#) while their activities report higher satisfaction and well-being [\[21\]](#), while flow requiring a high amount of attention and awareness to the present moment.

Higher levels of self-compassion are associated with greater life satisfaction, emotional intelligence, social connectedness, and stronger mastery goals, as well as with lower levels of depressive symptoms and anxiety [\[87\]](#). In a meta-analysis, [\[145\]](#) found an overall magnitude of the relationship between self-compassion and well-being of $r = .47$. Furthermore, SC predicted significant variance in positive psychological health beyond that attributable to personality [\[88\]](#). Self-compassion also relates to better health behavior

and a more resilient coping [17, 107].

The tendency to avoid and suppress unpleasant inner states and experiences is described as experiential avoidance [57]. As a transdiagnostic context factor [15, 122], it could be a crucial aspect in explaining how a higher attention to inner unpleasant states as mindfulness techniques train could lead to higher well-being. For example, higher experience avoidance predicts increases in anxiety and depression and is associated with a reduction in well-being [142]. Changes in experience avoidance were able to explain the impact of increased self-compassion on anxiety, depression, and well-being after SC training [141]. According to [57], experience avoidance contributes to increased symptoms and psychopathology in different ways: Conscious avoidance strategies activate through the mental symbolic representation of what is to be avoided the access to this and thus influence further cognitions and behaviors.

3.1.3. Training-related Changes

Mindfulness and acceptance-based approaches therefore try to counteract the avoidance of experience and promote contact and non-judgmental direct access by the person to their own experience. This idea is based on results which for example show that thought suppression led to an increase of that thought, resulting in a paradoxical mechanism [133].

During the past two decades, several empirical studies have shown that mindfulness-based trainings result in higher mental health and well-being [58, 109, 128] and lower perceived stress [68]. A recent meta-analysis on well-being intervention programs showed that Mindfulness-Based Programs (MBPs) were the most effective interventions in improving well-being compared to distinct types of psychological interventions [128]. The efficacy of mindfulness-based interventions has been proven for several mental disorders, like anxiety, depression, eating disorders and chronic pain, but it also enhances well-being and lowers stress in healthy populations [65]. Studies show differential effects on varying outcomes: The strongest effects are reported for emotional and interpersonal aspects, medium effects for attention and smallest effect for more cognitive measures [109, 120].

Self-compassion was proposed as a crucial mechanism in explaining the effectiveness of mindfulness-based training and the higher levels of well-being after such an intervention [65]. Self-compassion training improves well-being and reduces psychopathological symptoms [39, 66, 137]. Further, the relationship between self-compassion and mental health may be mediated by emotion regulation [66]. A meta-analysis on self-compassion related therapies [137] showed medium effect sizes on anxiety and depressive symptoms, however, when in studies which included an active control condition, no significant differences between the intervention and the control group were found. Likewise, in a meta-analysis of [131] on self-compassion related therapies which showed a significant, medium effect size throughout the studies, greater effect sizes were found with longer dura-

tion of interventions and when comparing to waiting control groups instead of active control groups.

Enhanced emotion regulation has been suggested to underline many of the beneficial effects of mindfulness meditation. A range of implicit and explicit emotion regulation processes has been proposed, and mindfulness-based emotion regulation may involve a mix of these processes, including attentional deployment (attending to mental processes, including emotions), cognitive change (altering typical patterns of appraisal regarding one's emotions) and response modulation (decreasing tonic levels of suppression). Through the enhanced and expanded attention and awareness in the present moment, "mindfulness may improve individuals' ability to attend to specific aspects of a situation (e.g., expanding beyond a narrow focus on threat), as well as aspects of their own experience (e.g., body awareness), and therefore improve their detection of the need to implement (or adjust) regulation strategies" [97]. The adjusted form of perceiving inner states may reduce the intensity of emotional responses and negative valuation of emotions may lessen. The process of mindfulness meditation is characterized as an active cognitive regulation in meditation beginners, who need to overcome habitual ways of internally reacting to one's emotions and might therefore show greater prefrontal activation. Expert meditators might not use this prefrontal control. Rather, they might have automated an accepting stance towards their experience and thus no longer engage in top-down control efforts but instead show enhanced bottom-up processing. Mindfulness meditation resembles an exposure situation because practitioners turn towards their emotional experience, bring acceptance to bodily and affective responses, and refrain from engaging in internal reactivity towards it. To conclude, mindfulness is an indispensable cognitive process which forms the basis for psychological change. Nonetheless mindfulness alone is not sufficient and needs complementary implementation with further components targeting further psychological processes.

