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POSITIVE PSYCHOLOGY, A SCIENCE OF STRENGTHS AND VIRTUES: BEYOND PATHOLOGY AND MEDICATION*

PSICOLOGIA POSITIVA, CIÊNCIA DAS FORÇAS E VIRTUDES: MAIS ALÉM DA PATOLOGIA E DA MEDICAÇÃO

LA PSICOLOGÍA POSITIVA, UNA CIENCIA DE LAS FUERZAS Y VIRTUDES HUMANAS: MÁS ALLÁ DE LA PATOLOGÍA Y LA MEDICACIÓN

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Abstract: Social sciences in general, and psychology in particular, have mainly approached children and adolescents through a focus on deviation from normality and of incidence of pathology. Even preventive approaches involve the expectation of potential illness. Taking into consideration that the choice for following this trend was based on a good intention of understanding and ending human suffering this has, nevertheless, created a bias in the way we study and

intervene with youth. It even interfered with how we think and what we expect from them. Paired with other factors like changes in social, economic, family and school domains, and with the growing power of pharmaceutics, this has led to a tendency of diagnosis in the youngest, with a concomitant impressive raise in percentages of children taking psychotropic medication. The newly positive psychology movement invests otherwise in assessing and optimizing the best in people. Interested in studying humans in terms of strengths, it can be a way to critically analyze, and hopefully reduce, what can be seen as a negative drift - either in terms of overuse of medication for behavioral and emotional problems in children, or of mainly consider treatment instead of facilitation of the best possible outcomes. Disempowered regarding their own diagnosis of psychopathology, and subsequent medication, children and adolescents are more prone to unethical and morally dilemmatic choices from caregivers. The aim of this article is to deconstruct the illness ideology, and to list hopeful alternatives underway in Portugal to deal with contemporary mental health in youth.

Key words: Positive psychology; strengths; children; psychotropic medication; positive interventions

Resumo: As ciências sociais em geral, e a psicologia em particular, abordaram as crianças e adolescentes através da busca de desvios à normalidade e incidência de patologia. Mesmo os modelos preventivos envolvem a expectativa e o horizonte de doença potencial. Reconhecendo que a escolha por esta tendência se baseou na boa intenção de compreender e minimizar o sofrimento humano, ela implicou, ainda assim, a criação de um enviesamento na forma como investigamos e intervimos com as crianças e adolescentes. Infelizmente, mudanças nas relações sociais, económicas, familiares e escolares, bem como no aumento do poder das farmacêuticas, tiveram como consequência uma tendência crescente para diagnosticar os mais jovens com psicopatologias, e em polimedicá-los com psicotrópicos. O recém-criado movimento da psicologia positiva investe, em alternativa, na identificação e optimização do melhor das pessoas. Interessado em estudar e potenciar as suas forças, pode vir a ser uma forma de criticamente analisar, e atenuar, esta onda negativa, quer em termos da sobremedicação das crianças e adolescentes para problemas comportamentais e emocionais, quer do excesso de atenção a tratá-las quando ficam perturbadas, em detrimento de promover a sua saúde mental. Sem poder para tomarem decisões sobre se têm ou não uma psicopatologia, e sobre se tomam ou não medicação para os seus problemas psicológicos, estão especialmente vulneráveis a escolhas pouco éticas. O objectivo deste artigo é desconstruir a ideologia dominante na doença mental, e rever actuais alternativas esperançadas através da descrição de intervenções positivas que têm sido concretizadas com jovens em Portugal.

Palavras-chave: Psicologia positiva; forças; crianças; medicação psicotrópica; intervenções positivas

"An intellectual is someone whose mind watches itself."
Albert Camus

Positive psychology as a frame of values

For most of its history, psychology has been worried with the negative side of life, and has been interested in identifying human weaknesses and correcting or ameliorating them (Seligman, 2000; Seligman, Steen, Park & Peterson, 2005; Schwartz, 2000). It has understood human functioning and mental health using a disease model, much more than advocating for a paradigm of healthy development or a positive change model.

Positive psychology, on the contrary, brings scientific tools to the study of what makes people flourish and what goes right with life, taking seriously the things in our existences that make them most worth living (Gilman, Huebner & Furlong, 2009; Huebner, Gilman & Furlong, 2009; Peterson, 2006).

