COPYRIGHT AND CITATION CONSIDERATIONS FOR THIS THESIS/ DISSERTATION

- Attribution — You must give appropriate credit, provide a link to the license, and indicate if changes were made. You may do so in any reasonable manner, but not in any way that suggests the licensor endorses you or your use.

- NonCommercial — You may not use the material for commercial purposes.

- ShareAlike — If you remix, transform, or build upon the material, you must distribute your contributions under the same license as the original.

How to cite this thesis

The Effect of Positive Psychology Interventions on Hope and Wellbeing Among Adolescents Living in a Child and Youth Care Centre

by

Krysia Teodorczuk

Minor dissertation

submitted in partial fulfilment of the requirements for the degree of

MASTER OF ARTS

(CLINICAL PSYCHOLOGY)

in the

FACULTY OF HUMANITIES

at the

UNIVERSITY OF JOHANNESBURG

Supervisor: Prof T Guse
Co-Supervisor: Dr G du Plessis
Date of submission: April 2015
Acknowledgements

I would like to express my gratitude and appreciation to those who have contributed to my personal growth, my return to study, and to making this research possible:

To my husband, for his silent support, patience, and love; my personal teacher, my best friend, and my soul mate.

To my parents, for being role models that I aspire to, who have guided, encouraged, and supported me throughout my childhood, adolescence, and adult life. To my mother for her compassion, love, and generosity, and to my father for his wisdom, insight, and resilience, qualities I am grateful to have inherited.

To my sisters, Ania, Monia, Lucy, and Mary, for their humour, friendship, support, generosity, kindness, and love, without them I would be lonely and lost.

To Professor Tharina Guse, my supervisor, and Doctor Graham du Plessis, my co-supervisor for sharing their abundance of knowledge, giving generously of their time, and for their patience in guiding me through the research process.

To the courageous adolescents who partook in this study, for their dedication, hopeful outlook, strength, and resilience, I am grateful and honoured to have had the pleasure of working with such an inspirational group.

To the child and youth care centre and the supportive childcare management team who offered me the opportunity and facilitated my research, for their generosity and compassion and their support and enthusiasm for my study.

To my friends, near and far afield, who have and always will be both my inspiration and my supporters.

I dedicate this study to my father, who has always valued education, believed in me, encouraged my growth and independence, and of whom I am extremely proud.

Mój Najdroższy Tata,
Dziękuję tobie za świat, który dla mnie stworzyłeś.
Będę zawsze Ciębie miała w moim sercu.
Kocham Cię.
Financial assistance provided by the National Research Foundation (NRF) in respect of the costs of this study is hereby acknowledged. Opinions or conclusions that have been expressed in this study are those of the writer and must not be seen to represent the views, opinions or conclusions of the NRF.
Abstract

Research within the field of positive psychology and more specifically studies implementing positive psychology interventions (PPIs) have proved effective in building character strengths, increasing positive affect, reducing negative affect, and ultimately enhancing wellbeing in adults, adolescents, and children. Notably, a large proportion of these studies focused on non-clinical populations. More recently however, studies within clinical, susceptible, and referred populations have been successful in enhancing positive characteristics whilst reducing psychological distress and symptoms of psychopathology. Despite the burgeoning research within this field, little is known about the impact PPIs have on vulnerable adolescents residing in child and youth care centres (CYCCs).

By the transformational nature of adolescence, this period of life can be experienced by family-nurtured youths as stressful, confusing, difficult, and unsettling. These experienced pressures and emotions may be exacerbated in less fortunate adolescents residing in CYCCs. A primary developmental task that requires mastery during this frequently tumultuous phase is that of identity formation. As such, adolescence is a prime time to introduce interventions aimed at identifying and building character strengths, developing future aspirations, and enhancing wellbeing. Development of such positive characteristics may contribute to successful transformation of this psychosocial stage of development.

The aim of this study was to implement a PPI among a group of adolescents residing in a CYCC within the Gauteng province of South Africa, and to evaluate its effect on levels of hope and wellbeing within this vulnerable population. To achieve this aim, a quantitative quasi-experimental non-equivalent control group design was implemented. Both the presence of wellbeing and the absence of psychopathology can be viewed as symptoms of complete mental health. As such, wellbeing and psychopathology along with hope were measured before as well as one and five weeks after the intervention. The sample comprised adolescents (N=29) from a single care facility, who through matched sampling were allocated to either the experimental (N=14) or the control (N=15) group. The experimental group partook in one-hour weekly intervention sessions for a period of six weeks. To determine whether the PPI had a significant impact on adolescents’ levels of hope and wellbeing, independent- and paired-samples t-tests were conducted to establish group differences at the three time intervals (before, one, and five weeks after the intervention).
Surprisingly, the results indicated no statistically significant changes in levels of hope or wellbeing between the experimental and control groups one week after the intervention or at the follow-up assessment four weeks later. Additionally, neither group experienced significant within group transformations on measures of hope or wellbeing one or five weeks after the intervention. Further research is needed to better understand the impact PPIs have on vulnerable adolescents. Recommendations for future research within this context are discussed.

*Key words: South Africa, vulnerable adolescents, looked-after youth, child and youth care centres, residential care, positive psychology interventions, wellbeing, hope.*
# Table of Contents

Acknowledgements .................................................................................................................... i

Abstract .................................................................................................................................... iii

Chapter 1: Introduction, Research Aims and Overview .......................................................... 2

1.1 Introduction and Problem Statement ............................................................................. 2
1.2 Research Aims ............................................................................................................... 5
1.3 Chapter Overview .......................................................................................................... 6

Chapter 2: Adolescence in the Context of Child and Youth Care Centres ......................... 8

2.1 Introduction ................................................................................................................... 8
2.2 Adolescence ................................................................................................................... 8
   2.2.1 Defining Adolescence ............................................................................................. 8
   2.2.2 Development and Developmental Tasks in Adolescence ....................................... 9
       2.2.2.1 Biological and Physical Development ............................................................. 9
       2.2.2.2 Cognitive Development ................................................................................. 10
       2.2.2.3 Psychosocial Development ............................................................................ 12
   2.2.3 Conclusion ............................................................................................................. 14
2.3 Care Facilities .............................................................................................................. 14
   2.3.1 Child and Youth Care Centres ............................................................................... 15
   2.3.2 Adolescents Residing in Child and Youth Care Centres ....................................... 15
       2.3.2.1 Pre-Care Experience ...................................................................................... 16
       2.3.2.2 The Experience of Living in a Child and Youth Care Centre ....................... 17
       2.3.2.3 Vulnerability to and Prevalence of Mental Health Problems in Looked-After Youth .................................................................................................................. 18
       2.3.2.3.1 Risk, Resilience and Protective Factors .................................................. 18
       2.3.2.3.2 Psychological Health Difficulties ........................................................... 20
   2.4 Summary ...................................................................................................................... 21
Chapter 3: Adolescent Wellbeing, Hope and Positive Psychology Interventions .......... 22

3.1 Introduction .................................................................................................................. 22

3.2 Historical Treatment of Mental Health Difficulties in Looked-After Youth .......... 22

3.3 Positive Psychology as a Theoretical Framework .................................................... 23

3.3.1 The Development of the Field of Positive Psychology ........................................... 23

3.3.2 Defining Positive Psychology ................................................................................. 25

3.4 Wellbeing ................................................................................................................... 25

3.4.1 Perspectives on Wellbeing ..................................................................................... 26

3.4.1.1 Hedonic Wellbeing ........................................................................................ 26

3.4.1.2 Eudaimonic Wellbeing ................................................................................. 27

3.4.2 Keyes’ Complete Model of Mental Health ........................................................... 28

3.4.2.1 Mental Health ................................................................................................. 29

3.4.3 Empirical Findings on Wellbeing in Adolescence ................................................ 30

3.5 Hope ........................................................................................................................... 32

3.5.1 Snyder’s Hope Theory ............................................................................................ 33

3.5.1.1 Goals .............................................................................................................. 33

3.5.1.2 Pathways Thinking ......................................................................................... 34

3.5.1.3 Agency Thinking ............................................................................................ 34

3.5.1.4 Putting the Components of Hope Together .................................................... 35

3.5.2 Hope as a Character Strength ................................................................................ 35

3.5.3 Empirical Findings on Hope in Adolescence ......................................................... 36

3.5.4 Hope in Vulnerable Adolescents ......................................................................... 37

3.5.5 Conclusion ............................................................................................................. 38

3.6 Positive Psychology Interventions ............................................................................. 39

3.6.1 Defining Positive Psychology Interventions ......................................................... 39

3.6.2 Theoretical Considerations for the Design of PPIs ................................................. 39
3.6.3 Specific Positive Interventions Applied in this Study ........................................... 40

3.6.3.1 Gratitude Interventions .................................................................................. 40

3.6.3.1.1 ‘Counting Blessings’............................................................................... 41

3.6.3.2 Interventions Aimed at Increasing Present Moment Enjoyment ............... 43

3.6.3.2.1 ‘Acts of Kindness’................................................................................... 43

3.6.3.2.2 ‘Savouring’.............................................................................................. 44

3.6.3.2.3 ‘Loving-Kindness Meditation’................................................................ 45

3.6.3.2.4 Character Strength Building Interventions......................................... 46

3.6.3.2.4.1 ‘You at Your Best’........................................................................... 47

3.6.3.2.4.2 ‘Strength Spotting’........................................................................... 47

3.6.3.2.4.3 ‘Using Character Strengths in a New Way’..................................... 48

3.6.3.3 Hope-Based Interventions .............................................................................. 50

3.6.3.3.1 ‘Best Possible Future Self’ ...................................................................... 51

3.6.3.3.2 ‘Goal Mapping’....................................................................................... 53

3.6.4 Conclusion............................................................................................................. 53

3.7 Concluding Summary.................................................................................................. 54

**Chapter 4: Research Methodology** ........................................................................ 57

4.1 Introduction ................................................................................................................. 57

4.2 Research Question and Aims....................................................................................... 57

4.3 Research Design .......................................................................................................... 58

4.4 Sampling...................................................................................................................... 58

4.5 Demographic Characteristics of Participants .............................................................. 59

4.6 Procedures ................................................................................................................... 60

4.6.1 Procedural Overview............................................................................................. 60

4.6.2 Intervention Content and Implementation............................................................. 61

4.6.2.1 Gratitude – ‘Counting Blessings’................................................................. 62
4.6.2.2 Kindness – ‘Acts of Kindness’ ................................................................. 62
4.6.2.3 Character Strengths – ‘You at Your Best’ ............................................. 63
4.6.2.4 Character Strengths – ‘Strength Spotting’ and ‘Using Character Strengths in a New Way’ ................................................................. 63
4.6.2.5 Hope – ‘Best Possible Future Self’ ......................................................... 64
4.6.2.6 Hope – ‘Goal Mapping’ ................................................................. 64

4.7 Measuring Instruments ................................................................................. 65
4.7.1 Biographical Questionnaire ........................................................................ 65
4.7.2 Mental Health Continuum Short Form (MHC-SF) (Keyes, 2005b) .......... 65
  4.7.2.1 Rationale ................................................................................................. 65
  4.7.2.2 Nature and Administration ...................................................................... 65
  4.7.2.3 Scoring and Interpretation ....................................................................... 66
  4.7.2.4 Reliability and Validity ......................................................................... 66
4.7.3 Children’s Hope Scale (CHS) (Snyder et al., 1997b) .................................. 67
  4.7.3.1 Rationale ................................................................................................. 67
  4.7.3.2 Nature and Administration ...................................................................... 67
  4.7.3.3 Scoring and Interpretation ....................................................................... 67
  4.7.3.4 Reliability and Validity ......................................................................... 67
4.7.4 Revised Child Anxiety and Depression Scale - Short Version (RCADS-SV)
  (Ebesutani et al., 2012) ..................................................................................... 68
  4.7.4.1 Rationale ................................................................................................. 68
  4.7.4.2 Nature and Administration ...................................................................... 68
  4.7.4.3 Scoring and Interpretation ....................................................................... 69
  4.7.4.4 Reliability and Validity ......................................................................... 69

4.8 Data Analysis ................................................................................................. 69
4.9 Ethical Considerations .................................................................................... 70
Chapter 5: Results

5.1 Introduction

5.2 Descriptive Statistics

5.2.1 Reliability Indices of Measuring Instruments

5.2.2 Means, Standard Deviations, Kurtosis, and Skewness of Measuring Instruments

5.3 Inferential Statistics

5.3.1 Comparison of Pre-Test Scores between the Experimental and Control Groups

5.3.2 Significance of Differences in Hope One Week after the Intervention

5.3.2.1 Significance of Differences in Hope within the Experimental Group before and One Week after the Intervention

5.3.2.2 Significance of Differences in Hope within the Control Group before and One Week after the Intervention

5.3.2.3 Significance of Differences in Hope between the Experimental and Control Groups One Week after the Intervention

5.3.2.4 Conclusion

5.3.3 Significance of Differences in Hope Five Weeks after the Intervention

5.3.3.1 Significance of Differences in Hope within the Experimental Group before and Five Weeks after the Intervention

5.3.3.2 Significance of Differences in Hope within the Control Group before and Five Weeks after the Intervention

5.3.3.3 Significance of Differences in Hope between the Experimental and Control Groups Five Weeks after the Intervention

5.3.3.4 Conclusion

5.3.4 Significance of Differences in Wellbeing One Week after the Intervention
5.3.4.1 Differences in Wellbeing within the Experimental Group before and One Week after the Intervention .......................................................... 79

5.3.4.2 Differences in Wellbeing within the Control Group before and One Week after the Intervention ........................................................................... 80

5.3.4.3 Significance of Differences in Wellbeing between the Experimental and Control Groups One Week after the Intervention ........................................ 80

5.3.4.4 Conclusion ..................................................................................................... 81

5.3.5 Significance of Differences in Wellbeing Five Weeks after the Intervention...... 81

5.3.5.1 Significance of Differences in Wellbeing within the Experimental Group before and Five Weeks after the Intervention ........................................... 81

5.3.5.2 Significance of Differences in Wellbeing within the Control Group before and Five Weeks after the Intervention ................................................................ 82

5.3.5.3 Significance of Differences in Wellbeing between the Experimental and Control Groups Five Weeks after the Intervention ........................................ 82

5.3.5.4 Conclusion ..................................................................................................... 83

5.3.6 Summary of Inferential Statistics .......................................................................... 83

5.4 Summary of the Results ............................................................................................... 83

Chapter 6: Discussion and Conclusion ................................................................................. 85

6.1 Introduction ................................................................................................................. 85

6.2 Discussion of the Results ............................................................................................. 85

6.2.1 Results in Relation to the Aims of the Study .......................................................... 85

6.2.1.1 Differences in Level of Hope One Week after the Intervention .................... 85

6.2.1.2 Differences in Level of Hope Five Weeks after the Intervention .............. 86

6.2.1.3 Differences in Level of Wellbeing One Week after the Intervention ........... 86

6.2.1.4 Differences in Level of Wellbeing Five Weeks after the Intervention ............ 87

6.2.2 Results in the Context of Existing Literature .......................................................... 87
6.2.2.1 Baseline Levels ........................................................................................................ 88

6.2.2.1.1 Hope ........................................................................................................ 88

6.2.2.1.2 Wellbeing ................................................................................................ 89

6.2.2.1.3 Conclusion ............................................................................................... 90

6.2.2.2 Ceiling effect .................................................................................................. 91