3.2. Component 2– Emotion Regulation (ER)

Emotions are subjective experiences consisting of different components [118]: A subjective feeling, along with an action tendency which motivates a certain behavior, an appraisal component, which helps to make sense of an experience, a motor activity which leads to communication on an interpersonal level, and lastly a physiological component, which supports the emotional experience on a bodily level, e.g. blood flow and changes in pulse. Functions of emotions are the selection of behaviors according to needs and situations, the regulation of the intensity and endurance of the various behaviors and remembering behaviors that were successful or led to failures.

3.2.1. ER as a Transdiagnostic Factor

Emotion regulation (ER) has been determined as a trans-

diagnostic factor multiple times and as relevant for psychopathology [1, 7, 9, 24, 47]. To understand emotion regulation more fundamentally, the process model of emotion regulation from [47] became dominant and hugely influential. According to Gross, emotions are helpful when they appropriately guide sensory processing; they provide information and others' behavioral intentions and motivate socially appropriate behaviors. Emotions are harmful when they are the wrong intensity, duration, frequency, or type for a particular situation, and maladaptively bias cognition and behavior [49,

50]. Emotion regulation in this model describes any attempts to influence which emotions one has, when one has them, and how one experiences or expresses them. The goal to influence the emotion trajectory is activated. It can be either conscious or unconscious. The defining feature of emotion regulation is the activation of a goal to influence the emotion trajectory [48]. Emotion regulation refers to actions that seek to influence emotions by changing (a) the world, (b) the perception of the world, (c) the way the world is cognitively represented, or (d) emotion-related actions.

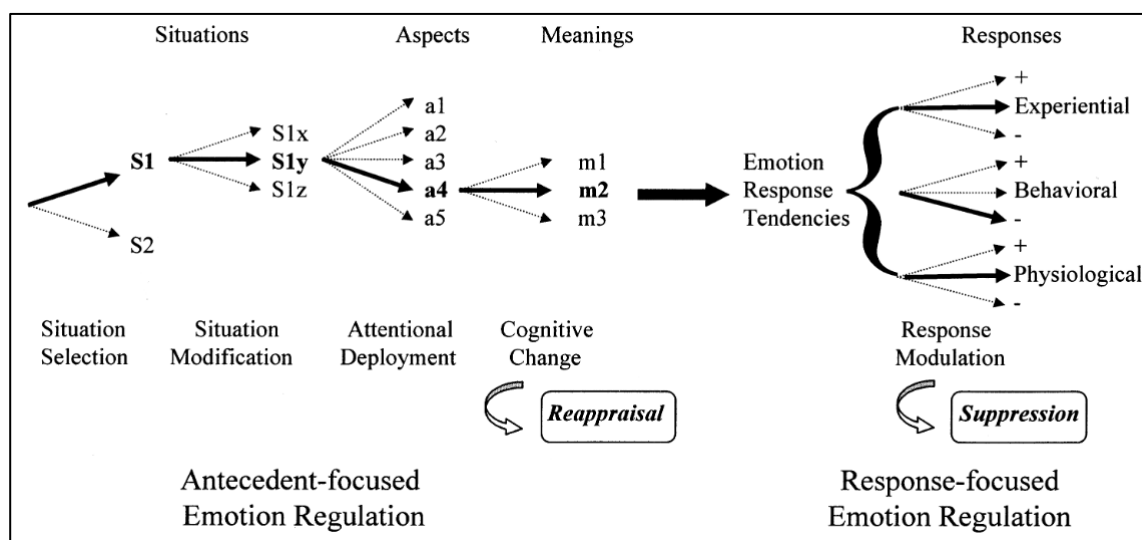


Figure 2. Process model of emotion regulation [47].