Positive psychology can then be described as an effort to use the tools of rigorous science to help us understand the sources and nature of positive human strengths, characteristics, resources, and aspirations. As a utility science, positive psychology covers a wide breadth of topics, and the number of paths for application is massive (Parks-Scheier, 2009). Being an interdisciplinary field, research and intervention programs have skyrocketed in the last decade in several areas, like business, coaching, poverty and peace intervention, medicine, education, and many others. One aim of this effort is to use the acquired knowledge to promote the development of those positive features of human functioning, by guiding both individuals and the institutions within which they function. The goal is to enhance basic human strengths such as optimism, courage, honesty, flow, self-understanding, and well-being (Peterson & Seligman, 2004; Seligman & Csikszentmihalyi, 2000), instead of focusing on "the broken things" and on repairing the damage of past traumas. The question has changed from "What goes wrong?" to "What makes it optimal?"

This conceptualization is applied both to adults and youth. Regarding mental health interventions with children and adolescents it addresses functioning in a way that goes beyond (a) revealing the insufficiencies, typical of a purely medical model of mental health, (b) a primary focus on negative outcomes, and (c) considering that the most effective means to deal with mental health is through treatment in the presence of a disease (Cowen & Kilmer, 2002).

Treating mental problems is not the equivalent of promoting optimal functioning. If we assume that we get more of what we focus on, and if we consistently spotlight remedying weaknesses, then we will struggle to help children to flourish. Attention is on the wrongs, not on the rights. Conversely, if we focus on promoting positive habits of thought, speech and behavior, and invest in psychological well-being, we will help the youngsters to develop even further and to move towards wellness, happiness and excellence.

Interconnected with either of the choices is a value-driven science and a value-driven practice. For years, the aim of research and conceptualizations in psychology was supposed to be value-free, considering that science should be detached from taking positions, namely on how to live a good live. As we see it, factually as academics and practitioners we always take stances, moral positions and guide our options with principles, ideals and moral codes.

Traditionally, the existing research and methodological choices have been inviting people to be part of a scientific language where commonly the "subject" of the study is silent, enrolled or captured in the unfolding of an existing speech and frame (Irigaray, 2002). Concomitantly, psychologists gained more and more expertise in diagnosing pathology, in psychological assessment supported in psychometric theories, and in clinical strategies to treat those that are considered depressed, anxious, delinquent, anorexic... The emphasis on treatment models and techniques with rigid guidelines, the complicity with the medical models, and the hegemony of biological approaches (Duncan & Miller, 2000) set a clear framework and ideology. Terms as *symptom*, *pathology*, *illness*, *diagnosis*, *treatment*, *patient*, *clinical*, *suffering*… are impressively more common than *strengths*, *virtues*, *growth*, *self-actualization*, *meaning, happiness, fulfillment*…, exposing a view on human nature and its functioning that is psychopathology-centered, depressing and pessimistic in itself (Maddux, 2009).

David Myers (2000) points out that the literature on depression in 30 years, from the seventies to the beginning of this millennium, had around 46,000 articles published in scientific journals, compared with 400 on joy. Strangely enough, psychology even neglected the impressive growth effect of the worst negative experiences in people – recognizing that in so many cases they create conditions for the persons to become even better human beings, and allowing for their strengths and creativity to flourish under harsh circumstances.

The space for new conversations, in the terms of the other involved, and in the context of a more hopeful language, considered socially-constructed (Gergen & Gergen, 2005; Gergen, Hoffman, & Anderson, 1996), is hard to find. We believe that psychological research "is conventionally part of a linear, vertical, hierarchical relational structure, element of the singular, causal and pre-determined language of science, and its up-down structure does not allow much opportunity for a co-constructed, communal meaning, experienced as human and humane, that can be outside the chains of logical thought. Science is a sound product, that must be accounted for, under the numerical gaze of several kinds of managements and wordings ("empirically based"; rigorous), of right or wrong methods (disorder vs. normality), and of dualisms (for instance, quantitative vs. qualitative; subjective vs. objective; cognitive vs. affective, internal vs. interactional). They create tensions that might not be helpful to think differently, or that does not allow for the courage of doing otherwise. Some methodologies allocate processes at play that bring forth thoughtful and compassionate responsivity and an ever-shifting understanding of such complex realities as happiness, gratitude or forgiveness in

people's lives" (Marujo & Neto, under revision). Those practices do not lead to a pre-determined and pre-arranged answer (Hoffman, 2006), or a consensual truth about who has a disease or not, but will help us to "know how to go on" (Wittgenstein, 1953) as a reflexive and morally active scientific community.