6.2.2.3 Methodological Moderators .......................................................................... 91

6.2.2.3.1 Measuring Instruments ............................................................................ 92

6.2.2.3.2 Duration of the Intervention .................................................................... 92

6.2.2.4 Participatory Moderators .............................................................................. 93

6.2.2.4.1 Self-Selection, Motivation, and Effort .................................................... 93

6.2.2.4.2 Social Support ........................................................................................ 94

6.2.2.4.3 Timing of and Variation in Exercise ....................................................... 95

6.2.2.4.4 Suitable Person-Activity Fit .................................................................... 97

6.2.3 Conclusion ............................................................................................................ 97

6.3 Limitations .............................................................................................................. 98

6.4 Recommendations for Future Research ............................................................... 99

6.5 Concluding remarks ............................................................................................. 100

6.6 Conclusion ............................................................................................................. 103

References ...................................................................................................................... 104

Appendix ......................................................................................................................... 138

Declaration Regarding Plagiarism .................................................................................. 138
List of Tables

Table 4.1 - Demographic Characteristics of Participants .................................................... 60
Table 5.1 - Cronbach’s Alpha Reliability Coefficients for all Measuring Instruments ........ 72
Table 5.2 - Means, Standard Deviations, Skewness, Kurtosis, and Normality Distribution of All Measures for the Experimental and Control Groups .......... 74
Table 5.3 - Significance of Differences in Hope and Wellbeing between the Experimental and Control Groups before the Intervention ................................................. 75
Table 5.4 - Significance of Differences in Hope within the Experimental Group before and One Week after the Intervention ................................................................. 76
Table 5.5 - Significance of Differences in Hope Scores within the Control Group before and One Week after the Intervention ................................................................. 76
Table 5.6 - Significance of Differences in Hope Scores between the Experimental and Control Groups One Week after the Intervention ................................................. 77
Table 5.7 - Significance of Differences in Hope within the Experimental Group before and Five Weeks after the Intervention ................................................................. 78
Table 5.8 - Significance of Differences in Hope within the Control Group before and Five Weeks after the Intervention ................................................................. 78
Table 5.9 - Significance of Differences in Hope between the Experimental and Control Groups Five Weeks after the Intervention ......................................................... 79
Table 5.10 - Significance of Differences in Wellbeing within the Experimental Group before and One Week after the Intervention ......................................................... 80
Table 5.11 - Significance of Differences in Wellbeing within the Control Group before and One Week after the Intervention ......................................................... 80
Table 5.12 - Significance of Differences in Wellbeing between the Experimental and Control Groups One Week after the Intervention ..................................................... 81
Table 5.13 - *Significance of Differences in Wellbeing within the Experimental Group*

*before and Five Weeks after the Intervention* ................................................... 82

Table 5.14 - *Significance of Differences in Wellbeing within the Control Group*

*before and Five Weeks after the Intervention* ................................................... 82

Table 5.15 - *Significance of Differences in Wellbeing between the Experimental and Control Groups Five Weeks after the Intervention* ........................................... 83
“... anything less than flourishing in adolescents and adults is associated with greater burden to self and society. ... Flourishing individuals have high levels of hedonic and eudaimonic well-being, meaning they feel good about life and are functioning well in life.” (Keyes & Annas, 2009, p. 199)

“When families are strong and stable, so are children - showing higher levels of wellbeing and more positive outcomes. But when things go wrong - either through family breakdown or a damaged parental relationship - the impact on a child’s later life can be devastating.” (Duncan-Smith, 2012, para. 6)
Chapter 1: Introduction, Research Aims and Overview

1.1 Introduction and Problem Statement

From research conducted by many scholars within the field of positive psychology and as succinctly stated by Keyes and Annas (2009), it appears apparent that flourishing, a symptom of mental health indicated when individuals experience high levels of hedonic and eudaimonic wellbeing, is both beneficial and desirable to the human condition (Fredrickson & Losada, 2005; Keyes, 2005a, 2006; Seligman & Csikszentmihalyi, 2000). However, studies revealed that only 38% of American adolescents (Keyes, 2006), and 42% of South African adolescents (van Schalkwyk & Wissing, 2010) experienced these optimal levels of wellbeing associated with flourishing. Moreover, a negative correlation was suggested between age and optimal wellbeing, indicating that the experience of wellbeing declines in maturing adolescents (Keyes, 2006).

Adolescence is a transitional period of life involving rapid development in biological, cognitive, and psychosocial processes (Arnett, 2010; Berger, 2011; Harris & Butterworth, 2010; Steinberg, 2011). These substantial changes contribute towards a notoriously tumultuous and challenging decade of life wherein individuals progress from childhood to adulthood (Santrock, 2010). Throughout this phase, adolescents are not only required to negotiate the challenges of maturational change, but they are also expected to master fundamental tasks that are essential for successful transformation into adulthood (Hazen, Schlozman, & Beresin, 2008). According to Erikson’s life-cycle theory (1980), the major developmental tasks within adolescence are to establish independence, to build and renegotiate relationships, and to form an identity (Hazen et al., 2008). The developmental processes and related tasks are associated with and effect the individual’s emotional transformation, thereby influencing levels of wellbeing. Thus ultimately promoting or inhibiting one’s ability to function optimally (Forbes & Dahl, 2010).

Youths inhabiting ordinary, healthy, and supportive home and social environments might experience adolescence as a stressful, confusing, and unsettling period of life. Less fortunate youths faced with suboptimal, poverty-stricken, traumatic, deprived, neglected, or abusive circumstances may enter into the child welfare system and come to reside in Child and Youth Care Centres (CYCCs). For these youths, adolescence can be especially tempestuous. Research has repeatedly revealed significantly higher levels of psychopathology (Kjelsberg
& Nygren, 2004; Pilowsky, 1995; Richardson & Lelliott, 2003) and lower levels of wellbeing (Leslie, Gordon, Ganger, & Gist, 2002; Zimmer & Panko, 2006) among residents of youth care facilities when compared to their family-nurtured peers. Moreover, these vulnerable youths are also prone to low levels of self-worth, self-esteem, and hope towards positive outcomes for their future (Aguilar-Vafaie, Roshani, Hassanabadi, Masoudian, & Afruz, 2011; Dumain, 2010; Milkman & Wanberg, 2012). In combination, increased psychopathology, reduced wellbeing, and low levels of hope reduce vulnerable youths’ prognosis for optimal functioning.

Traditionally, the mental health of youths in general and more specifically vulnerable youths has been researched and treated with the focus almost exclusively on psychological disorder (Evans et al., 2005). Additionally, the treatment of emotional and behavioural conditions has been framed within the disease model, illuminating and treating that which is deemed deficient, defective, fragmented, damaged, or absent (Kelly, 2003; Weisz & Bearman, 2008). Within the pathogenic framework, interventions employ behavioural modification strategies that aim to negate deficient or unhealthy ways of being, thereby controlling maladaptive propensities (Kelley, 2003; Kendall, 2011; Weisz & Bearman, 2008). Notably however, interventions within this paradigm give no attention to individuals’ positive attributes or strengths (Seligman, 2002b; Seligman & Csikszentmihalyi, 2000). In order not only to alleviate ill health but also to promote mental health and to enhance levels of wellbeing, inevitably encouraging optimal functioning in this youthful population, attention must be given to that which is positive, adaptive, unsullied, and whole (Peterson & Seligman, 2004).

In other words, it is suggested that by focusing on individuals’ strengths and positive characteristics youths may not only overcome their challenges but also experience enhanced levels of wellbeing and optimal functioning.

Interventions grounded in the positive psychology paradigm focus on identifying and building individuals’ strengths; within this framework the promotion of wellbeing serves as a major objective. As such, positive psychology interventions (PPIs) apply methods aimed at enhancing individuals’ positive characteristics and emotions, with the ultimate aim of increasing wellbeing (Seligman, 2010; Seligman & Csikszentmihalyi, 2000). Wellbeing essentially refers to optimal psychological experience and functioning (Deci & Ryan, 2008) and includes facets such as positive affective experience, good relationships, feelings of
meaning and life satisfaction, and the actualisation of potentials (Diener, 2000; Kasser, 2004; Seligman 2002a; Waterman, 2008).

More specifically, wellbeing can be conceptualised from two perspectives. The first, the hedonic perspective, focuses on emotional wellbeing indicated by the presence of positive affect, absence of negative affect, and subjective judgement that one’s life consists of more pleasant than unpleasant factors (Deci & Ryan, 2008). The second is the eudaimonic perspective and encompasses psychological and social wellbeing. From the eudaimonic standpoint, wellbeing incorporates developing nascent abilities, building strengths, and fulfilling one’s potential; thus enabling individuals to live meaningful lives and to function optimally in their personal capacities and as social citizens (Deci & Ryan, 2008; Keyes, 2006). For the purpose of this study, wellbeing is conceptualised to comprise both hedonic and eudaimonic wellbeing and by this nature encompasses emotional, psychological, and social wellbeing.

Many psychological constructs have been positively correlated with wellbeing. Hope is one such variable that has been associated with wellbeing both as a means to amplify experiences thereof and as an auspicious upshot of interventions aimed at enhancing wellbeing. Hope, as conceptualised by Snyder (Snyder, 1994, 2000, 2002; Snyder et al., 1991, 1997b) and purposed in the current study is a cognitive-motivational construct that encompasses three interrelated components namely goals, pathways, and agency. Additionally, within this conceptualisation, hope also includes an emotional element as goal-directed thoughts and actions drive emotional experiences. According to Snyder, human actions are goal directed and goals provide the targets for both pathways and agentic thoughts; pathways create the means and agency the motivation to achieve desired goals (Snyder, 2002). Based on Snyder’s conceptualisation of hope, Peterson and Seligman (2004) identified hope as one of 24 character strengths in the Values in Action classification of strengths. This character strength has been positively correlated with wellbeing (King, 2001; Marques, Lopez, & Pais-Ribeiro, 2011; Park, Peterson, & Seligman, 2004).

Research within the positive psychology framework offers theoretical and empirical evidence supporting the efficacy of such positively focused interventions, as demonstrated in a meta-analysis (Sin & Lyubomirsky, 2009) and other studies (Emmons & McCullough, 2003; Marques et al., 2011; Seligman, Steen, Park, & Peterson, 2005). In their meta-analysis Sin
and Lyubomirsky (2009) concluded that PPIs significantly decreased depressive symptoms and enhanced wellbeing in clinical and subclinical samples. Likewise, research revealed enhanced wellbeing and reduced symptoms of depression and anxiety in participants of PPIs focusing on identifying and utilising character strengths (Cheavens, Feldman, Gum, Michael, & Snyder, 2006; Emmons & McCullough, 2003; Seligman et al., 2005). Furthermore, Marques and her colleagues (2011) showed that PPIs enhanced hope, life satisfaction, and self-worth in middle-school children with the positive effects maintained at an 18-month follow-up.

Research utilising PPIs in the South African clinical context is sparse. A gap within this field focusing on enhancing wellbeing, character strengths, and optimal functioning of troubled adolescents residing in CYCCs appears evident. Through implementing PPIs, adolescents could gain an opportunity to identify and enhance character strengths and to cultivate positive emotions, which in turn may increase hope and wellbeing. These improvements may enhance their ability to respond to the multitude of challenges they will face within residential care and later in their lives within independent living; thereby assisting them in creating a healthier future (van Breda, Marx, & Kader, 2012). As Steinebach and Steinebach (2008) reported, it is through a combination of external supports and internal strengths that adolescents develop the ability to overcome life’s challenges and function optimally. Against this backdrop, the current study aims to implement a positive psychology intervention among a group of adolescents residing in a child and youth care centre within the Gauteng province of South Africa, and to evaluate its effect on levels of hope and wellbeing.

1.2 Research Aims

The broad aim of the study is to implement and determine the effect of a PPI on levels of hope and wellbeing among adolescents residing in a CYCC. The PPI, as suggested by Seligman (2002a) and explicated in the literature review, will include activities focused on giving attention to past, present, and future aspects of the adolescents’ emotional life. These tasks will be centred on gratitude, kindness, character strengths, and hope. To facilitate the broad aim, the following specific research aims have been identified:

- To investigate whether significant differences in levels of hope are achieved one week after partaking in a PPI when compared to baseline levels of hope.
To investigate whether significant differences in levels of hope are achieved five weeks after partaking in a PPI when compared to baseline levels of hope.

To investigate whether significant differences in levels of wellbeing (as indicated by a presence of positive functioning and an absence of psychopathology) are achieved one week after partaking in a PPI when compared to baseline levels of wellbeing.

To investigate whether significant differences in levels of wellbeing (as indicated by a presence of positive functioning and an absence of psychopathology) are achieved five weeks after partaking in a PPI when compared to baseline levels of wellbeing.

1.3 Chapter Overview

The current chapter served to introduce and set a contextual backdrop for the study. Further, the broad and specific research aims were presented.

The following chapter describes the period of adolescence and delineates the developmental processes and associated tasks therein. Thereafter, the worlds of vulnerable adolescents are explored through existing literature detailing their experiences before and during their residence in CYCCs. Subsequently, the youths’ vulnerabilities and susceptibilities are explicated and consideration is given to the risk and protective factors influencing their lives.

Chapter three introduces positive psychology as the theoretical lens through which this research is conducted. The psychological constructs of hope and wellbeing are conceptualised and explored making reference to empirical findings within adolescent populations. Thereafter, positive psychology intervention exercises used in this study are explicated and intervention research findings are discussed.

The methodology is discussed in chapter four, wherein the research design and aims are delineated and the method of the sampling, participants, and procedures are described. Thereafter, the content and implementation of the PPI is outlined, the measuring instruments, data analysis, and statistical techniques are explained, and ethical concerns are considered.

Chapter five delivers the findings of the current study. Subsequently, the concluding chapter presents the results in relation to the aims of the study. Thereafter, the outcomes are discussed.
and interpreted with theoretical evidence presented to formulate a better understanding of the factors that may have contributed to the findings. Finally, limitations of the study are identified, recommendations for future research are offered, and a self-reflection of the presented study is disclosed.
Chapter 2: Adolescence in the Context of Child and Youth Care Centres

2.1 Introduction

Adolescence is a period of significant transformation and development. During this time fundamental tasks need to be mastered in order to transition successfully from childhood to adulthood. These developmental tasks are traversed whilst adolescents experience substantial physical, biological, cognitive, and psychosocial growth. Additionally, adolescent development and the associated developmental tasks are influenced by the social context within which youths grow up. As such, a suboptimal environment may have negative consequences for a successful transition into adulthood.

Understanding the participants of the study, in terms of the challenges they face, the developmental expectations and tasks they need to meet, and the social circumstances from which they emanate is crucial in order to implement a comprehensive and potentially meaningful programme. As such, this chapter describes the nature of typical adolescent development and investigates the developmental tasks essential for successful negotiation of this developmental stage. Thereafter, as this study focuses on adolescents residing in Child and Youth Care Centres (CYCCs), this contextual environment and vulnerable population are explored.

2.2 Adolescence

2.2.1 Defining Adolescence

Adolescence is a culturally constructed period of life wherein a person moves from the immaturity of childhood into the maturity of adulthood (Arnett, 2010; Steinberg, 2011). During this time youths increase in wisdom, self-awareness, and independence and become better equipped to make their own decisions about the future. Adolescent development is defined in terms of biological changes as well as social and cultural expectations and norms (Steinberg, 2011). Given individual and cultural variability, it is suggested that the most meaningful way of defining adolescence is through the developmental tasks required of this stage of development (Hazen et al., 2008). These developmental tasks fall within the broader interconnected biological, cognitive, and psychosocial processes. Additionally, for the purpose of this study Steinberg’s (2011) definition of the period of adolescence as of the second decade of life is implemented, with teenagers (13-19 years) being the focus of this
study. Notably, understanding the processes and tasks that unfold throughout adolescence is important for this study as these developments closely relate to and effect emotional and motivational transformations that influence adolescent behaviour, mental health, and wellbeing (Forbes & Dahl, 2010). An exploration thereof follows.