3.2.2. Relationship to Mental Well-being and Mental Health

The relationship between adaptive emotion regulation and good mental health as well as high subjective well-being (SWB) has been empirically attested in numerous studies. High emotional competence is associated with the higher subjective well-being: In a meta-analysis, [104] showed that the significant relationship between SWB and emotional competence is $r = 0.32$, while the association is higher for the cognitive component of SWB ($r = 0.35$) than with the affective component ($r = 0.29$). An adaptive emotion regulation is an important protective factor for mental health [11] and dysfunctional emotion regulation competence has been associated with lower well-being and higher occurrence of psychopathological symptoms [1, 24]. Individuals with psychological disorders use less frequently adaptive ER strategies and/or use maladaptive strategies more often [24]. Furthermore, they may show a lower effectiveness in the implementation [49]. Concerning different types of emotion regulation, [143] showed that the higher frequency of using cognitive reappraisal predicts lower psychopathology [45]. Deficits in emotion regulation are mediator factors between childhood experiences and psychopathology in adulthood

[11]. Individuals with psychological disorders use adaptive ER strategies less frequently and/or tend to use maladaptive strategies more frequently [24]. Beyond that, they show a lower effectiveness in the implementation phase when using adaptive strategies. Higher levels of adaptive emotion regulation are associated with better mental health: depressive people have more difficulties to accept and tolerate negative emotions [20], and depressive symptoms go hand in hand with catastrophizing and rumination classified as dysfunctional emotion regulation strategies [1].

3.2.3. Training-related Changes

How emotional competence and adaptive emotional regulation can be improved, is of particular interest and depends on the approach one takes towards emotional competence or emotional intelligence [60]: The ability approach considers emotional intelligence (EI) to be composed of specific abilities, for example, the four branch model of Mayer and Salovey which understand emotional intelligence as the ability to perceive emotions, assess and generate emotions, understanding and managing them [81]. The trait approach sees EI as disposition, hierarchically lower than personality traits which influences how people behave in emotional situations [93] while the so-called mixed models, e.g. the emotion-

al-social intelligence model of [4] and Golemans model of emotional competencies [16] are located in between those approaches. [60] state that EI might be a multilevel construct, resulting in different operating levels of EI. Training and interventions trying to improve EI usually target specific abilities such as perceiving and understanding emotions.

Emotional competence trainings have displayed positive results in various RCTs, in subclinical as well as clinical populations [83]: An emotional intelligence program led to higher well-being, life satisfaction, adaptive coping and self-acceptance as decreasing negative affect [115]. The Affective Regulation Training (ART), developed by Matthias Berking, has shown promising results in different empirical studies [7, 8]. Adding the ART to a cognitive based therapy (CBT) resulted in a greater reduction in depression in comparison to a regular CBT [6]. An EC-enhancing intervention resulted in lower cortisol secretion, and higher subjective and psychological well-being as well as higher perceived quality of social relationships [75].

3.3. Component 3 – Self-reflection

In recent years, the concept of acceptance has garnered increasing attention within the field of psychotherapy, where it is considered a pivotal factor in promoting psychological well-being and facilitating therapeutic change [53, 134]. Within the framework of the so-called “third wave” of psychotherapeutic approaches [54], acceptance occupies a significant role. These approaches emphasize the paradoxical nature of acceptance, particularly as explored by humanistic and existential theorists who have examined its salutary effects. Experiencing negative internal and external stimuli in a willing and nonjudgmental manner—without attempts at avoidance—has been shown to reduce psychological distress and anxiety.

In the context of this paper, self-acceptance refers to the perception and relationship an individual maintains toward the self. Individuals with elevated levels of self-acceptance “acknowledge and accept multiple aspects of self, including good and bad qualities, and feel positive about past life” [102]. While psychological research in the late 20th century predominantly focused on self-esteem as a key construct related to mental health and well-being [98], the past decade has witnessed a shift toward related constructs that share a common core: an accepting and integrative attitude toward the self, encompassing both strengths and weaknesses.

The term “unconditional self-acceptance” (USA) [36] describes the absence of global self-evaluation regarding personal worth or ability, coupled with full acceptance of oneself. Ellis defines USA as “acknowledging that as a person you are human, unique, complex, in flux and fallible and that this is true about you no matter what conditions exist in the world” [34]. Therefore, the self cannot be meaningfully evaluated in absolute terms but may instead be embraced unconditionally. Ellis emphasized the cultivation of

self-acceptance as a cornerstone of psychological well-being, advocating for therapeutic work that fosters a realistic self-view—one that embraces human fallibility and the inevitability of mistakes. Importantly, self-acceptance is not contingent upon success, achievement, or external validation.