We argue for a psychology that can illuminate what a human life at its best can be, and show how to help children and youth, integrated in their relational communities, to live good and fulfilled lives. In short, we defend a psychology of hope, enrolled in a particular position in terms of the phenomenology of human existence, less centered in intra-individual perspectives of maladjustment (described appreciatively as "problems in living", Maddux, 2009), but instead more on cultural, social, economical, artistic, conversational contexts; less focused on the person as a passive recipient of the expert's care, and more as seeing the person itself as an expert of his or her own life – even if we are working with children and adolescents. Recently, an 8 year-old told me that her problem – presented by the parents as a self-regulation problem concerning strong difficulty in managing her diabetes – was her father bringing home to the family all kinds of sweets for them to savor, when at the same time they expected her to be able to self-control and to eat only her own special food. The solution she prescribed: a change in the system, a change in the family. She knew in a clear and practical way what the key I was.

This paradigm shift implies to take a stance, to opt for particular values instead of others, to use new languages and wordings in a grammatical change. We assume that psychology should help us to understand increasingly how to nurture strong and resilient people and help live rich and meaningful lives, connected to their communities and groups.

Together with the interesting debate around definitions of wellness or optimal development, and controversial perspectives upon the label of positive psychology itself and its dualisms (positive-negative; good life, bad life…), or about the simplicity of some of its empirical data and applications, positive psychology is inviting for a revival of a science, where values such as human strength and fulfillment, civic virtues, or social responsibility, are called upon. The time has come for psychology to serve a sensitizing model and framework to make a significant difference in people's, community's and nation's lives. "Unlocking" the sometimes hidden individual and collective capacities, namely in the presence of trauma, is in our view a vital complement to the dominant trend towards depicting entropy, disorganization, pathology, or the alleviation of maladjustment, disability or discomfort (Maddux, 2009). This actualizing tendency of the science itself implies a change in ideology and metaphor - from the ideology of illness and the metaphor of medicine, to the ideology of "fishing strengths" and the metaphor of a "river in flow". It is time for a more balanced science (Snyder & Lopez, 2007), where positive psychologists "reject (a) the categorizing of humans and human experiences; (b) the increasingly common pathologizing of humans and human experience; (c) the idea that so-called mental illness and

mental health exist inside people rather in the relationships between people and their social, community, and cultural environments; and (d) the assumption that understanding what is worst and weakest about people is more important than understanding what is best and bravest" (Maddux, 2009, p. 177).

As a consequence, the task of psychologists, in particular those who work with children and adolescents, moves from the position of "identifying (diagnosing) disorders (diseases) inside the person (patient) and prescribing an intervention (treatment) for eliminating (curing) the internal disorder (disease) responsible for the symptoms" (Maddux, 2009, p. 176) to the understanding and promoting of "goals, well-being, satisfaction, happiness, interpersonal skills, perseverance, talent, wisdom, personal responsibility, self-organization and self--direction (…), and recognizing that people and experiences are embedded in a social context" (op. cit. p. 176). Psychologists will diminish their power in terms of feeding prejudice and discrimination, or investing in somewhat arbitrary social-constructions of pathology (as an example see the changes in the DSM classifications of disorders along the way since it was first published, instead promoting the formation of positive identities, and hopeful aspirations for the future. We will be psychologists whose new functions should be mainly as facilitators, coaches, teachers, consultants, social activists, agents of sustainability, driving-forces towards justice…and we will work increasingly in community and sport centers, schools, well-being facilities, churches… linked with municipalities, politicians, public opinion-makers, media, community leaders…and less in specialized clinical facilities as experts in diagnosing and treating mental problems (op. cit. p. 177).

Therefore, the target of change…changes. The methods of research become less "photographs of the person's experience" and develop into more transformative and collective actions (Marujo & Neto, 2011; Neto & Marujo, 2011). The vision and the mission become more optimistic, and the psychological science acquires more social meaning.

Mainstream interventions in children and youth services

Whenever we read a literature review on the issue of mental health statistics regarding this sample of the population, in particular from the English-speaking world, data is itself disheartening. Depression is presented as common, inflicting 10% of children before the age of 14 (the few Portuguese data points to 11%, according to Cardoso, Rodrigues & Vilar, 2004), and anxiety, mood, disruptive or substance use disorders are listed as even higher, affecting from 10 to 20% of young people by the age of 18 (Keyes, 2009). Numbers regarding drop out of school, suicide consideration sexual abuse, and moderate to high risk for mental health problems tend to be in the same range, and they fuel a psychopathology approach and a treatment perspective. The serious and subsequent concern