2.2.2 Development and Developmental Tasks in Adolescence

The physical transformation from childhood into adulthood has traditionally been divided into growth and sexuality (Berger, 2011). Additionally, a third aspect of physical transformation includes changes in the adolescent brain. Together, these three biological factors relate to and effect adolescent cognitive and psychosocial development. As such, adolescent development encompasses three interacting and overlapping processes. These biological, cognitive, and psychosocial processes are responsible for the fundamental changes in adolescence (Steinberg, 2011). The combination of physical maturation, advances in cognitive ability, and changes in personal and social expectations give rise to new developmental tasks that need to be traversed. These tasks represent the cultural understanding of normal development within this period of life (Cobb, 2010). A discussion of these processes and the developmental tasks required in adolescence follows.

2.2.2.1 Biological and Physical Development

Biological changes are central to adolescent development and are responsible for physical, hormonal, sexual, and cognitive transformations (Arnett, 2010; Santrock, 2010). Elevated hormonal levels initiate puberty; a period that spans approximately the first half of adolescence wherein the child's body sexually matures and becomes capable of sexual reproduction. The major biological changes that constitute puberty involve rapid physical growth, biochemical fluctuation, changes in physical appearance, the onset of fertility, and the maturation of the reproductive system (Arnett, 2010; Beckett & Taylor, 2010; Belsky, 2010; Berger, 2011; Steinberg, 2011). The timing and tempo of these biological changes varies between individuals. Consequently, large transient differences in physique, sexual maturation, and cerebral functioning of adolescents of similar chronological ages are discernable (Hauspie & Roelants, 2012). These differences in physical appearance as well as in emotional and mental capacities between peers can affect adolescent psychosocial functioning and development.
One of the developmental tasks corresponding with the physical changes of adolescents involves learning to accept and adjust to the newly developing adult body. Body image is a psychological aspect that largely comes into play during the adolescent years. As such, dramatic physical changes coupled with the social meanings and emphasis placed on body shape, weight, and general physical appearance can have an intense impact on maturing adolescents (Hendry & Kloep, 2002; Santrock, 2010). Additionally, the variance in hormonal levels found in adolescents can contribute to the increased negative, inconsistent, and unpredictable emotions associated with the teenage years. Furthermore, these hormonal factors are associated with aggression, violence, behavioural problems, negative affect, mood fluctuations, and depression (Santrock, 2010). Therefore, the process of, and the transformation brought about by puberty can affect the adolescent’s self-image, relationships, mood, overall functioning, and sense of wellbeing (Steinberg, 2011). As such, a basic insight into the biological changes in adolescence is of vital importance in understanding and improving functioning and wellbeing in this impressionable and challenging developmental stage. Another area of major growth in adolescent development is that of cognitive change; these transformations are explored in the following section.

2.2.2.2 Cognitive Development

Adolescence is a time of change, not only physically but also cognitively with the newly developed ability to engage in abstract, logical, systematic, hypothetical, and complex thinking. These advances in thought, according to Piaget’s cognitive model (1926, 1970, 1972), occur in the fourth and final stage of development and are referred to as formal operational thought (Berger, 2011; Cobb, 2010; Santrock, 2010). Hypothetical thought involves the capacity to think of possibilities beyond the present moment reality and to create theories regarding these prospects. Once the adolescent has developed the capacity for hypothetical thought, deductive reasoning evolves. Hypothetical-deductive reasoning employs the use of logic to draw conclusions regarding abstract hypothetical speculations (Berger, 2011). Additionally, in a process cognitive psychologists refer to as metacognition, adolescents gain the ability to monitor their own cognitions, a strategy that, like other advanced thought processes, significantly aids adolescents in problem-solving situations and learning (Arnett, 2010; Santrock, 2010; Steinberg, 2011). Metacognitions are also at play when adolescents experience increased levels of self-consciousness, introspection, intellectualisation, and self-reflection (Steinberg, 2011).
Drawing from and elaborating on Piaget’s concept of formal operations, Elkind (1967) argues that adolescents who have advanced to formal operational thought are capable of seeing beneath the façade of rules (Belsky, 2010; Berger, 2011). These adolescents are now able to identify the double standards that adults employ when preaching one way of being whilst practicing another. As a consequence of identifying the flaws in other people’s behaviour, adolescents engage in metacognitions of self-reflection and obsess about what others may be thinking about their own flaws. This type of obsessive thought about one’s self paired with the feeling that one’s actions are at the centre of everyone else’s consciousness leads to a state referred to by Elkind as adolescent egocentrism (Belsky, 2010; Berger, 2011). This phenomenon is common in and continues throughout adolescence and is highly prevalent in teenagers who experience aggression, eating disorders, and delinquent behaviour (Berger, 2011).

Elkind described a number of characteristic thought patterns that are involved in adolescent egocentrism including: personal fable, invincibility fable, and imaginary audience. Adolescents frequently believe that they are totally special and unique and that they may be destined for heroic and legendary status, a characteristic referred to as personal fable (Belsky, 2010, Berger, 2011). Additionally, some teenagers fall prey to the invincibility fable, where they believe that no harm, danger, or death can befall them, regardless of their risky behaviour (Berger, 2011). A third characteristic, the imaginary audience, refers to the tendency of teenagers to believe that everyone is watching them and noting their appearance, ideas, and behaviours (Belsky, 2010; Berger, 2011). The various components of adolescent egocentrism may help explain adolescents’ amplified feelings of self-consciousness, their desire for extreme privacy, as well as their risk-taking behaviour (Berger, 2011; Cobb, 2010).

Cognitive development is an area of growth and maturation that underpins many tasks of development, from understanding others and building relationships, to scholarly performance, pro-social actions, and risk-taking behaviour; to the ability to reason, form logical arguments, and debate. Additionally, cognitive schemas and processes underlie the mental components of wellbeing, hope, rumination, anxiety, and depression (Arnett, 2010; Cobb, 2010; Steinberg, 2011). As such, this fundamental overview of cognitive development will form the foundation to understanding and exploring hope and wellbeing, two constructs to be discussed in chapter three.
2.2.2.3 Psychosocial Development

Thus far the physical, biological and cognitive developmental processes and their corresponding developmental tasks have been discussed in the context of adolescent development. Another area of growth that remains to be investigated involves psychosocial transformation. At this stage, it is important to note that these domains do not function independently, but are rather in a state of constant flux as they interact with each other (Hazen et al., 2008). Therefore for example, the physical changes that develop as a result of puberty need to be incorporated into the adolescent’s newly forming self-identity; the recently acquired cognitive functions of introspection and self-reflection are required in adolescent self-differentiation; and the social skills advanced through cognitive development give adolescents a greater awareness of how they are perceived by others, as well as assist them in building and renegotiating their familial, social, and romantic relationships (Diehl, Youngblade, Hay, & Chui, 2011). These functions are developed within the psychosocial domain of adolescent development, wherein the major developmental tasks can broadly be divided into two categories, that of identity formation and relationship building (Beckett & Taylor, 2010; Hazen et al., 2008).

Erik Erikson (1980), an influential scholar in adolescent development conceptualised eight stages of development from infancy to old age. He proposed that at each stage of development an individual is faced with a developmental task in which a binary crisis must be negotiated and resolved (Hazen et al., 2008; Santrock, 2010). Noteworthy, crisis, as used by Erikson does not refer to an impending catastrophe, but rather to a point of transformation where the individual is required to select one of two trajectories as it is no longer possible to continue as before (Cobb, 2010). Erickson believed adolescence to be a period of identity formation and separation from parents or caregivers (Hazen et al., 2008). As such, he suggested that developing a coherent sense of identity is the major psychosocial crisis faced in adolescence, a stage he referred to as identity versus role confusion (Beckett & Taylor, 2010; Belsky, 2010; Berger, 2011; Hazen et al., 2008). According to his theory, should adolescents explore roles and remain on a positive trajectory they will master the crisis and achieve a positive identity, followed by parental separation. However, if they fail, role confusion prevails (Hazen et al., 2008; Santrock, 2010).

A concern related to mastering Erikson’s ‘identity versus role confusion’ crisis that incorporates adolescents’ increased cognitive skills, their developing sense of self, and the
adolescent-parent relationship is a process referred to as individuation, whereby adolescents are able to distinguish their own attitudes and beliefs from those of their parents. Adolescents’ ability to express their own ideas, noting how they differ from others, whilst being open to, and respectful of the opinion of others reflects both individuality and connectedness: facets required for individuated relationships. Adolescents within such relationships experience a clear and distinct sense of self, yet, feel emotionally connected to others. With an individuated relationship, adolescents are able to maintain a close relationship with their parents without loss of their own distinctiveness. In this way the adolescent-parent relationship is renegotiated and redefined as it moves towards greater mutuality and equality (Cobb, 2010).

As indicated within the individuated relationship, adolescents’ growing understanding of the self and creation of self-identity are not only achieved through introspection and internal focus, but also through relationship development and social process (Santrock, 2010). It is through social interactions, friendships, familial and romantic relationships, viewing themselves in relation to others and to society, playing different roles within society, making decisions about subject choice, working holiday jobs, and questioning their future that adolescents learn to self-identify (Santrock, 2010; Steinberg, 2011). However, early adolescence is more focused on group cohesion than on self-identification (Noam, 1999), where peer popularity, group membership, and identifying with group values is of primary importance. Thus, in early adolescence individuals gain popularity through identifying with specific group values and norms, with the upshot of generating confidence. During later adolescence, self-assured youths have the freedom and confidence to selectively choose to which groups and values they subscribe (Hazen et al., 2008). Additionally, as adolescents mature their friendships become more time consuming, intimate, and purpose-filled providing them with emotional support, intimacy, and advice; roles predominantly associated with parenting during childhood (Arnett, 2010; Cobb, 2010). These social interactions and intimacies experienced through friendships and social groups assist adolescents in ascertaining key elements of their self-identities.

Identity formation is the central task of psychosocial adolescent development. This complex task is made possible through and affected by the dynamics and nature of the various adolescent relationships, as well as cognitive and biological advances throughout adolescent development. As successful identity formation has been correlated with enhanced wellbeing
(van Hoof & Raaijmakers, 2002), a general understanding of identity formation is essential for the purpose of this study. Additionally, considering that youths are developing their identities, adolescence is a prime time to introduce character strength interventions that may assist individuals in identity formation: contributing to successful transformation of this psychosocial stage of development.

2.2.3 Conclusion

The major developmental processes of adolescence cannot be considered in isolation. The biological, cognitive, and psychosocial elements of development are intricately interwoven, where each process shapes, advances, influences, or restricts another (Santrock, 2010). Moreover, these interlinked transformative processes bring about a new set of developmental tasks. These tasks, including accepting the changing body, becoming familiar with sexuality, developing and advancing cognitions, forming an identity, and building and negotiating existing and new relationships, need to be traversed and transcended. The way in which these tasks are tackled as well as the outcomes thereof may affect the adolescent’s sense of wellbeing. Accordingly, for the purpose of this study, a grasp of basic developmental processes is important. Furthermore, the continuous changes throughout adolescence may prove to be both stressful and challenging, therefore, interventions aimed at enhancing wellbeing may serve to protect against stressors during this time of transformation. Such interventions may be particularly important for youths living in care facilities.

2.3 Care Facilities

It is within the South African Constitution, that “every child has the right to … family care or parental care, or to appropriate alternative care when removed from the family environment” (Currie & de Waal, 2005, p. 599). Adoption, foster homes, and residential care facilities offer alternative care environments to children who have been orphaned, neglected, abandoned, abused, or for other reasons are no longer able to be cared for in a family setting (The Presidency, 2009). As of April 2010, in accordance with section 196 of the Children’s Act (Act 38 of 2005), as amended by the Children’s Amendment Act (Act 41 of 2007), residential care facilities including children’s homes, places of safety, secure care facilities, and schools of industry have been included under the broader ambit of Child and Youth Care Centres (Mahery, Jamieson, & Scott, 2011; Meintjes, Moses, Berry, & Mampane, 2007). This research was conducted within a children’s home setting and in accordance with the
Children’s Act (Act 38 of 2005), as amended, such a facility falls within the confines of Child and Youth Care Centres (CYCCs).

2.3.1 Child and Youth Care Centres

According to the Children’s Act (Act 38 of 2005), as amended, a CYCC is defined as “a facility for the provision of residential care to more than six children outside the child’s family environment in accordance with a residential care programme or programmes suited for the children in the facility” (Act 41 of 2007, p. 35). The Act excludes partial care facilities, school hostels, and prison environments from the domain of CYCCs. Further, it prescribes that CYCCs must offer therapeutic programmes tailored to the specific needs of individuals and designed for the appropriate residential care, treatment, and development of the children residing within the care facility.

In their report, The Presidency (2009), reflected that official data regarding the range and number of existing residential care facilities was limited, and they further stated that the country lacked consolidated statistical data in this regard. However, various commissioned audits revealed between 193 and 355 registered CYCCs accommodating between 12 920 and 21 047 children (Department of Social Development [DSD], 2012; Proudlock, 2014; The Presidency, 2009). From these data it is evident that the number of facilities as well as children cared for in these facilities is not well defined, however, all data seems to be in agreement regarding the reasons why children are admitted into CYCCs.

2.3.2 Adolescents Residing in Child and Youth Care Centres

Adolescents residing in CYCCs have frequently experienced home and social environments outside the care facility that are complex and suboptimal (van Breda et al., 2012). Poverty, family breakdown, insufficient adult supervision, and maltreatment as well as parental mental and physical health problems and substance abuse, are associated with these unsatisfactory external living conditions (Powers, Mooney, & Nunno, 1990; Uliando & Mellor, 2012). Children entering CYCCs often have a history of trauma, deprivation, neglect, and abandonment and may also be victims of emotional, physical, and sexual abuse (Kjelsberg & Nygren, 2004; Rushton & Minnis, 2002; Stanley, Riordan, & Alaszewski, 2003).
2.3.2.1 Pre-Care Experience

South Africa is a country in crisis, where epidemic unemployment, poverty, inequality, HIV/AIDS, substance abuse, crime, violence as well as moral degeneration are rife (Berry & Guthrie, 2003; Louw, 2009; DSD, 2012). These socioeconomic issues have been identified as key factors affecting families in South Africa (DSD, 2012; The Presidency, 2009). Such extreme poverty, prevalence of illness, as well as moral and behavioural turbulence sets the backdrop for increased dysfunctional and parentless families, thus rendering large numbers of children in need of care (Abraham Kriel Childcare, 2013).

Research based on information gathered from 34 children’s homes in South Africa reported a number of reasons for children being admitted into the various care facilities. In this study, Meintjes and her colleagues (2007) found that abuse and/or neglect accounted for over 30% of the children’s residency in care facilities. A further 24% of children living in residential care settings were recorded as abandoned children and 11% had been admitted following the death of one or both parents. Further, the study reported that parental illness accounted for 6% of youths residing in children’s homes, whilst illness of children explained an additional 2%. Finally, as a result of managers not willing to reveal the reason for admission or reasoning admission was court ordered, 17% of admissions were recorded as indeterminate (Meintjes et al., 2007).

South African statistical data gathered by the Department of Social Development (2010) and the Community Agency for Social Enquiry (CASE, 2012) supported these findings, reflecting that most children were admitted to CYCCs as a result of abandonment or neglect. Abuse and orphaning followed as the next largest contributors to children being admitted into care facilities. Further, 5% of children were admitted into CYCCs as a consequence of living, working, or begging on the streets; an additional category reported on in these data.