3.3.1. SR as a Transdiagnostic Factor

Self-related aspects are named as transdiagnostic factors in several cases within multiple mental disorders, especially self-criticism, self-doubt, and low self-esteem.

Self-esteem in contrast comes with an aspect of self-evaluation, an overall global assessment of oneself [98]. In the past, research surprisingly showed that high self-esteem leads to less beneficial aspect as most practitioners thought [5]: It does lead to higher activity and initiative and just feels good. High self-esteem can be seen as adaptive trait that helps to deal with life, challenges and problems and therefore leads to higher mental health and well-being [91]. But skepticism and mixed empirical evidence have led to the emergence of alternative concepts such as self-acceptance. At this point, it is worth drawing attention to other theoretical conceptions such as Ryff’s model of psychological well-being where she includes self-acceptance as one dimension of PWB stating that “*holding positive attitudes toward oneself emerges as a central characteristic of positive psychological functioning*” [102]. It finds recurrence in different models and can be viewed as a core dimension of mental health. SA and self-esteem are positively correlated with each other, being similar to each other, while still having unique aspects [22, 78]. Self-esteem seems to depend more on affect and current emotional states, while SA is closer correlated to PWB. Self-criticism can be observed as generally higher in people diagnosed with eating disorders and non-suicidal self-harm [144], adding to the perspective of it as a transdiagnostic process. In the conceptual model by [23] self-criticism is included as a specific transdiagnostic risk factor next to further factors, producing self-harming behavior when experiencing a negative life event.

3.3.2. Relationship to Mental Well-being and Mental Health

High self-acceptance is associated with high subjective well-being and affect balance [67, 105, 140]. The relationship between mindfulness and SA is in general of a medium size [126, 127]. It is also associated with lower anxiety, depressive symptoms, negative affect, and stress [67, 90, 94, 140]. [90] conducted a 20-year prospective cohort study and come to the conclusion that “self-acceptance decreased mortality risk by 19% and added 3 years of life even after controlling for other psychological components and potential confounders”. Self-acceptance is also a mediator factor between mindfulness and SWB [140] and perceived stress [95]. Measures of life satisfaction and happiness are modestly to strongly associated with the self-acceptance scale [103].

Lower self-acceptance is associated with higher levels of depression [40] and anxiety [22]. Similarly, [138] confirmed the mediating path of self-acceptance in their study, influencing the path from discrimination to distress for both overall heterosexism and microaggressions.

3.3.3. Training-related Changes

Several acceptance-based interventions have been developed to improve specific disorders, e.g., anxiety [96], depression [71] and depressive relapse [124]. Acceptance techniques were integrated into other therapies like Acceptance and Commitment Therapy [56], Dialectical Behavior Therapy [76], and mindfulness-based approaches [106, 110]. Acceptance of disorders may lead to modified beliefs about symptoms, less distress about the symptoms and improve the willingness to experience the symptoms while continuing with other actions.

Several studies have investigated the effect of acceptance-related exercises within therapeutic interventions: Training in the use of cognitive and behavioral shame regulation and support-building skills led to significant improvements in self-acceptance, shame, and borderline personality disorder. Even at follow-up, higher quality of life and better emotion dysregulation were observed, while depression, loneliness, and stress were lowered [108]. An unconditional self-acceptance exercise [10] less self-blame and shame, while experiencing higher empathy. Training that redefined self as inner experiences then developed compassion and mindfulness skills with inner experiences led to improved mood disturbance, less stress, self-regard, and a better ability to be present [80]. Mindfulness-based interventions can also improve self-acceptance [25]. In line with those results, self-compassion found to mediate the relationship between mindfulness and SWB and between mindfulness and depression scores [63].