about children's welfare, that we all should have, do not take into account, as a rule, the way these data were collected, the options from the researchers and statisticians, nor the way we read and interpret the numbers. If looked closer, they indicate that 80 to 90% of our youth is healthy and well, or free of mental disorder (Keyes, op. cit.). If we study further, we might discover that they may be thriving and flourishing, even if "problem-free does not mean fully prepared" (Pittman, 1992, p. 27, cit. in Keyes, 2009). Anyhow, what do we grasp and conclude? That our youth is in great risk and we need to diagnose each one of them as earlier as possible in the life course, and treat them – with psychotherapy and/or pharmacology. Countries such as the USA are gradually moving into this direction, assessing psychologically all the children in all the schools. If we look for problems, we can be sure we will find them. If we have a fixation with categories, nomenclature, and diagnostic grouping, and allow for the medical model to rule psychology, we agree to have political and economic factors, more than science, guiding our work and values (Duncan, Miller & Sparks, 2004). A diagnosis highlights weaknesses at the expense of resources, and tends to be an unrepresentative, feeble and disempowering narrative of a person's life story (op. cit.). Relational distress and complexity of life circumstances are the most common reasons to seek psychological support. However, the mental health services in general, and clinical services in particular, neglect these contextual issues to impose an intra-individual perspective of what is wrong with the person. In children and youth, this is particularly common, since it is easier to point fingers to them – they do not have the power to say they disagree or not accept the label or treatment. This way, psychologists inflict blame, hopelessness and helplessness, fueling the stigma that is still carried around the idea of going to therapy or seeking a psychologist. In school contexts, for instance, it is very common to have children and adolescents refusing to come to the psychologist office because, as they assert, "they are not mad". Using as an example the "delinquent" teenager, what we do is to blame kids – either by diagnosing or by imprisoning, using psychological and psychiatric mechanisms, or legal ones – for faults that the society promoted trough injustice, broken-homes, imposed violence…We are good at excluding the feeble and the excluded (Scisleski & Guareschi, 2010). Once a diagnosis has been attached to someone, it will be difficult to disappear, as an identity-glue, labeling the wrongs, the individual evils. As the writer Gabriel Garcia Marques puts it "It is hard not to become whatever others think of us".

This is, unfortunately, the *status quo* in psychology for decades, with very high costs for children's mental health outcomes and unpredictable consequences in the future of this generation, that has grown inside services and systems that tolerate and promote this pathological and medicating frame. Psychologists became part of the problem, not of the solution.

Taking into account Schwartz model (2000), some of the possible pitfalls that define psychology as part of the problem are the following: a) life needs to be perfect, so expectations are very high and unrealistic; b) individualist values are

at the center of our cultures, so perfection will come from personal efforts, personal growth and autonomy; and c) intra-psychic focus undermined the belonging to social groups, institutions and faith communities, diminishing the importance of creating meaning through social relations. More focus on the self, less on the relational efforts and on social cohesion, has undermined the emergence of other kind of changes and models. Psychology has exacerbated these trends, in a way that paired with the incredible tendency to diagnose pathologies in the psychiatric and medical world, is now co-responsible, with economy and social choices, for an increase in psychopathology.

What we have been creating with psychology in recent years is to potentiate a credibility problem, as much as a moral and ethic one.

Reaffirming the unique identity of positive approaches to children's mental health services, I thereby defend "the road less travelled". As Sally Hage describes in the abstract of her 2003 article, "Opting for this model provides an opportunity for counseling psychologists to reexamine both their commitment to the scientist-practitioner model and their unique professional identity. I support the position that a shift to the evidence-based worldview would move the field further away from its roots as a specialty, including its particular commitment to prevention, multiculturalism, and social justice. A set of standards or competencies to advance counseling psychologists' commitments to a prevention-oriented, social justice approach is needed to guide counseling training, practice, and research. In addition, significant barriers to the implementation of a prevention--oriented agenda in counseling psychology will need to be overcome."

Until the beginning of this millennium, there has been no evidence to summarize, critique, or review in a profound way the field of child and adolescent services. There are, of course, historical roots for this situation. In fact, from a chronological standpoint, it is noticeable that the concept of childhood mental illnesses did not arise until the late 19th century. These illnesses were typically not seen as unique to children or distinguishable from adult mental illnesses until the early part of the 20th century. The first English-language text on child psychiatry was published in 1935, the term "mental disease" was coined in 1949, and the first serious attempts to assess the use of mental health services by children and adolescents begun in the late 1980s **(**Hoagwood et al., 2001). It is estimated that 90% of the world countries have no specific politics for children and adolescents in terms of mental health (DosReis et al., 2005).