Notably, poverty was not directly listed as a reason for children entering care facilities in South African statistical data (CASE, 2012; DSD, 2012) and accounted for only 3% of admissions in the Meintjes et al. (2007) residential care report. However, as Meintjes and her colleagues (2007) reason, poverty is so pervasive that it tends to become an accepted feature of life and consequently may not be recognised as a driving cause of childrens’ admission into care facilities (2007). However, the cycle between poverty, neglect, and abuse is common, where the risk of neglect, abandonment, and abuse is exacerbated within families.
that live in poverty (Mamelani Projects, 2014; Meintjes et al., 2007; Meintjes & Hall, 2008). Similarly, HIV/AIDS was not listed as a major reason for admission into CYCCs, however orphaning, abandonment, and neglect are directly associated with this epidemic (Meintjes et al., 2007; van Vilsteren, Haffejee, Patel, & Bowman, 2011). Consequently, the reason for admission in children affected by poverty and/or HIV/AIDS may be listed within other admittance categories. Reasons for admittance into CYCCs highlight and provide an understanding of vulnerable adolescents’ frequently traumatic histories. Such an understanding is vital to the study, as their pre-care experiences need to be considered when planning an intervention with exposed youths.

2.3.2.2 The Experience of Living in a Child and Youth Care Centre

According to the Children’s Act (Act 38 of 2005), as amended (Act 41 of 2007), residential care placement is intended as a short-term alternative to unsuitable home environments, where the duration of placement should not extend beyond two years. Additionally, during the period of placement, therapeutic and psychosocial support should be offered to both vulnerable children and their families to assist them in overcoming the challenges they face; thus providing a safe and supportive environment to which the children may return. Unfortunately, due to financial constraints and high caseloads, adequate support to these families is often restricted. Consequently, many of the difficulties faced by these families remain unresolved with the knock-on effect that children become long-term residents remaining in care beyond the stipulated two years (Mamelani Projects, 2014).

Meintjes and her colleagues (2007) noted that the international welfare sector unanimously advocates residential care as a temporary ‘last resort’ for children. This stance is based upon literature that repeatedly reiterates the negative impact residential care facilities have on children. These scholars detail the international welfare concerns shared with the major international agencies involved in the needs and rights of children, such as UNICEF and Save the Children. Included in these concerns are: threatened normal developmental processes in children as a consequence of the lack of individual attention and opportunities for attachment with adults; and the failure to transfer necessary life-skills to children (Meintjes et al., 2007). These concerns support Tizard and Rees’s (1975) assertion that children raised in residential care facilities face two major challenges: stunted individuality resulting from habitual conformity to institutional rules; and arrested emotional growth spawned from love starvation.
Additionally, although the expectation of residential care facilities is to protect children and adolescents from further maltreatment, research has provided evidence to the contrary (Farmer & Pollock, 1998; Hobbs, Hobbs, & Wynne, 1999; Richardson & Joughin, 2000). Looked-after adolescents may experience multiple placements, separation from siblings, and neglected health needs (Stanley et al., 2003). Further, whilst residing in care facilities adolescents may become victims of emotional, physical, and sexual abuse at the hands of residential peers, caregivers, family members, or adults outside the care setting (Iwaniec, 2006; Lindsay, 1999; Sinclair & Gibbs, 1998; Stanley et al., 2003). The complex relationship between the adolescents’ adverse circumstances prior to entering the CYCC and the experience of living in a residential care facility place these youths at higher risk of developing psychiatric disorders (Kjelsberg & Nygren, 2004; Stanley et al., 2003).

2.3.2.3 Vulnerability to and Prevalence of Mental Health Problems in Looked-After Youth

2.3.2.3.1 Risk, Resilience and Protective Factors

Poverty, long-term family disadvantage, parental physical and mental illness, child health problems, deviant friendships, abuse, maltreatment, neglect, and abandonment are among established risk factors known to predict negative outcomes for developing adolescents (Berger, 2011; Coleman & Hagell, 2007). Within the South African context, Cluver and Gardner (2007) reported risk factors influencing AIDS orphans in Cape Town including: parental bereavement, family conflict, domestic violence and abuse, poverty, poor physical health, unsatisfactory caregiving, caregiver illness, multiple placements in out of home facilities, and lack of family contact.

Studies have established that risk factors can and often do co-occur giving rise to cumulative risk, where exposure to a greater number of risks increases the likelihood of negative outcomes (Appleyard, Egeland, van Dulmen, & Sroufe, 2005). The high occurrence of individual, family, and community risk factors that impact on looked-after adolescents, place them at high risk for a poor prognosis involving social, psychological, and behavioural problems culminating in restricted life opportunities (Coleman & Hagell, 2007; Fergusson & Horwood, 2003). Notably however, some individuals display remarkable resilience and despite their exposure to major adversity, appear to cope well, adapt positively, and triumph. These resilient youths are able to draw from various resources that may assist them to resist significant stress, trauma, and adversity. The reservoir of resources, including individual,
family, and community attributes are referred to as protective factors (Aguilar-Vafaie et al., 2011; Coleman & Hagell, 2007).

Conceptually, risk and protective factors counter each other and can be seen as opposite forces. As such, protective factors are associated with the increased prospect of positive outcomes as well as the decreased likelihood of undesirable consequences from exposure to risk (Aguilar-Vafaie et al., 2011). Accordingly, by increasing the relative balance of protective processes over risk factors, the potential for improving the developmental trajectory of at-risk adolescents is enhanced. Consequently, the risk of psychopathology is diminished and the development of adaptive functioning may be realised (Cicchetti, 2010).

Research focused on optimal youth development draws the distinction between protective factors at an individual level as well as those at a social-contextual level that include family and community attributes (Aguilar-Vafaie et al., 2011; Coleman & Hagell, 2007). Cluver and Gardner (2007) indicated that little research has been carried out regarding protective factors with looked-after adolescents in the South African context. However, they reported familial and social protective factors of enhanced caregiver reliability, support and closeness, better neighbourhoods and schools, and pro-social peer relationships, as well as positive activities including sport, dancing, and reading were associated with lower levels of anxiety and depression. Additionally, research abroad has identified individual protective factors in at-risk children including attributes such as hope (Hagen, Myers, & Mackintosh, 2005; Herth, 1998), positive views of the self (Cicchetti, 2010; Coleman & Hagell, 2007; Daniel, Wassell, & Gilligan, 1999; Fergusson & Horwood, 2003), goal-setting and achievement orientation (Cicchetti, 2010; Coleman & Hagell, 2007), pro-social values, relationships, and behaviours (Aguilar-Vafaie et al., 2011; Cicchetti, 2010; Daniel et al., 1999; Milkman & Wanberg, 2012; Mullan & Fitzsimons, 2006), the development of skills (Coleman & Hagell, 2007; Mullan & Fitzsimons, 2006), as well as identification and use of character strengths (Moore, 2010; Park, 2004). Enhancing attributes that have been identified as individual protective factors may serve to buffer these vulnerable youths against stressful and negative life circumstances. The development of character strengths, goal-setting and goal oriented thinking, and hope are addressed in chapter three.

Children in care facilities are more likely than their peers to have experienced cumulative risk factors increasing their vulnerability to mental disorders. Additionally, these youths are
exposed to fewer familial and social environments and experiences that serve as protective factors. Moreover, they are at risk of developing fewer individual protective factors further predisposing these youths to mental health difficulties (Richardson & Lelliott, 2003).

2.3.2.3.2 Psychological Health Difficulties

The prevalence of mental health problems among adolescents living in CYCCs is high when compared to the general child and adolescent population (Armsden, Pecora, Payne, & Szatkiewicz, 2000; Barber, Delfabbro, & Cooper, 2001; Stanley et al., 2003; Tarren-Sweeney & Hazell, 2006). Studies revealed between 29% and 96% of youths residing in residential care facilities experienced psychiatric disorders (Kjelsberg & Nygren, 2004; Pilowsky, 1995; Richardson & Lelliott, 2003; Stanley et al., 2003). Psychopathology in this group of adolescents includes internalising and externalising disorders, such as anxiety and depression as well as aggressive and suicidal behaviour, substance abuse, and behavioural problems (Kjelsberg & Nygren 2004; Sawyer, Carbone, Searle, & Robinson, 2007). Adolescents with emotional and behavioural disorders experience low self-worth and self-esteem with unaspiring expectations for success in life (Aguilar-Vafaie et al., 2011). Furthermore, they display low levels of hope (Dumain, 2010; Milkman & Wanberg, 2012) along with deficits in future goal-setting abilities and fewer character strengths, when compared to a normative sample (Furlong, Sharkey, & Boman, 2007; Oswald, Cohen, Best, Jenson, & Lyons, 2001).

A basic understanding of the underlying factors that increase vulnerability to mental health problems in looked-after youth, as well as the prevalence of mental illness in this population, is essential for the purpose of this study. This fundamental grounding points to areas of weakness that require strength-focused attention in these vulnerable adolescents. Low levels of hope and self-identification as well as lack of goal orientation and future vision are elements that can be targeted through an intervention process. In focusing on building the adolescent’s strengths, theory indicates that amelioration of mental health difficulties including depression and anxiety may occur (Cheavens et al., 2006; Emmons & McCullough, 2003; Peterson & Peterson, 2008; Seligman et al., 2005; Seligman, Rashid, & Parks, 2006). As Luthar (2006) asserted, “it is far more prudent to promote the development of resilient functioning early in the course of development rather than to implement treatments to repair disorders once they are already crystallized” (p. 739). Additionally, Whittaker (in Mudaly, 1985) suggested that as opposed to focusing on amelioration of psychopathology, residential
care programmes would find most success in actively focusing on growth and development in all spheres of the child’s life.

2.4 Summary

Adolescence refers to the transitional stage of life between childhood and adulthood; a period of development marked by physical, biological, cognitive, and psychosocial change associated with numerous developmental tasks that require negotiation and mastery. Successful negotiation of these tasks, including adapting to and accepting one’s maturing body, developing and advancing cognitions, forming an identity, as well as developing and renegotiating familial and social relationships, has a crucial influence on functioning and wellbeing in adulthood. Notably, managing, traversing, and accomplishing these developmental changes and tasks can be challenging, confusing, and stressful for the transforming adolescent. The combination of the physically metamorphosing body, familial distancing, relational disruption, and rapid shifts in mood can make this period of transformation especially tumultuous. Furthermore, the contexts within which adolescents grow up play an important role in development and may offer protective or risk factors that may promote or impede successful development.

Children in CYCCs experience stressors beyond those of their family-nurtured peers. As a consequence of a history of suboptimal home, school, and social environments these youths are vulnerable to increased developmental challenges, negative affect, low levels of hope, and psychopathology. As such, capitalising on their strengths and cultivating positive attributes may offer these susceptible adolescents individual protective factors that may buffer challenging life circumstances and the development of psychological maladies. Positive psychology interventions offer a manner in which to support and enhance positive growth through identification, utilisation, and cultivation of character strengths, thus, presenting a means to enable and empower impressionable youths. The following chapter introduces positive psychology as a framework that offers tools to identify and advance character strengths and foster wellbeing.
Chapter 3: Adolescent Wellbeing, Hope and Positive Psychology

Interventions

3.1 Introduction

Psychopathology in general and more specifically mental disturbance in troubled adolescents has traditionally been framed within the disease model, focusing on ameliorating illness and rectifying negative thoughts and problem behaviours. The emphasis on identifying and enhancing individuals' strengths and positive attributes, however, is grounded in positive psychology. The current study aims to implement a positive psychology intervention (PPI), focused on discerning and cultivating character strengths in a group of vulnerable adolescents residing in a Child and Youth Care Centre (CYCC). Further, the study will evaluate the effect of the PPI on the adolescents’ levels of hope and wellbeing. As such, this chapter explores positive psychology as an explanatory framework for this study. Thereafter, the constructs of wellbeing and hope are explored according to major theoretical conceptualisations, with specific reference to adolescents in general, vulnerable adolescents, and those residing in residential care facilities. Finally, the chapter defines PPIs and delineates the theoretical and empirical basis for employing the exercises that will be implemented in this study.

3.2 Historical Treatment of Mental Health Difficulties in Looked-After Youth

Historically, psychological treatment has focused on individuals’ problems rather than their strengths (Evans et al., 2005; Maslow, 1954; Seligman, 2002b; Seligman & Csikszentmihalyi, 2000). Likewise, research and treatment of delinquent behaviour and youths with emotional and behavioural disorders have largely been framed within the disease paradigm, making use of contemporary psychological models for the control and prevention of delinquent behaviour (Dinisman, Montserrat, & Casas, 2012; Dishion & Andrews, 1995; Evans et al., 2005; Houston, 2006; Kelley, 2003; Weisz & Bearman, 2008). Within the disease framework interventions focusing on behavioural modification strategies and cognitive interventions are utilised (Kelley, 2003; Kendall, 2011; Weisz & Bearman, 2008). The pathogenic model works on the assumption that youths with emotional and behavioural problems are damaged or deficient in some way. Treatment is predominantly focused on symptoms with interventions attempting to fix that which is identified as defective or missing (Kelly, 2003; Weisz & Bearman, 2008). Interventions within the disease model aim to supply the essential factors missing from the troubled youth. These missing elements may include
social skills, assertiveness, functional cognitions, self-esteem, and impulse control. By repairing what is damaged or providing the absent elements, the disease model aims to prevent or control the adolescent’s dysfunctional tendencies (Kelley, 2003). However, in order to promote potential and enhance the wellbeing of these troubled adolescents a different approach and set of questions needs to be employed (Peterson & Seligman, 2004); positive psychology offers an alternative perspective.

3.3 Positive Psychology as a Theoretical Framework

The underpinnings of positive psychology need to be explored in order to recognise how this approach can be employed to encourage wellbeing in adolescents residing in CYCCs. As such, the following section explores the development of positive psychology; thereafter, an explanation of this field of study ensues.

3.3.1 The Development of the Field of Positive Psychology

In 1998, in his Presidential Address to the American Psychological Association, Seligman introduced the positive psychology paradigm. Identifying the imbalance in the field of psychology and recognising that mental health is more than an absence of mental illness, Seligman encouraged his colleagues to remember psychology’s forgotten mission: to build human strength and to nurture genius (Seligman, 1999). Although Seligman reintroduced and formally labelled the evidence-based practice of positive psychology, research and philosophy underpinning this practice dates back to the Greek philosopher Aristotle. As positive psychology focuses on positive subjective experiences, individual character strengths and civic virtues, it strongly identifies with the Aristotelian model of human nature (Jorgensen & Nafstad, 2004).