3.4. Component 4 – Resource Activation

Through the last years, a shift has been observed within psychotherapy and psychological intervention science: From focusing on symptoms, problems and what is wrong with the person, towards focusing on the positive, what the person already brings into therapy, the strengths of the patients and positive emotions like hope and optimism, while trying to activate those. The idea that we need to work on what is important to people, what they thrive for, in what contexts they will flourish and develop their best possible selves is summarized in the second component of resource activation (RA). Resource orientation within psychotherapy or psychological intervention aims at the utilization of already existing resources to achieve the targets.

3.4.1. RA as a Transdiagnostic Factor

The starting point in this change of approach within psychology was marked by the introduction of Positive Psy-

chology by Martin Seligman in his inaugural speech as the American Psychological Association Presidency in 1999 [112, 113, 114]. Since then, it has inspired a great amount of research and practical interventions to foster well-being and mental health. Well-being may lead to external benefits, better mental health and is crucial for personal and professional success. Seligman states five elements of well-being: Positive Emotion, Engagement, Relationships, Meaning and Accomplishment, resulting in the acronym of PERMA. Positive psychology has received growing research interest in the last years [101].

Barbara Fredrickson and colleagues have provided evidence that positive emotions counteract the detrimental effects of negative emotion on physiology, attention, and creativity [43, 44] and are a crucial factor to resilience and coping with critical life events. [44] reported that positive emotions and a broad thought-action repertoire amplify each other, leading to an upward spiral of well-being. This data supports the hypothesis that low positive emotion may be causal in depression and that building positive emotions will buffer against depression. Happiness and life satisfaction predict gains in income [89] and lead to better performance in companies and enhanced work performance [33, 125].

But the idea of the need to activate the resources of the patient or client is not limited to the positive-psychology-movement: It is also present within the solution-focused therapy approach and has also emerged within cognitive-behavioral therapies [41]. Solution-focused therapy, founded by Steve de Shazer and Insoo Kim Berg [35, 116, 117] and the works of Milton Erickson [37] emphasize the importance of focusing on solutions, resources, and paths to develop them. For solution-focused therapy, significant reductions on anxiety and depression levels were attested [74] with an average of $d = .36$. [14] studied the effectiveness of solution-focused therapy with children and adolescents which is most effective in an early stage of interventions and on anxiety and depressive symptoms. Resource orientation is relevant within psychological disorders, like social anxiety [136]. Resource activation enhances self-efficacy [3] and encourages people to try new things, take on challenges and new situations [129].

3.4.2. Relationship to Mental Well-being and Mental Health

A strong sense of purpose is associated with improved health outcomes and behaviors: It can be seen as a catalyst for successful ageing [51] and also predicts better physical health both having a sense of purpose and holding onto it may be important for physical health in middle to older adulthood [135].

3.4.3. Training-related Changes

In recent years, positive psychology interventions have shown to increase well-being in nonclinical samples [100,

119]. Condensing across these different strategies, two meta-analyses have found support for the general efficacy of positive activity interventions for increasing SWB (effect sizes between $d = .34$ and $.29$) [13, 119]. Larger effects were found in interventions with a longer duration, in individual interventions (compared with self-help), when the interventions were offered to people with certain psychosocial problems and when recruitment was carried out via referral from a health care professional or hospital. Quality rating also moderates the effect on depression: the higher the quality, the smaller the effect. [13] found an average effect size of $d = .34$ for subjective well-being, $d = .20$ for psychological well-being and $.23$ for depression. [119] found an average effect size of $d = -.61$ for enhancing well-being and $d = .65$ for reducing depression in a meta-analysis of positive psychology treatments.

Abbreviations

ACT	Acceptance and Commitment Therapy
CBT	Cognitive-behavioral Therapy
EI	Emotional Intelligence
ER	Emotion Regulation
MI	Mindfulness
MBCT	Mindfulness-based Cognitive Therapy
MBSR	Mindfulness-based Stress Reduction
MBP	Mindfulness-based Program
PERMA	Positive Emotion, Engagement, Relationships, Meaning and Accomplishment
PP	Positive Psychology
PWB	Psychological Well-being
SA	Self-acceptance
SC	Self-compassion
SR	Self-reflection
SWB	Subjective Well-being
RA	Resource Activation
USA	Unconditional Self-acceptance

Author Contributions

Sarah Franziska Tran-Huu is the sole author. The author read and approved the final manuscript.

Conflicts of Interest

The authors declare no conflicts of interest.

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