Historically, two important factors galvanized developments in children's mental health services in countries like the USA or UK, factors that can be generalized to countries like Portugal or Spain: recognition that these services were scattered across a vast array of service organizations and systems (including community centers, schools, pediatric health settings, hospitals, child welfare agencies, church youth programs, and juvenile corrections facilities), and acknowledgment that important percentages of children who had identified mental health needs received help. In this area, the latest data points to 20% of children "neglected"

or without receiving mental health services, and percentages of 36% in particular areas like suicide risk (Conoley & Conoley, 2010; Hoagwood et al., 2001).

Faced with these results, some countries organized their services to create coordinated points of entry for delivery of mental health interventions. In the last twenty years, the legal systems and the educational policies advanced in ways that fostered values and principles focused on protecting the rights of children, either maintaining children in their communities, coordinating services, involving families, or instantiating attention to the social and cultural relevance of the interventions for the desirable outcomes. Accordingly, there was a development of the scientific agenda highlighting the relationship between children's needs for psychiatric or psychological care and the availability of such care, and also, more recently, of the quality of the services themselves. In any case, during its past history the aims and ethics of the foundations in children's mental care were the same: identifying who is not functioning well, and introducing some kind of treatment to solve the problem.

The immense power granted to these problem-solving paradigm, and to those entrusted with the mental health of children and adolescent is not accidental. It is allocated to the identification, diagnosis and treatment of people with disorders and to the pharmaceutical business, a big industry, that keeps creating new drugs to treat the new diseases that mental health professionals construct and deliver (Duncan & Miller, 2000; Sparks & Duncan, 2004).

At an alarming rate, adolescents and children are being medicated with psychiatric drugs. The trend began in the 1990s mainly in the English-speaking countries, rapidly spreading to Europe and the rest of the developed world (Zito et al., 2003). In the United States, for instance, the larger and most comprehensive study on the topic shows that psychotropic utilization with children tripled since then (op. cit.). According to an IMS Health Survey, in that country, and only in the four years that elapsed between 1995 and 1999, "the use of antidepressants increased 151% in the 7-12 age group and 580% in the under-6-years-old population. Children under 18-years-old saw nearly a 300% increases in the use of antipsychotic medications" (Sparks & Duncan, 2004, p. 25). Certain groups of children and adolescents showed other alarming data: those in foster care were 16 times more likely to receive a prescription than their non-foster care counterparts, those in welfare, from families living in poverty, were 2 to 3 times more likely to be medicated (Zito et al., 2003; DosReis et al., 2005), and children in the 2-through 4-years-old were prescribed methylphenidate (a stimulant prescribed for Attention Deficit Hyperactivity Disorder, ADHD) by an increase of 169% between 1991 and 1995 (Zito et al., 2003). The ultimate trend is the polypharmacy, which means prescribing more than one drug simultaneously (Olfson, Marcus, Pincus, Zito, Thomson, & Zarin, 1998, cit. in Duncan & Miller, 2000).

Unfortunately, this chapter does not present data from Portugal because it was not possible to locate it for Portuguese children in this realm, to allow for a comparison. We were able to identify a document from a Task Force for

the Promotion of the Rights of Children in Hospitals, from *Alto Comissariado da Saúde*, (*Health High Commission*) but it has no reference to psychotropic drug administration and care. We found another important and recent document titled "*Politica do medicamento, dispositivos médicos e avaliação de tecnologias em saúde*", part of the *Plano Nacional de Saúde 2011-2016*, but again it has no reference to psychiatric medication, apart from a very technical and brief note on the prescription of benzodiazepine. In the previous document, the *Plano Nacional de Saúde* (*National Health Plan*) 2004-2010, the assertions regarding children and adolescent psychiatric conditions suggest that the actual services are insufficient, that there are no epidemiological data on prevalence of mental illness in these populations (they present data from international studies). The proposals for action during the period of the *Plano Nacional de Saúde* (*National Health Plan*) under consideration relate with the priority of this services, the integration of institutions, better information, studies on the epidemiology, prevention and promotion of mental health, and graduate training in the domain. We could not find (yet) the report on the outcomes of these proposed measures, to assess how much and which of these interventions were actually done and what were the results.

The ethics of diagnosing and medicating youth

People are often miserable for very good reasons. Suffering and mental illness are given facts in our lives and our work as psychologists. Nevertheless, we might be contributing to turn normal behavior in sickness, and that deserves our deepest attention. Medication fits well in a society of immediacy and victimization. I do not think this is the image of the humankind we dream about.