Further, positive psychology draws from modern psychology, building on the works of among others Freud, Jung, James, Johoda and Adler, Frankl, Rogers, and Maslow; scholars who can be credited with the respective roles they played in understanding the notion of the pleasure principle, individuation as well as personal and spiritual wholeness, optimal human functioning, the constitution of mental health as motivated by social interest, finding meaning under the most dire human circumstances, fully functioning persons, and self-actualisation in healthy individuals (Coetzee & Viviers, 2007; Duckworth, Steen, & Seligman, 2005).
Moreover, although Seligman and Csikszentmihalyi (2000) understate the role of humanistic psychology in their conceptualisation of the positive psychology paradigm, the self-actualisation theories of Maslow (1968) and Rogers (1961) reflect Aristotle’s thoughts on the human entelechy (Hergenhahn, 1992). Therefore, the roots of positive psychology can be traced to the academic humanistic psychology movement (Duckworth et al., 2005; Hoy & Tarter, 2011), which on Aristotelian foundations built structures identifying the need for understanding human health as “not simply the absence of disease or even the opposite of it” (Maslow 1954, p.14). Humanistic psychologists developed theory attempting to appreciate and comprehend humans beyond their psychological maladies. Although these scholars acknowledge that humans also employ unhealthy “defensive manoeuvres of crippled spirits” (Maslow 1954, p.14), they conceptualise humans as organisms involved in a process of self-actualisation with the aim of developing their full potential by working in their highest capacities and embodying their healthy and strong selves (Hergenhahn, 1992). Similarly, rather than maintaining focus on the medical-orientated model, the positive psychology approach conceptualises and understands the inherent potential humans have for developing character traits and virtues, with the capacity for growth and the tendency and desire to improve and to self-actualise (Jorgensen & Nafstad, 2004).

In framing positive psychology, Seligman (2002a) makes the following three assumptions: there is human nature; action originates from character; and character encompasses equally fundamental bad and good or virtuous components. By highlighting these assumptions, Seligman (2002a) points to the major distinction between contemporary psychology and positive psychology. He asserts that current mainstream psychology gives priority to dysfunctional behaviour and mental disease, whilst positive psychology is concerned with the latent potential of all that individuals can become through realising their essential nature and employing and cultivating positive character, strengths, and virtues (Seligman, 2002a).

Additionally, in line with Aristotelian tradition, positive psychology advocates that individuals are socially and morally motivated beings with potential for goodness. This view is in contrast to contemporary psychology, which in line with the English philosophy of Thomas Hobbs (1588-1679) argues the perspective of the individual as egoistic and directed by one true negative motivation system of self-interest. This contemporary view contends that all other positive motivation including moral and social motivation derives from self-interest (Jorgensen & Nafstad, 2004). Positive psychology rejects this contention and aligns
itself with the Greek tradition and virtue ethics, where individuals are not only concerned with their own interests and betterment, but also interested in sharing with, giving to, and taking care of each other. This tradition, therefore asserts that humans have characteristics that serve and protect their own wellbeing, as well as civic virtues that are concerned with the welfare of others. These civic virtues give rise to positive relationships as well as social and communal responsibility. In combination, these positive social relationships and cultivated character strengths allow individuals to benefit from the good life and to flourish (Jorgensen & Nafstad, 2004).

3.3.2 Defining Positive Psychology

Positive Psychology is a broad umbrella that is fundamentally concerned with the scientific understanding and promotion of what makes life worth living (Seligman & Csikszentmihalyi, 2000). Within this conceptual union the principal focus is on human strengths and virtues (Seligman, Parks, & Steen, 2004). Moreover, the field of positive psychology emphasises the positive aspects of life, including creativity, wisdom, responsibility, and perseverance, where personal elements such as positive emotion, engagement, relationships, meaning, and accomplishment are central to the theory. Additionally, positive psychology can be described as the science of improving life quality through focusing on human strengths, rather than on pathology, and applying methods to build characteristics and positive emotions that allow individuals to enhance their wellbeing and to flourish (Seligman, 2010; Seligman & Csikszentmihalyi, 2000). Enhancing wellbeing through building character strengths and resilience as well as through increasing levels of hope, life satisfaction, and positive affect whilst reducing negative affect is the primary focus of interventions grounded in the positive psychology framework (Bolier et al., 2013; Guse, 2014; Sin & Lyubomirsky, 2009). As such, wellbeing and the cultivation thereof is one of the central focuses within positive psychology and will be explored in the following section.

3.4 Wellbeing

In the positive psychology paradigm, as in the Aristotelian tradition, reflected in Aristotle’s work *The Nicomachean Ethics* (c.330 BC/2009), functioning optimally and realising one’s full potential in accordance with one’s internal virtues are functions associated with the concept of the good life or wellbeing (Jorgensen & Nafstad, 2004; Kashdan, Biswas-Diener, & King, 2008). Aristotle distinguished between pleasure and the good life, also referred to as
hedonia, with the introduction of the concept of eudaimonia that was offered as an alternate to sheer hedonism (Kashdan et al., 2008; Riva, Baños, Botella, Wiederhold, & Gaggioli, 2012). Positive psychology draws on and endorses this conviction suggesting that wellbeing can be conceptualised from two relatively distinct, but overlapping perspectives: the hedonic perspective, where life’s purpose is to achieve the greatest balance of pleasure over pain; and the eudaimonic perspective embracing the belief that happiness arises from positive functioning as well as cultivating and developing virtues (Kashdan et al., 2008; Keyes & Annas, 2009; Ryan & Deci, 2001; Waterman, 2008). Although these perspectives work in concert with one another, for purposes of clarification, each approach will be expanded on separately in the following sections.

3.4.1 Perspectives on Wellbeing

3.4.1.1 Hedonic Wellbeing

Early Greek philosophy dating back to 400 BC equated wellbeing with hedonic pleasure. As such, this perspective has a rich and long history with teachings expressing that the goal of life is to experience maximum pleasure whilst minimising exposure to pain, where happiness is experienced through life’s hedonic moments. Many scholars, including Hobbes, DeSade, and Bentham followed the Greek hedonic philosophy, but expressed variation with regard to the form of pleasure sought, from the narrow focus of bodily sensations to the broader categories of human appetites and self-interests (Ryan & Deci, 2001). More recently, contemporary psychologists have generally adopted the broader concept of hedonia that embraces pleasures of the body as well as those of the mind (Kubovy, 1999). Specifically, contemporary definitions of hedonic wellbeing encompass perceptions of self-proclaimed interest in, and satisfaction with life coupled with the balance of positive to negative affect (Diener, 1984; Diener, Emmons, Larsen, & Griffin, 1985; Kahneman, Diener, & Schwarz, 1999).

Seligman, Rashid, and Parks (2006) endorsed the hedonic perspective of wellbeing advocating that plentiful positive emotion regarding the present, past, and future is required to subjectively experience wellbeing. Additionally, they stated that in order to experience maximum pleasure, individuals are required to learn skills that amplify the intensity and duration of these positive emotions. Seligman and colleagues (2006) postulated that positive past emotions such as satisfaction, contentment, pride, and fulfilment could be cultivated...
through practices of gratitude and forgiveness. Likewise, they suggested future emotions of hope, optimism, and confidence could be enhanced through hope and goal-directed exercises. Finally, satisfaction resulting from character strength identification and utilisation as well as pleasures derived from immediate somatic indulgences, which could be enriched through practices such as savouring, addressed positive emotions in the present moment (Seligman et al., 2006). Accordingly, through cultivating these favourable emotions individuals are able to achieve the greatest balance of total good moments over bad moments, ultimately enhancing their overall subjective experience of emotional wellbeing.

For the purpose of this study, hedonia is conceptualised as the subjective experience of emotional wellbeing that is associated with happiness, commonly defined as the presence of positive affect and the absence of negative affect. It also includes a subjective judgement of one’s life as consisting of more pleasant than unpleasant facets (Deci & Ryan, 2008; Diener, 1984; Diener et al., 1985). A positive life, however, is about more than just hedonics, individuals not only want to feel positive emotions, but also need to feel that these positive emotions have been earned through positive functioning (Keyes & Annas, 2009; Seligman & Pawelski, 2003). Eudaimonia, which is discussed in the following paragraphs, addresses these aspects of wellbeing.

3.4.1.2 Eudaimonic Wellbeing

Like hedonic theories of pleasure, eudaimonia has its roots in Greek philosophy. In classical Hellenic philosophy, Aristotle advanced that eudaimonia could be defined as an “objective condition associated with living a life of contemplation and virtue” (Waterman, 2008, p. 235). Eudaimonia, so called to reflect the belief that wellbeing consists of the realisation of one’s daimon or true nature, was seen as a consequence of striving towards excellence in accordance with virtue (Deci & Ryan, 2008; Ryff & Singer, 2008; Waterman, 2008). Further, Aristotle explicated that to achieve the highest good or eudaimonia, activities should be goal-directed and have purpose and they should be accomplished to the best of one’s ability (Ryff & Singer, 2008). As such, Aristotle’s conceptualisation of eudaimonia was the objective account of achieving excellence through human action and by definition did not involve subjective experience (Ryff & Singer, 2008; Waterman, 2008).

Contemporary philosophers and psychologists, however, view eudaimonia as a construct involving a constellation of subjective experiences. These experiences include among others
feelings relating to identity, achievement, purpose, and competence (Waterman, 2008).

Further, according to Keyes and Annas (2009) most notions of eudaimonia incorporate pleasure, even though pleasure is not the ultimate aim of life. Consequently, modern eudaimonia is conceptualised as a highly positive affective condition that represents an individual’s judgements on their functioning in life (Keyes & Annas, 2009; Waterman, 2008).

Two scholars, Ryff and Keyes, who have been prolific in the contemporary field of eudaimonic wellbeing, defined the constructs of psychological and social wellbeing as forms of subjective eudaimonia (Keyes & Annas, 2009). Therefore, for the purpose of this study eudaimonic wellbeing focuses on psychological and social wellbeing and encompasses a meaningful life, lived with purpose and satisfaction. Furthermore, eudaimonic wellbeing gives attention to developing nascent abilities and capacities that enable individuals to become more complete and fully functional in their personal capacities and as social citizens (Keyes, 2006).

In sum, hedonic and eudaimonic wellbeing differ primarily with regard to individuals’ feelings towards life and their functioning in life. Although these constructs are frequently defined as distinctive processes, it is widely held that they are interrelated and overlapping; where each one is complementary to the other, representing psychological mechanisms that operate together (Biswas-Diener, Kashdan, & King, 2009; Kashdan et al., 2008; Keyes & Annas, 2009). As such, both feeling good about life and functioning well in life need to be considered when exploring wellbeing. The following section elucidates Keyes’ (2002, 2005a) theoretical understanding of wellbeing.

3.4.2 Keyes’ Complete Model of Mental Health

For the purpose of this study, wellbeing is conceptualised as encompassing both hedonic and eudaimonic wellbeing, and more specifically of emotional, psychological, and social wellbeing. As proposed by Keyes (2005a), wellbeing can be regarded as a symptom of complete mental health. Keyes (2005a) conceived that mental health was a “state in which individuals are free of psychopathology and flourishing with high levels of emotional, psychological, and social well-being” (p. 539). The following section details Keyes’ (2002, 2005a) complete model of mental health and explores the concepts therein.
3.4.2.1 Mental Health

Keyes (2002) introduced the complete model of mental health, where the absence of psychopathology did not necessarily indicate mental health; rather, he suggested that mental health could be defined as an absence of mental illness in concert with “a syndrome of symptoms of positive feelings and positive functioning in life” (p. 208). As such, mental health is presented with a set of symptoms along with the manifestations thereof, effecting everyday cognitive and social functioning. Keyes (2002) described the dimensions of wellbeing as the symptoms of mental health. Additionally, he suggested that mental health falls on a continuum delimited by complete and incomplete mental health (Keyes, 2002). A description of the three dimensions of wellbeing (emotional, psychological and social wellbeing), as defined by Keyes and Lopez (2005), and the complete model of mental health follows.

Keyes (2005a) posited that just as depression has symptoms of anhedonia, mental health presented with symptoms of hedonia or positive feelings towards one’s life. The presence of positive affect, together with the absence of negative affect and perceived life satisfaction are the three elements that comprise emotional wellbeing (Keyes, 2002). Keyes (2002) argued that in the same way that depression presents with more than anhedonia, mental health is more than the presence of emotional wellbeing. Accordingly, he postulated that in order to experience complete mental health, individuals should practice positive functioning in life. Psychological wellbeing encompasses six domains of positive functioning including: self-acceptance, positive relations with others, personal growth, purpose in life, environmental mastery, and autonomy. Keyes (2002) suggested that positive functioning should not only be mastered on an individual level, but also in a social capacity. The evaluation of pro-social functioning on more public and social dimensions including, social-coherence, -actualisation, -integration, -acceptance, and -contribution, encapsulates social wellbeing. Keyes (2002) stated that individuals function well and experience social wellbeing when they believe they contribute to society and experience society as acceptable, meaningful, involving, inviting, and as having the potential for growth. Thus, according to Keyes (2002, 2005a), a balanced combination of emotional, psychological, and social wellbeing indicates complete mental health. For the purpose of this study social, psychological, and emotional wellbeing are collectively referred to as wellbeing. As such, the measure of individuals’ wellbeing, as
measured by the Mental Health Continuum (Keyes, 2002, 2005a), is indicative of their complete mental health.

Keyes (2002, 2005a) postulated that mental health and mental illness do not fall on opposite ends of a single continuum; rather they are separate constructs that negatively correlate with each other. As such, his complete model of mental health (2002) delineated a two-continuum model with the distinct but correlated latent factors of mental health and mental illness. According to this model, individuals who are **flourishing** are said to experience complete mental health, where high levels of wellbeing are coupled with low levels of mental illness. When flourishing, individuals feel good about life and believe that they are functioning well in life. Conversely, **languishing** individuals are low on the dimensions of wellbeing, meaning they do not experience enjoyment in life and do not consider their functioning in life to be positive. Languishing individuals experience emptiness, despair, and stagnation. Moreover, mental illness is highest in individuals who are languishing. The final category defined by Keyes (2002) represented the moderately healthy classification indicated in those individuals who are neither flourishing nor languishing in life.

In summation, according to Keyes (2002, 2005a, 2006, 2007), in order to experience complete mental health individuals need to be free of mental disorder and flourish. Where flourishing entails: a) the experience of life satisfaction coupled with high levels of positive and low levels of negative affect; b) the realisation of abilities, experience of autonomy and life purpose, and optimal functioning; and c) social responsibility. In other words, individuals devoid of psychopathology who sustain high levels of emotional, psychological, and social wellbeing experience complete mental health. A synopsis of research exploring wellbeing in adolescence follows.

### 3.4.3 Empirical Findings on Wellbeing in Adolescence

Unsuccessful negotiations of developmental tasks and incomplete mental health in adolescents have implications for adult development and psychological health. Consequently, researchers driven by the importance of developmental success during adolescence have shown interest in the mental health status of youths and the study of wellbeing in this population (Keyes, 2006). One such study examined the prevalence of complete mental health within an American adolescent population and investigated the correlations between wellbeing and mental disorder, and psychosocial functioning (Keyes, 2006). In their sample
of over 1200 adolescents aged between 12 and 18 years, 38% were flourishing and experienced complete mental health, indicated by low levels of psychopathology combined with high levels of wellbeing. A further 56% of the population was described as moderately mentally healthy whilst the remaining 6% were found to be languishing. Keyes (2006) further reported a 10% loss of wellbeing between middle and high school students. Reportedly, children in high school experienced lower levels of flourishing and increased levels of moderate health, whilst the prevalence of languishing remained constant. Additionally, symptoms of mental health (i.e., levels of wellbeing) were positively correlated with self-confidence, self-efficacy, social relatedness, school integration, and pro-social behaviour. Moreover, mental health and wellbeing were negatively correlated with depressive symptoms and conduct problems (Keyes, 2006).

In a second study Suldo and Shaffer (2008) explored the complete mental health of 349 students aged between 10 and 16 years. Youths who were flourishing, as indicated by high levels of wellbeing with low incidence of mental illness accounted for 57% of the population, whilst 17% of the participants fell into the incomplete mental health category, experiencing low levels of wellbeing and high levels of psychopathology. The remaining 26% of this youthful population experienced moderate mental health. These researchers further reported that flourishing students performed better in academic achievement, reading tasks, and self-regulated academic behaviour than their incomplete mental health counterparts. Furthermore, flourishing youths experienced greater school attendance, social support and relatedness, academic self-perceptions, and self-perceived health when compared to their moderately healthy and languishing peers (Suldo & Shaffer, 2008).

In another study it was found that wellbeing predicted students’ grade point averages (Suldo, Thalji, & Ferron, 2011). Suldo and her colleagues (2011) revealed that students with high levels of wellbeing and low levels of mental illness achieved the best school attendance and grade point averages as well as displayed superior mathematical skills. Moreover, all three studies reported that overall performance was better among mentally ill adolescents who were high in wellbeing, when compared to their mentally ill peers low in wellbeing. Thus confirming that increased wellbeing serves as a protective factor against languishing.

In the South African context, a study that explored the levels of wellbeing among adolescents reported that White South African youths experienced lower levels of wellbeing than their
African, Indian, or Coloured peers. Specifically, significant differences in wellbeing were found between Black and White adolescents. This finding supported earlier studies that reported higher levels of wellbeing among African American adults when compared to their Caucasian counterparts (Guse & Vermaak, 2011).

Finally, research among various cared-for populations indicated that youths residing in residential care facilities experienced lower levels of wellbeing than adolescents living with their families (Dinisman et al., 2012; Muñoz & Ferrière, 2000; Rees et al., 2012). Dinisman et al. (2012) reported that school satisfaction played a major role in adolescents’ wellbeing. Their findings suggested that youths residing in care facilities experienced significantly lower satisfaction with schoolwork and social-school relationships. Additionally, their findings revealed that youths living in residential care facilities experienced low levels of life and self-satisfaction, happiness, and future expectancies. These youths were also reported to feel higher levels of loneliness when compared to children living with one or both parents.

Many factors, behaviours, and traits are known to effect and promote mental health and the experience of wellbeing. Hope is one such trait that has been associated with wellbeing, both as a means of enhancing wellbeing and as a positive outcome of interventions aimed at increasing wellbeing (Gallagher & Lopez, 2009). An exploration of hope as a cognitive future-oriented construct and as a character strength employed to enhance wellbeing is presented in the following section.

3.5 Hope

Hope is another construct that has a history dating back to ancient Greek philosophy. As portrayed in Greek mythology through the tale of Pandora, hope was understood to be an expectation. However, translations of the expectation varied from neutral to expectations of good and to those of evil, where the majority of historical writers described hope as an evil force. Later, philosophers including Sophocles, Nietzsche, Plato, Euripides, and Franklin supported this negatively framed conceptualisation of hope; suggesting that hope only served to prolong suffering and seduce humankind with false promise (Snyder, 2000). In the late twentieth century however, scholars explored hope through a positive lens. From this positive perspective, they defined hope in terms of positive expectations, with the underlying perception that one’s desired goals can be met (Snyder, 2000; Snyder et al., 1997b; Snyder, Ilardi, Michael, & Cheavens, 2000). Within the positive psychology framework, Snyder’s
theory of hope (Lopez, Snyder, & Teramoto-Pedrotti, 2003; Snyder, 1994, 2000, 2002; Snyder et al., 2000) has received considerable attention and has frequently been used to conceptualise this positively charged construct.

### 3.5.1 Snyder’s Hope Theory

Snyder et al. (2000) expanded on the traditional one-dimensional goal-expectancy perspective of hope. They defined hope as goal-directed thoughts in which individuals perceive that they are capable of producing the necessary routes to achieve goals as well as to maintain motivation to use these routes and realise desired goals. Higher levels of hope reflect increased belief in one’s abilities to achieve as well as to sustain focus and determination towards attaining goals (Snyder et al., 1997b). Within this theory, hope encompasses three interrelated cognitive components namely goals, agency, and pathways (Snyder, 2000; Snyder et al., 2000). The following section details this trilogy of goal-related thinking.

#### 3.5.1.1 Goals

Hope theory is built on the premise that goals are essential to everyday living. Further, hope theory makes the basic assumption that all purposive human actions are goal-oriented, where the goals serve as end points of hopeful thinking and as the objective of human desires (Snyder, 1995, 2000; Snyder, McDermott, Cook, & Rapoff, 1997c). Goals can be destinations, the acquisition of inanimate objects, or may reflect intangible objectives; they can vary in their temporal nature, ranging from long to short-term, but they always require the individual’s focus and attention. As such, goals provide the target for mental action sequences. In other words, a person’s thoughts focus on the goals they intend to realise (Snyder, 2000; Snyder et al., 1997c; Snyder et al., 2000). Therefore, goals reflect the cognitive foundation of hope theory and need to hold sufficient value and importance in order to stimulate and motivate behaviour. In addition, hopeful goals require a degree of uncertainty as those goals that entail absolute certainty do not generate hope and are associated with low levels of motivation, whilst the pursuit of unattainable goals is counter-productive and demoralising (Snyder 2000; Snyder et al., 2000). More recently however, Snyder (2002) amended the prerequisite of uncertainty in goal-setting, as he noted that individuals with high levels of hope may inject uncertainty into goals that seem undeniable,
thereby increasing the need for motivation and hope to achieve the same certain goals under more extreme and testing conditions.

3.5.1.2 Pathways Thinking

Desired goals would never be realised were it not for the requisite means to attain them. Accordingly, individuals approach goal-oriented tasks with thoughts pertaining to creating possible routes to reach the anticipated goals. In other words, individuals focused on goal-directed tasks constantly consider how to get from where they are to where they need to be in order to acquire the chosen goals (Snyder, 2000; Snyder et al., 1997c, 2000).

In pursuit of a specific goal, individuals high in hope are able to generate both a single plausible pathway as well as alternative routes more efficiently and with more focus and confidence than individuals low in hope. Additionally, if the original route to the specific goal becomes blocked, individuals with high levels of hope display more flexibility and adapt more easily to alternate routes than their low-hope counterparts. This flexibility is fundamental to pathways thinking. Furthermore, individuals with high levels of hope have not necessarily experienced lives of ease where all goals have been acquired through the originally mapped pathways. On the contrary, individuals high in hope have faced many barriers and have effectively created new pathways to successfully attain desired goals. In fact, when routes become blocked hopeful thinking is paramount to negotiating barriers and achieving goals (Snyder, 2000; Snyder et al., 1997c, 2000).

3.5.1.3 Agency Thinking

Agentic thought refers to the willpower required to employ the imagined routes generated to achieve desired goals. As such, agency involves motivation, determination, and commitment to embark and continue on the journey from point A to point B with the purpose of attaining anticipated goals. Frequently, self-affirming statements such as “I will get there” or “I know I can do this” are employed in agentic thought. These self-referential thoughts, embraced by individuals high in hope, capture the determination and mental energy required to remain motivated towards and focused on the chosen goals. Moreover, such perseverance and willpower resulting from agentic thinking, allows individuals to create alternative pathways when faced with barriers or blockages. Notably, agency thinking is stronger when goals are
clearly defined and when well-specified pathways have been generated (Snyder, 2002; Snyder et al., 1997c, 2000).

3.5.1.4 Putting the Components of Hope Together

High hope necessitates three mental components namely goals, pathways to reach desired goals, and motivation to utilise generated pathways. These three components are all necessary and sufficient for hopeful thinking and goal attainment. That is to say, no single component of the mental trilogy will independently yield successful goal acquisition, in this way the components are additive in nature. Additionally, increases in any one component of hopeful thinking, for example clearer goal-setting, better delineated pathways, or higher levels of motivation, should lead to increases in the other components. As such, these cognitive elements are iterative in nature (Snyder et al. 1997c, 2000).

Hope theory, as conceptualised by Snyder and his colleagues (Snyder, 1994; Snyder et al., 1991), was originally cognition-based, however the theory evolved to include an emotional element; where goal-directed thoughts drive emotional experiences. As such, positive emotions are experienced as a consequence of perceived success in the pursuit of goals, whilst negative emotions result from perceived failures. Additionally, as a result of successfully negotiating barriers and achieving desired goals, individuals experience positive emotions, zest, and confidence (Lopez et al., 2003; Snyder, 2000, 2002; Snyder et al., 2000). Therefore, hope can be defined as a character strength employed to enhance the overall experience of wellbeing. Hope, as a character strength will be elucidated in the following section.

3.5.2 Hope as a Character Strength

In accordance with the premise of positive psychology, to focus on human strengths, Peterson and Seligman (2004) developed the Values in Action (VIA) classification of strengths. This taxonomy described, assessed, and categorised 24 valued character strengths in terms of six broader virtue classes. The character strengths, which cluster into the virtuous categories of wisdom, courage, humanity, justice, temperance, and transcendence, are described as the core elements of human character. Within this model, character strengths are defined as positive traits reflected in thoughts, feelings, and behaviours, which when cultivated improves overall disposition and temperament (Park et al., 2004; Peterson & Seligman, 2004).
Hope is a character strength that falls into the virtuous category of transcendence that together with the other transcendental processes allows individuals to live more meaningful and connected lives. Further, the character strength of hope, which is based on Snyder’s Hope Theory (Snyder, 1994; Snyder et al., 1991), represents a cognitive, motivational, and emotional approach towards the future. As such, individuals with high levels of hope think about the future, generate positive expectations, and work actively towards achieving the perceived successful outcomes. As a consequence of perceived future success and achievement, individuals with high levels of hope are able to sustain positive emotions in the present whilst increasing motivation for goal-directed activity in the future (Peterson & Seligman, 2004).

3.5.3 Empirical Findings on Hope in Adolescence

Having delineated the theoretical foundation of hope and explored how it can be considered as a psychological strength, focus now turns to the empirical evidence demonstrating the role hope plays in the lives of adolescents. Research has established the importance of hopeful thinking and indicated positive correlations between hope and numerous factors that play a vital role in the development, health, and wellbeing of adolescents. In this regard research has demonstrated that individuals high in hope outperform their low-hope peers in the arenas of psychological and physical wellbeing, academic and athletic performance, and social functioning (Gilman, Dooley, & Florell, 2006; Lopez, Rose, Robinson, Marques, & Pais-Ribeiro, 2010; Snyder, 1997b, 2002; Valle, Huebner, & Suldo, 2006).

Numerous studies have investigated the relationship between hope and psychological adjustment, where evidence consistently suggests that adolescents with high levels of hope experience greater life satisfaction, higher positive affect and personal adjustment, and lower emotional distress than their low-hope counterparts (Edwards, Ong, & Lopez, 2007; Gilman et al., 2006; Marques, Pais-Ribeiro, & Lopez, 2007; Park & Peterson, 2006; Shogren, Lopez, Wehmeyer, Little, & Pressgrove, 2006; Snyder 1997b, 2002; Valle et al., 2006). Additionally, research findings suggested that high hope endorses emotional empathy, awareness, and regulation (Lee & Reedy, 2013) as well as self-esteem (Lee & Reedy, 2013; Snyder, Cheavens, & Sympson, 1997a; Snyder et al., 1997b) and optimism (Edwards et al., 2007; Snyder et al., 1997a, 1997b). Further, individuals high in hope consider themselves more competent with greater perceptions of self-worth, self-acceptance, self-appearance, and social support when self-compared to their peers low in hope (Edwards et al., 2007, Marques
et al., 2007; Snyder et al., 1997a). Studies also revealed that high hope is negatively correlated with symptoms of depression and clinically relevant levels of psychological distress (Gilman et al., 2006; Snyder, 1997b). Indeed, studies indicated that low hope serves as a predictor to subsequent levels of depressive symptoms and internalising behaviours (Kwon, 2000; Valle et al., 2006). Within the South African context adolescents across racial groups were found to experience relatively high levels of hope that were positively correlated with wellbeing (Guse & Vermaak, 2011; January, 2010).

Research has further suggested that hope may also play a role in other important areas of adolescent existence. For example, higher hope has been related to improved scholastic performance (Gilman et al., 2006; Snyder et al., 1997b; Valle et al., 2006) and lower levels of school related distress (Gilman et al., 2006). Hope has also been found to enhance athletic performance, encourage sport-specific goal-setting behaviour, and sports participation as well as to deter sports related attrition (Brown, Curry, Hagstrom, & Sandstedt, 1999; Gilman et al., 2006). Other studies have indicated that adolescents who experience high levels of hope display greater social competence and derive more pleasure from interpersonal interactions when compared to their low-hope counterparts (Barnum, Snyder, Rapoff, Mani, & Thompson, 1998; Snyder et al., 1997b). Additionally, hopeful thinking has proved valuable in adolescents’ adherence to prescribed medications and to their recovery from physical illness (Berg, Rapoff, Snyder, & Belmont, 2007; Parry & Chesler, 2005). Research has also investigated the role hope plays in vulnerable adolescents; an exploration thereof follows.

3.5.4 Hope in Vulnerable Adolescents

A foundational principle of positive psychology is that character strengths or positive traits serve to protect individuals against the negative effects of challenging life circumstances (Masten & Coatsworth, 1998; Rutter, 1994). Notably, Valle et al. (2006) revealed hope as a moderator between stressful or negative events and mental health outcomes. Further, in agreement with Snyder’s hope theory, their research suggested that hopeful thinking becomes more critical when multiple stressors have been experienced.

Research conducted with high-risk children of incarcerated mothers revealed that children low in hope experienced more internalising and externalising problems in comparison to hopeful children who displayed fewer behavioural problems. The study suggested that maintaining a positive attitude and having confidence in one’s ability to master difficulties
and attain goals despite challenging life events served as a protective factor against psychological problems. Moreover, it indicated that hope predicted adaptive functioning, and conversely, that children low in hope were at risk of developing adjustment problems (Hagen et al., 2005). In another study focused on vulnerable children, attention was directed towards the adolescent children of alcoholics. In this study, Mylant (2002) found that negative self-directed feelings, thoughts, and behaviours, which included hopelessness, factored in predicting high-risk behaviours. Further, the researcher reported that children of alcoholics were significantly more depressed and hopeless than their controlled counterparts (Mylant, 2002). Additionally, within the arena of substance abuse, it was reported that low levels of hope put adolescents at greater risk for alcohol, tobacco, and other substance use whilst high levels of hope contributed to inhibiting the relapse of recovering individuals (Krentzman, 2013).

Within the environmental context of this study, research revealed that hope was inversely related to psychological disorders within a group of children living in a residential care facility (McNeal et al., 2006). Additionally, the researchers reported substantial improvements in the hopeful thinking of these vulnerable children. This study also stated that youths with higher initial levels of psychopathology exhibited greater increases in agentic thought, indicating greater pre–post changes in more troubled children (McNeal et al., 2006). These findings are important, as research has associated childhood trauma with significantly lower levels of hope in adulthood, where the development of agency thinking has been stifled following traumatic experience (Creamer et al., 2009). McNeal and his colleagues’ research gives hope to children in residential care who have endured trauma, as the outcomes of their study indicated that residents of CYCCs, including adolescents faced with more serious psychopathology, can experience increases in hopeful thinking (McNeal et al., 2006).

3.5.5 Conclusion

Hope has been defined as a cognitive-motivational construct that is linked to positive emotional states and better adjustment and outcomes in terms of wellbeing (Valle et al., 2006). Within adolescent populations hope has been positively correlated with wellbeing, life satisfaction, positive affect, physical and mental health, scholastic and sporting performance, social functioning, and positive self-perception. Additionally, research has explored the role of hope within the lives of vulnerable adolescents, with findings indicating that enhanced
levels of hope can be achieved with positive correlational outcomes in this high-risk population.