Is marketing masquerading as science (Sparks and Duncan, 2004)? Are we informed about the dangers inherent in light of the limited knowledge base that underlies medication use in young children? Do we, as psychologists in clinical, educational practices, or working with families under welfare, anticipate the possible flaws and consequences of our act of diagnosing children and adolescents with psychological disorders, and of writing assessment reports on our view and labels over their mental problems? As a beginning answer to these last questions, "a 1993-1994 survey of outpatient psychiatrists done in the USA indicated that 59% of children and adolescents were diagnosed with depressive disorder, and that these youngsters were six times more likely to receive a prescription for an anti-depressant than their counterparts in 1985 (Olfson, Marcus, Pincus, Zito, Thomson, & Zarin, 1998, cit. in Duncan & Miller, 2000, p. 33).

The recent data on conspicuous unethical behaviours and conflicts of interest between mental health researchers, academics, and pharmaceutics, namely with "ubiquitous and manifold…financial associations" (Angell, 2000, p. 1516) should preoccupy all of us. The arena of pediatric psychopharmacology fails to put this astonishing rampant rise and associations into perspective, and even

to convince us about the evidence regarding efficacy of the drugs for these age groups (Sparks & Duncan, 2004). Repetitive and unreflected ways of intervening, traditional clinical ways of looking at problems of all kinds, and prominent relations with doctors and pharmaceutics need, in our opinion, to be scrutinized. Marketing and media saturations reinforce the ideas of effectiveness of psychotropic drugs, and spread "truths" that are not discussed in the scientific community. As psychologists, equipped with other kind of instruments for change, we have a moral right to rapidly invest in contention, common sense and scientific grounding regarding our part in the widespread psychotropic medication for children and adolescents.

Most mental health professionals do not have the time, the information, or the will, to reflect and discuss the controversies regarding pharmacological treatment of children, and rethink the choices they are doing in their own professional and scientific practices. But the consequences are so complex and dangerous that there is an urgent need to open a public debate, as much as to train psychologists on the ethics of diagnosing and medicating children and youth.

In parallel, there is a need to create new areas and topics of research, and new avenues for intervention, where the myopic main-stream ideology is subverted and traditional psychology practice with children, adolescents, families and communities can be respectfully challenged and insurrected.

Psychologists have been specializing in instrumental interventions, more than in metaphysical ones. As previously discussed, currently, the investment in optimizing the best in people pale in importance when compared with diagnosing and treating them. Changing fruitfully and restructuring confidently the nature of education, work, family life, politics, economy, justice or social relations has clearly been less present in the choices of psychologists. Maybe the time has come.

Positive Interventions as points of light

Creating mental health services that shift to a positive, strengths-based and promotional focus has not happened yet, but it is on its way (Tedeschi, & Kilmer, 2005). The view on positive mental health and alternative paradigms are consistent with the movement of positive psychology. But even for those under the positive approach umbrella, the idea of complete positive mental health is abstract or difficult, since the question still remains: are the 80% of problem-free youth, mentally healthy in a positive sense (Keyes, 2009)? Are they happy, flourishing? We believe these questions risk to fuel again the negative view upon these populations, and maintain the doubt on their possibilities as the centrality point of our science. Maybe the inquiry it is not "if" but "when" are they flourishing; possibly the query is not "how much" happy but just "how" are they happy; perhaps the investigation is less about the "I" but more about the "we" (the balance between

the I and the we is discussed by Seligman (2000) as one of several possible explanations for the epidemic of depression in our new generations in developed societies around the world; less concerned with the past (a diagnosis is a frame about the past with dark implications for the out-of-control future), but more in relation to the horizons of the best possible future that can be co-constructed and delivered.

In the words of Sparks, Duncan and Miller (2000, p. 215) "we are all implicated, and we all own a piece of sorting out what works from what perpetuates the very problems we oppose".

Internationally, and even considering that until recently much of the work focused on research with adults, it is striking that only in 2009 the scientific community edited a comprehensive book depicting research on positive psychology involving children and youth, focused in particular within the school context (Gilman, Huebner & Furlong, 2009). It is clear that positive psychology approaches are growing, in special in schools, but are far from being in the mainstream or even near the conventional mental services for children and youth.