Adolescents in care facilities frequently experience low self-worth, anhedonia, anxiety, and depression as well as high levels of hopelessness, expressed by low expectations for success. Moreover, these vulnerable adolescents demonstrate few, if any, character strengths. Peterson and Seligman (2004) identified hope as one of the 24 VIA character strengths. As such, PPIs targeted towards cultivating character strengths may enhance hope. Additionally, as explicated in the following section, interventions based on hope theory aimed at increasing levels of hope may enhance wellbeing. A discussion on PPIs and more specifically interventions aimed at increasing hope and wellbeing in vulnerable adolescents follows.

3.6 Positive Psychology Interventions

3.6.1 Defining Positive Psychology Interventions

Within the framework of positive psychology, most interventions aim to enhance wellbeing (Guse, 2014; Lyubomirsky & Layous, 2013; Sin & Lyubomirsky, 2009). PPIs focus on actively cultivating and developing positive emotions, behaviours, and cognitions (Guse, 2014; Sin & Lyubomirsky, 2009). The focus is on the positive, as opposed to ameliorating pathology or correcting negative thoughts or maladaptive behaviour (Sin & Lyubomirsky, 2009). Outcomes of PPIs are frequently measured by monitoring changes in wellbeing as reflected in increased levels of positive affect and life satisfaction combined with decreased negative affect (Guse, 2014). Sin and Lyubomirsky (2009) detailed that a diverse range of positive interventions including writing gratitude letters, practicing optimistic thinking, replaying positive experiences, and socialising increased wellbeing in non-clinical samples. The premise of PPIs is that building positive emotions and wellbeing is associated with reducing psychopathological symptoms, with studies revealing that positive emotions can counteract and protect against negative emotions (Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008; Tugade & Fredrickson, 2004).

3.6.2 Theoretical Considerations for the Design of PPIs

The PPIs envisaged for implementation in this study aim to identify and build character strengths as well as cultivate hope and positive emotions. As such, the intervention activities may enhance wellbeing and reduce symptoms of depression and anxiety. Character strengths
play an important role in positive youth development, vulnerability and resilience, functional success or failure, and onset and persistence of emotional and behavioural disorders (Oswald et al., 2001; Park, 2004). Notably, adolescents living in residential care facilities demonstrate fewer character strengths than youths in general (Farmer et al., 2005; Oswald et al., 2001; Furlong et al., 2007). However, this does not indicate a deficit in strengths, rather, it is indicative of the environment that has not allowed skills to develop (Epstein, 2000). The importance and availability, but lack of development in character strengths in youths residing in CYCCs, highlights the significance of identifying and building strengths in this group of adolescents. Various PPIs targeting the disparate character strengths can be administered. The following section explicates interventions focused on gratitude, kindness, positive emotions in the present moment, character strengths, and hope.

3.6.3 **Specific Positive Interventions Applied in this Study**

Seligman and his colleagues (Duckworth et al., 2005; Seligman, 2002a; Seligman et al., 2006) purported that giving attention to and generating positive emotions about the past, present, and future aspects of one’s emotional life enhances wellbeing. Positively interpreting past events, identifying blessings rather than burdens, and expressing gratitude for these boons can enhance positive emotions of the past (Seligman, 2002a). Present moment enjoyment can be experienced through acts of kindness, savouring, and loving-kindness meditation as well as through identifying and utilising character strengths. Finally, cultivating hope and enhancing goal-directed thoughts are future-oriented practices that build positive emotions in the present. An exploration of gratitude, an exercise that gives positive attention to the past, follows.

3.6.3.1 **Gratitude Interventions**

The order in which positive intervention activities are administered may make a difference to the outcome of an intervention. Gratitude has been suggested as a good starter exercise (Layous, Lee, Choi, & Lyubomirsky, 2013b), as expressing gratitude may serve as a trigger that gives rise to an upward spiral of positive emotions (Fredrickson, 2001). In addition to opening individuals to new possibilities and thereby broadening the range of their behaviour and building resources (Akhtar, 2012), gratitude interventions have been found to enhance wellbeing, life satisfaction, and optimism as well as reduce negative affect and lower levels of depression and anxiety (Emmons & McCullough, 2003; Froh, Sefick, & Emmons, 2008;
Layous, Chancellor, & Lyubomirsky, 2011; Seligman et al., 2005). Counting blessings (Emmons & McCullough, 2003) is a gratitude intervention that has been successfully implemented in adolescent populations producing significant results with regard to enhanced wellbeing and symptom reduction (Akhtar & Boniwell, 2010; Froh et al., 2008; Ruini, Belaise, Brombin, Caffo, & Fava, 2006).

3.6.3.1.1 ‘Counting Blessings’

Counting one’s blessings is akin to a grateful outlook; in an effort to better understand the link between gratitude and wellbeing, Emmons and McCullough (2003) introduced ‘counting blessings’ as an exercise to induce a state of gratitude. ‘Counting blessings’ entails reflection over a specific time period in one’s life and then identifying and diarising up to five things for which one is grateful over the specified duration of time; this listing exercise is then repeated at given intervals. The frequency of each blessing count and the duration of the intervention can be manipulated; where blessings can be counted daily or weekly and the intervention can extend to any period over two weeks. Contradictory results have been reported with regard to the frequency of the task. Emmons and McCullough (2003) reported greater benefit in completing the task daily for two weeks rather than once a week over a ten-week period. However, other researchers reported that participants who counted their blessings on a weekly basis experienced greater increases in wellbeing than those participants who expressed their gratitude daily over the same six-week period (Lyubomirsky, Sheldon, & Schkade, 2005). On the whole, however, counting one’s blessings has been found to enhance gratitude, wellbeing, and positive affect (Chan, 2013; Emmons & McCullough, 2003; Froh et al., 2008; Lyubomirsky et al., 2005; Watkins, Woodward, Stone, & Kolts, 2003).

Of all gratitude interventions, listing exercises have been researched the most, being used in more than half of the gratitude intervention studies (Wood, Froh, & Geraghty, 2010). The technique is especially beneficial, as it has been reported that participants find the exercise enjoyable and reinforcing, and often continued the practice post intervention (Seligman et al., 2005). Emmons and McCullough (2003) originally introduced the practice of ‘counting blessings’ in a three-part study that established the benefits of regularly counting one’s blessings. This study focused on an adult population of college students and reported that counting blessings enhanced optimism, positive affect, life satisfaction, pro-social motivation, and sleep quality. Further, they stated that the gratitude intervention led to fewer reported physical symptoms and reductions in negative affect. Subsequently, numerous
studies employed the listing task to enhance gratitude and confirmed the beneficial effects of counting one’s blessings on adult wellbeing. The benefits reported on adult wellbeing included increased life satisfaction (Chan, 2010), positive affect (Chan, 2010; Watkins et al., 2003), and happiness (Lyubomirsky et al., 2005; Seligman et al., 2005; Watkins et al., 2003) as well as reduced symptoms of depression (Seligman, 2005; Watkins et al., 2003), narcissism, and anger-related emotions (Watkins et al., 2003).

More recently, research investigating the effects of gratitude interventions in adolescent populations reported promising outcomes (Akhtar & Boniwell, 2010; Froh et al., 2008; Suldo, Savage, & Mercer, 2013). Replicating Emmons and McCullough’s (2003) original study, Froh et al. (2008) reported that enhanced gratitude as a result of counting one’s blessings led to increased wellbeing in school-aged children. Specifically, they revealed that the listing task induced gratitude, enhanced optimism and life satisfaction, improved the subjective experience of school, and decreased negative affect in their adolescent population. Additionally, research focused on alcohol-misusing adolescents reported that gratitude, in the form of counting one’s blessings, enhanced positive affect and happiness. Alcohol consumption was also significantly reduced in this population who practiced counting blessings as part of a more comprehensive intervention programme (Akhtar & Boniwell, 2010).

Although research findings on the ‘counting blessings’ listing intervention are promising, conflicting evidence has been reported. Sheldon and Lyubomirsky (2006) found that although counting blessings significantly reduced negative mood in a student sample, the control condition as well as the second experimental group practicing the ‘best possible future self’ exercise also showed significant improvement in negative mood. Moreover, there were no significant differences reported in positive affect after the gratitude intervention. In a similar study conducted with a sample of children, Owens and Patterson (2013) compared ‘counting blessings’ and ‘best possible future self’ with similar findings, where counting blessings showed no significant effect on positive or negative affect, life satisfaction, or self esteem. In the South African context, Kruger (2013) also reported no significant effect on wellbeing among adolescents who kept a gratitude journal as part of a gratitude intervention.
3.6.3.2 Interventions Aimed at Increasing Present Moment Enjoyment

Engaging in the positive of the present moment may induce an upward spiral of positive emotions, ultimately enriching one’s life through enhancing individuals’ wellbeing and their ability to thrive (Guse, 2014). Acts of kindness, savouring, and loving-kindness meditation are exercises that focus on enhancing positive emotions in the present moment experience.

3.6.3.2.1 ‘Acts of Kindness’

Evidence suggests that pro-social activity may buffer vulnerable adolescents from engagement in disruptive and problem behaviour (Milkman & Wanberg, 2012). Further, such altruistic behaviour may serve to build resilience, self-respect, and hopefulness which may protect vulnerable youths against feelings of defeat and despair. More specifically, holding positive values and acting in a helpful, generous, responsible, and caring manner may enhance character strengths and safeguard adolescents against vulnerability (Aguilar-Vafaie et al., 2011; Brooks, 1994; Daniel et al., 1999; Milkman & Wanberg, 2012). Additionally, these well-intended behaviours can enhance social relationships and increase wellbeing (Guse, 2014; Suldo & Michalowski, 2007).

Lyubomirsky and her colleagues (Lyubomirsky, Tkach, & Sheldon, 2004) introduced the practice of committing ‘acts of kindness’ as an exercise aimed to boost moods and to enhance long-lasting wellbeing. Such voluntary acts of kindness, employed as an activity intended to enhance human-relatedness, elevate mood, and increase wellbeing, were found to be most effective when kind acts were varied and involved engagement (Guse, 2014; Sheldon, Boehm, & Lyubomirsky, 2013). Greater effect was also noted when multiple kind acts were performed on a single day rather than over a period of a week (Lyubomirsky et al., 2005). By counting and diarising acts of kindness, individuals become more aware of their kind actions in daily life. Moreover, listing acts of kindness may have a knock-on effect of wishing to be more kind, enacting more kind acts, and perceiving the self as kind, resulting in positive motivations, thoughts, and actions, ultimately enhancing wellbeing (Otake, Shimai, Tanaka-Matsumi, Otsui, & Fredrickson, 2006).

In an inaugural study focusing on happiness-relevant activities, Lyubomirsky and her colleagues (Lyubomirsky et al., 2004) reported that students who performed five acts of kindness in a single day once a week over a six-week period experienced significantly
increased wellbeing. Subsequently, studies in student and adult populations have confirmed that carrying out acts of kindness enhanced wellbeing (Gander, Proyer, Ruch, & Wyss, 2012; Layous, Chancellor, & Lyubomirsky, 2013a; Otake et al., 2006; Sheldon et al., 2013), increased performance motivation (Otake et al., 2006), and alleviated symptoms of depression (Gander et al., 2012). Research has also demonstrated that child and adolescent populations may also benefit from altruistic behaviour, where doing good things for others benefitted the givers of kindness, not only by increasing wellbeing (Haworth et al., 2013, as cited in Layous et al., 2013a; Nelson, Layous, Oberle, Lyubomirsky, & Schonert-Reichl, 2011, as cited in Nelson & Lyubomirsky, 2012; Layous, Nelson, Oberle, Schonert-Reichl, & Lyubomirsky, 2012b) but also through enhancing connectedness (Haworth et al., 2013 as cited in Layous et al., 2013a), peer acceptance, and popularity (Layous et al., 2012b).

Notably however, as indicated by Lyubomirsky et al. (2005), the timing of performing acts of kindness is critical. In their study Lyubomirsky and her colleagues found that spreading five acts of kindness throughout the week had no significant effect on wellbeing. Similarly, Sheldon and his colleagues (2012, 2013) suggested variety in acts of kindness was pivotal in enhancing wellbeing, with their results revealing decreases in happiness when the same acts of kindness were repeatedly performed on a weekly basis.

### 3.6.3.2.2 ‘Savouring’

Savouring can be defined as the process through which people “attend to, appreciate, and enhance the positive experiences in their lives” (Bryant & Veroff, 2007, p. 2). As such, the savouring process sustains and intensifies positive emotions in the present moment (Jose, Lim, & Bryant, 2012). Through savouring, time is purposefully slowed by focusing on the current experience and sensation, remaining in the present moment before moving on to something new (Suldo & Michalowski, 2007). Moreover, savouring encourages immersion in positive experience, thereby strengthening awareness of the positive and pleasurable, a practice that reduces negativity bias and defends against negative emotions (Akhtar, 2012). By engaging in cognitive and behavioural strategies individuals can regulate the intensity and duration of positive feelings associated with positive experiences (Jose et al., 2012). Such strategies include: slowing down, stretching and becoming immersed in the experience, focusing exclusively and engaging full attention on the present sensation, making use of all five senses, and reflecting on the source of enjoyment (Akhtar, 2012; Guse, 2014).
Intervention studies implementing savouring exercises have reported positive correlations with wellbeing (Bryant, Smart, & King, 2005; Jose et al., 2012). In a study that explored the relations between emotional experience and savouring positive events through reminiscing, Bryant et al. (2005) suggested that reminiscence is a constructive tool that enhanced awareness and provided a sense of perspective in the present moment. They also reported that reminiscence increased the percentage of time that participants felt happy when compared to the control group (Bryant et al., 2005). Additionally, studies reported that savouring the moment was positively correlated with positive moods (Jose et al., 2012) and negatively correlated with negative affect and depressive symptoms (Hurley & Kwon, 2012). Moreover, research in adolescent populations reported positive correlations between savouring and self-esteem, positive affect, and life satisfaction, as well as negative correlations with negative affect (Cafasso, 1994, 1998).

It is noteworthy, however, that not all studies reporting on savouring strategies revealed affirmative outcomes with regard to positive affect. In their study, Parks and her colleagues (2012) revealed that savouring exercises did not enhance happiness or positive affect (Parks, Della Porta, Pierce, Zilca, & Lyubomirsky, 2012). Likewise, although Hurley and Kwon (2012) reported that participants experienced decreased depressive symptoms and negative affect after a two-week savouring intervention, no changes in positive affect were noted.

3.6.3.2.3 ‘Loving-Kindness Meditation’

Like savouring, loving-kindness meditation also offers the opportunity for enhancing positive emotions in the present moment. This meditation practice has its origins in the Buddhist traditions of emphasising and cultivating connectedness, whilst expressing positive and loving intentions towards others (Hutcherson, Seppala, & Gross, 2008). This meditative practice, initially developed by Salzberg (1995), involves concentration techniques that focus on intentionally cultivating warm, positive, and caring emotions within oneself and directing these compassionate and kind feelings towards oneself and others. Loving-kindness meditation encompasses experiencing tender feelings both in the body and in the mind. Participants are asked to focus on and visualise the heart region of the body and engender gentle feelings of love and compassion towards a familiar and endearing person in their lives. Thereafter, they are guided to re-direct these body-based empathic feelings towards themselves, loved ones, neutral persons, persons with whom they experience conflict, and
ultimately to all beings everywhere (Fredrickson et al., 2008; Garland et al., 2010; Salzberg; 1995).