We conclude this chapter with a characterization of what is the present destiny that we are already creating as alternative to the illness ideology in Portugal, both in research and applied arenas. We thereby review what we consider the substantial contributions from positive psychology so far to the work with children and adolescents in understanding and promoting flourishing and well-being in our country. Imperfect and limited as they are, they point nevertheless into a new direction.

Summary of selected topics from Positive Psychology ongoing research in Faculdade de Psicologia, Lisbon University:

1. Expressive writing in adolescents. Study of the effects of writing texts under the titles "Me at my best" and "A difficult problem I'm proud to have solved" (one group writing firstly about the problem solved and then about the high point in life, and the other in a reversed condition) and its relations with the enhancement of positive emotions and self-efficacy;
2. A randomized, experimental and control study building, implementing and assessing a one year-long program to enhance character strengths and virtues in school-age children (supported in Peterson & Seligman, 2004), paired with experience training in meditation, biological agriculture and ikebana. The study assessed the impact upon social and academic behavior, school and family relations, and upon feeling good and functioning well.
3. Assessing emotional and social implications and potential areas of change after one week of a daily implementation of an intervention program (named ZorBuddha, by Vasco Gaspar constructed around positive psychology exercises (Three blessings; setting daily goals, expressing gratitude…) with a group of adolescents finishing high-school.

4. The study of the positive social and emotional impacts of particular kinds of music (listening and playing) in a sample of high-school adolescents.
5. Values in action: studying the changes in values and self-concept in a group of adolescents after being involved in voluntary work for at least six months.
6. The study and the optimizing of mechanisms of hope in parents with chronically ill children, including building a program to develop hope and a family Genogram of hope.
7. The study of levels and longitudinal patterns of hope in parents of children undergoing psychotherapeutic processes.
8. The study of hope and optimism for the future regarding their kids' lives in parents undergoing therapy for drug addiction (methadone).
9. The study of levels and mechanisms of optimism and resilience in adolescents and children chronically ill or with terminal diseases. One of the studies involves assessing the social, emotional and physical impact in children with terminal or chronic diseases, on their health professionals and parents, of the completion of a dream (going to Disney World, meeting a very well-known football player, going to see Santa Claus at Patagonia…).
10. The study of a 3-year program called "Click for Change" for 9th graders in a deprived and isolated region of Portugal, the Azores islands (Terceira Island), aimed at constructing positive expectations, future-oriented projects, and paths to purpose (supported in William Damons's work, 2009). The deep objective is to promote positive links to school, persons of reference and education, and to find purpose through the discovery of personal strengths and important goals.
11. Studies on post-traumatic growth in children and adolescents that experienced traumatic events such as being institutionalized after neglect, abuse, extreme poverty in their family's contexts or after experiences of war and consequent migration. One of the studies also explores post-traumatic growth in the caregivers of these children and adolescents, some of whom were victims of physical violence from the children, and kept working in the same place and job.
12. A study on the levels and mechanisms of hope in mothers of children living in poverty. It explored what were the resources and strategies they used to keep and maintain hope in the present and for the future regarding their offspring.
13. A study of the mechanisms for hope, optimism and future expectations in institutionalized adolescents, some of whom that had problems with justice or the legal system.
14. A study focused on the behavioral and educational solutions used by parents and kids (besides medication, since they were all under psychotropic drugs) involving parents whose children were diagnosed with ADHD. It explored exceptions to symptomatic behavior, and resources that worked

on a daily-basis to deal with the "problem" in school and family contexts.
15. A study of a program constructed to enhance flow among student athletes (playing roller hockey) and its relation with quality of performance and team work.
16. A study on the reasons for the future positive expectations on their own possible and dreamed marriage in a group of adolescents whose parents had divorced;
17. A study on the gains and positive benefits, in terms of interpersonal communication patterns, between fathers and sons/daughters after their parents' divorce.

The guidelines for these research projects involved:

a) The use of qualitative methodologies for data recollection, to allow a deep understanding of the subjective experience of the children, adolescents and caregivers enrolled, and to ensure that they had a voice and were active and heroic participants in the process;
b) To consider that "asking questions is transforming", and therefore a research project imply an invitation to those involved to focus on a particular topic in a particular way. This indicates that researchers had to be very sensitive about what questions they asked, and how they did it;
c) In parallel, the meaning attributed to the empirical studies was to distancing from a "photograph of a reality" and approaching a "process of transformation", what we call a "transformative-research" (Marujo & Neto, under revision);
d) Consequently, we introduced Appreciative Inquiry methodology (Cooperrider, 2004; Preskill, & Coghlan, 2003) as the structural model to construct the interviews and focus-groups, in such a way that the method of inquiry is coherent with the positive quality of the topics and the value--driven paradigm;
e) Whenever possible, we did "relational and collective research", going beyond individual gathering of data, entailing dialogues between several people discussing the issue under consideration;
f) When achievable, participants were invited to be part of the discussion of results and were always recipients of those results, either through a writing document or a conversation;
g) The methods of recollection of data implied, in some instances, languages that were easier to the persons involve, like drawings, symbols, poetry, metaphors…exploring the use of both hemispheres and going beyond the traditional paper-and-pencil (actually never used) and verbal assembly of data;
h) When we used numbers to invite the persons to explain their perception of the experience being studied, we used the Scaling Question (De Shazer, 1991, 1994) and introduced the notion of "quantification with meaning",

since the persons were asked to pick up a number to classify their experience, but were then supposed to explain in detail the meaning attributed to the number chosen, what had to happen to be able to go up half a number in the scale, and so on.

Finally, independently of considering that all these moments of the empirical research (empirical in the etymological sense of experiential) were applied--positive psychology, this chapter ends up listing a couple of action-research procedures where the action was more important than the investigation:

- Translating, implementing and assessing effects of the Penn Prevention/ Resilience Program for a group of Portuguese teenagers in a private school;
- Translating, implementing, adapting, assessing and publishing (through a longitudinal study, currently in the third year) the Australian Optimism Program "Bright Ideas";
- Training in positive psychology principles and methods of thousands of teachers, parents and health professionals around the country;
- Developing co-constructed programs based in positive psychology in hundreds of schools (in particular on the topics of Educating for Optimism, Educating for Happiness and Increasing Sense of Humor);
- Developing co-constructed intervention programs to optimize strengths and relational-transformative conversations (Marujo & Neto, 2007) in foster care homes (involving children, adolescents, and their caregivers, and also including the family from where they come), network against poverty, or commissions engaged in the protection of children and youth at risk, in very well-know Portuguese institutions such as Instituto de Acção Social da Região Autónoma dos Açores, Casa Pia de Lisboa, Santa Casa da Misericórdia de Lisboa, Instituto de Apoio à Criança, Comissões de Protecção de Crianças e Jovens em Risco, Gabinetes de Apoio Familiar, Fundação O Século, and many others.

Into the future

As positive psychologists, we need to find ways to help promote positive change in the world, rather than investing in a clinical practice that convince people that changing their minds and thinking positive will ultimately be the solution for their problems. As much as we continue to indulge ourselves, as professionals, in the construction of more individual illnesses, of more diagnostic categories, and of more individual treatments, either through individual psychotherapy or psychotropic medication, we are, in my point of view, feeding the monster.

The risk of inducing people to accept intolerable and unjust social or educational conditions through helping them change the way they think about the

world is so dangerous as to induce them to think they have an individual, intra-psychic illness, are victims of a pre-determined biology shaped by a medical problem, and whose responsibility is theirs and only theirs, independently of their life circumstances, historical and cultural factors or social-economic position (Marujo & Neto, 2008).

We need to emancipate people - and the youngest in particular - from the deterministic influences of genetic programming, negative labeling of themselves, their families and communities, and of cultural conformity. The impacts of those beliefs include, but go beyond the heuristics or semantics, directly into the practical consequences into their self-concepts and their futures will be devastating, their appreciation of the level of control over their fates will be minimal, the easy solutions will be chemical, and hope will be a luxury. Subsequently, we need to discharge the enthroned image that the science of the negative aspects of human beings – greed, violence, depression, abuse, stress, alienation, delinquency, hyperactivity, risk…- is more authentic and implies being more easily measured than the science of the positive ones – joy, optimism, cooperation, flow, gratitude, sense of humor…Negativity, as it happens with fear, froze our actions and limit our options (Fredrickson, 2003). Growing up and growing old implies hope.

A new inquiry is probably the main resource into an envisioned future. How can we use psychology to create or nourish beauty? Construct collective well-being? Enhance social justice? Optimize meaningful lives? Enrich and elevate education systems? Indentify loving families? Build collaborative communities? How can we help others to uncover, craft and present their stories in a capacitating way? How might we create a human scientific monument (Seligman, 2000)? What can be done so that psychologists turn into ambassadors of the realm of human possibilities?

Albert Camus said that "all great deeds and all great thoughts have a ridiculous beginning." May the beginning of this paradigm shift appear somehow peculiar. That will probably mean that it has a good, shining future.

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