Research confirmed that loving-kindness meditation techniques employed in positive intervention studies and taught to engender positive emotions in the context of social and interpersonal relationships, produced positive outcomes. More specifically, researchers reported that the warm and caring feelings generated and extended to all beings during the present focused exercise enhanced positive affect, compassion, and empathy, promoted optimism, and reduced negative affect (Fredrickson et al., 2008; Garland et al., 2010; Hutcherson et al., 2008; Kristeller & Johnson, 2005; Salzberg; 1995).

3.6.3.2.4 Character Strength Building Interventions

Supporting a major tenet of positive psychology, the definitional hypothesis of character strength interventions emphasises that working to develop individuals’ strengths rather than focusing on their weaknesses produces greater benefits for the individuals (Quinlan, Swain, & Vella-Brodrick, 2012). Character strengths, as defined by Peterson and Seligman (2004) are psychological aptitudes based on universally valued moral traits, which when utilised, enhance happiness and fulfilment. These psychological aptitudes or strengths have further been defined as the thoughts, emotions, and actions for which an individual has a natural propensity; where engagement brings pleasure and allows the individual to achieve optimal functioning while pursuing valued endeavours. As such, character strengths act as protective factors that buffer youths against adverse life circumstances as well as support and enhance wellbeing (Quinlan, et al., 2012). Notably, character strengths can be cultivated and enhanced through regular utilisation and application in everyday living (Seligman et al., 2005).

The maladaptive home and social environments from which adolescents residing in CYCCs hail, often lack support and guidance which inhibit the adolescents from identifying and developing character strengths (Epstein, 2000). Significantly, research has shown that identifying, planning to develop, using, and building character strengths may increase wellbeing and alleviate depression (Gander et al., 2012; Proctor et al., 2011; Seligman et al., 2005). Therefore, it is important to give these vulnerable youths a general understanding of character strengths as well as the opportunity to identify, utilise, develop, and cultivate their strengths. Strengths-based interventions including ‘you at your best’ (Seligman et al., 2005),
‘strength spotting’ (Proctor et al., 2011), and ‘using character strengths in a new way’ (Seligman et al., 2005) have been advanced as effective exercises in this regard.

3.6.3.2.4.1 ‘You at Your Best’

Seligman et al. (2005) introduced the ‘you at your best’ exercise and reported that it produced immediate boosts in happiness. Further, they indicated that it served as a good character strengths introductory exercise, to be used in combination with identification and utilisation of signature strengths, as it had the potential to amplify the benefits on happiness and depression. In this exercise, participants were asked to write about a time when they felt they were at their best; this initial exercise was followed by a task attended to daily over the course of a week. In this daily task participants were asked to reflect on their story, taking note of their feelings at the time of the event, the strengths they displayed, and the time, effort, and creativity that was invested in that occasion (Seligman et al., 2005). Suldo and Michalowski (2007) additionally suggested that adolescents shared their stories within a group environment, as reflections on the positives within each story served to further identify and reaffirm the adolescents’ strengths.

In a seminal study that focused on the utilisation of psychological interventions to increase happiness in participants, Seligman et al. (2005) asked a treatment group to “write about a time when they were at their best” (Seligman et al., 2005, p. 416). A second treatment group identified their top five (“signature”) strengths by completing the online VIA-inventory. Although increases in happiness were reported for both treatment groups in the one-week post-test assessment, the exercises did not elicit long-lasting positive affect. As such, Seligman et al. (2005) suggested that the ‘you at your best’ exercise be utilised as an initial happiness-boosting introduction to character strengths-based interventions. These researchers further recommended that in order to achieve long-term increases in happiness, individuals should identify and then utilise their signature strengths in new ways after completing the ‘you at your best’ exercise.

3.6.3.2.4.2 ‘Strength Spotting’

In developing a general character strengths-based intervention for adolescents, Proctor et al. (2011) considered the pragmatics of providing character education to students based on their unique character strengths. They argued that the completion of the online 198-item VIA-
Youth measure to identify signature strengths was impractical in a classroom setting. Consequently, they developed the ‘strength spotting’ exercise based on the VIA strengths classification, which familiarised scholars with the 24 character strengths and enabled them to self-identify with their best qualities or signature strengths. In this exercise the scholars were presented with worksheets that listed and gave age appropriate descriptions of the 24-character strengths. The youths were invited to identify and write down which five strengths best described themselves. This exercise was aimed to help participants identify and become familiar with their signature strengths as well as to inspire them to spot strengths in others, promoting an awareness and acceptance of differences between individuals (Proctor, 2014; Proctor et al., 2011).

3.6.3.2.4.3 ‘Using Character Strengths in a New Way’

Identifying signature strengths, although valuable and critical for the use thereof, is insufficient in creating long-lasting effects on wellbeing and happiness (Seligman et al., 2005). ‘Using character strengths in a new way’ is an exercise aimed to encourage individuals to build and use their signature strengths. The exercise invites participants to use one of their top five character strengths in a new and different way each day for the period of a week (Seligman et al., 2005).

Seligman and his colleagues (2005) reported that participants who used their signature strengths in new ways showed long-term improvements, where enhanced happiness and decreased symptoms of depression were experienced six months post-intervention. The enduring effect of this exercise may be attributed to the increased effort and creativity required to utilise strengths in a new way (Seligman et al., 2005). Subsequent studies confirmed that employing signature strengths enhanced life satisfaction (Peterson & Peterson, 2008; Rust, Diessner, & Reade, 2009; Seligman et al., 2006), wellbeing, self-esteem (Proctor, Maltby, & Linley, 2010), goal directed behaviour, relatedness, competence, and the acquisition of basic needs for independence (Linley, Nielsen, Gillett, & Biswas-Diener, 2010) as well as reduced symptoms of psychological distress and depression (Peterson & Peterson, 2008; Seligman et al., 2006). Furthermore, the character strengths of hope, zest, love, and gratitude were shown to be positive predictors of life satisfaction and wellbeing (Park et al., 2004; Peterson & Seligman, 2004; Proctor et al., 2010).
Similarly, character strengths-based research conducted in adolescent populations found that regular participation in strengths-based exercises resulted in significantly improved levels of life satisfaction as well as increased experiences of positive affect, enhanced self-esteem, and reduced experiences of negative affect (Proctor et al., 2011). In another study, young adolescents identified their top strengths and were coached in ways to use their signature strengths over an eight-week intervention (Rashid et al., 2013). This study reported that enhanced wellbeing and improved social skills were maintained at a six-month interval, moreover, problem behaviour was decreased and academic performance improved post-intervention. Other studies in youths have similarly reported positive outcomes resulting from strengths-based interventions including: increased levels of engagement (Madden, Green, & Grant, 2011; Seligman, Ernst, Gillham, Reivich, & Linkins, 2009), improved school enjoyment, achievement (Austin, 2005; Seligman et al., 2009), and behaviour (Govindji & Linley, 2008, as cited in Quinlan et al., 2012) as well as enhanced hope (Madden et al., 2011), self-confidence, and motivation to achieve (Austin, 2005; Govindji & Linley, 2008, as cited in Quinlan et al., 2012). Additionally, as with adult populations hope, zest, love, and gratitude positively predicted life satisfaction and wellbeing among youths (Park & Peterson, 2006; Rashid et al., 2013). Further, hope, zest, leadership, persistence, honesty, prudence, and love were negatively correlated with aggression, anxiety, and depression (Park & Peterson, 2008), whilst hope, perseverance, fairness, gratitude, honesty, and perspective showed positive predictive associations with academic achievement after controlling for IQ in youthful populations (Park & Peterson, 2006, 2009).

It is noteworthy that although the majority of studies reviewed confirmed the positive effects of strengths-based interventions, some conflicting outcomes were reported. In a comprehensive three-part strengths-based study among grade six participants, Rashid et al. (2013) revealed that although all three interventions yielded significant changes in social skills, these improvements were not maintained at a six-month follow-up in the shorter eight-week intervention. Additionally and perhaps more remarkably, neither the two-year long interventions nor the eight-week intervention generated significant changes in wellbeing or life satisfaction among these adolescents. Similarly, in a second study that compared an intervention aimed at identifying and utilising one’s top five strengths versus one targeting the identification and utilisation of one’s weakest five strengths, Walker (2013) reported insignificant outcomes on both accounts. More specifically, participants showed no
significant changes in measures of positive or negative functioning after the interventions when compared to baseline levels obtained before the interventions.

3.6.3.3 Hope-Based Interventions

Hope-based interventions focus on generating positive emotions regarding future aspects in one’s life. These enhanced favourable future based emotions epitomise hope, a character strength associated with greater wellbeing, life satisfaction, and academic achievement (Duckworth et al., 2005; Park & Peterson, 2006, 2009; Rashid et al., 2013; Seligman, 2002a; Seligman et al., 2006). Conversely, low levels of hope are associated with depression, anxiety, and problem behaviour (Dumain, 2010; Feldman & Snyder, 2005; Milkman & Wanberg, 2012; Park & Peterson, 2008). Increasing levels of hope through specific activities may enhance wellbeing, positive affect, and goal-directed activity whilst reducing symptoms of depression and anxiety (Boehm, Lyubomirsky, & Sheldon, 2011; Cheavens et al., 2006; King, 2001; Feldman & Dreher, 2012; Layous, Nelson, & Lyubomirsky, 2012a; Marques et al., 2011; Pretorius, Venter, Temane, & Wissing, 2008). Additionally, enhanced levels of hope may serve to buffer individuals against negative and stressful life events (Suldo & Michalowski, 2007).

Research has shown that the strength of hope is malleable and enhancing levels of hope through interventions effective. Two school-based PPIs that successfully cultivated hope in students reported positive outcomes. In the first study, researchers conducted an experiment in which female senior school students were allocated either to the experimental hope-coached group or to the control group. The coached group received 10 hope-oriented sessions over a period of two school terms. The researchers reported significant improvements in cognitive hardiness and levels of hope, as well as reduced symptoms of anxiety and depression in the hope-coached adolescents and concluded that hope could be promoted through goal-setting and coaching interventions (Green, Anthony, & Rynsaardt, 2007). The second study employed a five-week hope-based intervention focused on middle-school children. In this study the intervention group showed significantly enhanced levels of hope, life satisfaction, and self-worth with benefits maintained at an 18-month follow-up. These researchers deduced that brief hope-based interventions could result in long-lasting benefits of enriched wellbeing (Marques et al., 2011).
Although hope-based interventions have shown promising results, it is worth mentioning that in a meta-analysis of 27 interventions, which employed hope-enhancing techniques, Weis and Speridakos (2011) reported significant, but small effect sizes for hopefulness and life satisfaction. Moreover, they found no correlation between hope and psychological distress. Consequently, the researchers concluded that only modest evidence was provided to support the ability of hope-based interventions to enhance hopefulness and life satisfaction among participants; further, no consistent evidence indicated towards the ability of hope-enhancing techniques to ameliorate psychological distress.

However, hope-based interventions including the ‘best possible future self’ (King, 2001) and ‘goal mapping’ (Feldman & Dreher, 2012) have been implemented successfully in adult, adolescent and child populations. These interventions focus on enhancing optimistic, agentic, pathways, and goal-oriented thinking and as such may enhance individuals’ levels of hope. An exploration of these future-oriented practices aimed at building positive emotions in the present follows.

3.6.3.3.1 ‘Best Possible Future Self’

Identity formation is one of the major developmental tasks required of adolescents. As such, adolescence is a period of identifying and creating possibilities, goals, and future aspirations. Additionally, during adolescence youths develop the cognitive ability to think hypothetically and are therefore able to conceptualise future possibilities and desires (Berger, 2011). Hypothetical images that represent possible future selves are critical for motivating actions involved in becoming one’s best and avoiding feared future outcomes (Oyserman, Terry, & Bybee, 2002). According to Oyserman and Markus (1990), these future prospects represent all that individuals “could become, would like to become, or are afraid of becoming” (p. 112), a cluster of self-potentials that Markus and Nurius (1986) termed “possible selves”. An individual’s best possible self, therefore, is highly positive in nature and represents the most cherished and desired future self-concept (King & Raspin, 2004; Seligman et al., 2005).

King (2001) introduced descriptively writing about one’s best possible future self as a method to enhance wellbeing. In her research, participants were instructed to write an essay for 20 minutes on four consecutive days in which they imagined the best possible circumstances and outcomes for their lives. Subsequently, research has proved significant in increasing positive affect with a single session of writing about one’s best possible future self
(Peters, Flink, Boersma, & Linton, 2010; Sheldon & Lyubomirsky, 2006). Additionally, ‘best possible future self’ mental imagery (Meevissen, Peters, & Alberts, 2011; Peters et al., 2010) and drawings (Owens & Patterson, 2013) have been effectively used to facilitate emotional and verbal processing, communication, and attention maintenance in exercises aimed to enhance self-esteem, life-satisfaction, positive affect, and optimistic expectancies for the future. Drawing has proved valuable in interventions with children, as youths are able to engage in activities for longer periods of time without the potential language limitations involved in writing (Owens & Patterson, 2013). Furthermore, both mental imagery and illustration support absorption, comprehension, visualisation, and crystallisation of ideas (Gambrell & Jawitz, 1993; Peters et al., 2013). Therefore, combining King’s (2001) original written exercise with mental imagery and illustration of one’s best possible future self may maximise the potential effect of this exercise in adolescents.

Hope-based interventions employing the ‘best possible future self’ were utilised in investigations with adult populations. These studies indicated that writing about one’s best possible future self promoted upshots including increased positive affect (King, 2001; Layous et al., 2012a; Meevissen et al, 2011; Peters et al., 2010; Sheldon & Lyubomirsky, 2006), psychological wellbeing (King, 2001), optimism (Meevissen et al, 2011), flow, and feelings of relatedness (Layous et al., 2012a). In addition to this, research showed that writing about one’s best possible future self reduced negative affect (Meevissen et al, 2011; Peters et al., 2010; Sheldon & Lyubomirsky, 2006) and physical illness (King, 2001).

Similarly, scholars investigated the benefits of conceptualising best possible future selves in young children (Owens & Patterson, 2013). In their study, Owens and Patterson asked children aged between five and 11 years to draw an image depicting their best possible future selves; thereafter they were asked to explain the content of their illustration. This study revealed that producing their best-imagined future self-image enhanced global self-esteem, however, life satisfaction and affect remained unchanged in this youthful population. In another ‘best possible future self’ intervention, Oyserman and her colleagues (2002) focused on enhancing adolescents’ abilities to imagine themselves as successful adults. In addition to creating a concrete picture of their future selves, this intervention included goal-directed activities aimed at connecting the youths’ future self to their current school involvement. This investigation reported improved school engagement, achievement, behaviour, and attendance,
indicating that goal-oriented activities directed towards achieving one’s best possible self may promote beneficial outcomes.

3.6.3.3.2 ‘Goal Mapping’

With the aim of enhancing hopeful goal-directed thought in a single ninety-minute intervention, Feldman and Dreyer (2012) introduced ‘goal mapping’, a hope-based goal oriented exercise incorporating visualisation. Results of this study revealed increased hope with regard to self-nominated goals and sense of life purpose and vocational calling. Notably, they also reported increased goal-directed progress at the one-month follow-up for individuals who partook in the intervention. In this ‘goal mapping’ exercise participants selected a personally relevant goal, created a three-stage pathway for achieving the elected goal, identified obstacles that could obstruct each progressive step in the nominated pathway, and created alternative pathways around the perceived obstacles. Additionally, the participants were required to write down methods of maintaining agency and motivation whilst in pursuit of their goal. Thereafter, the participants were guided through a vivid visualisation exercise; they were encouraged to make use of all five senses to realistically imagine taking each step on their goal map, encountering every obstacle, and motivating themselves throughout all stages of the process. This exercise culminated in the participants visualising themselves accomplishing their goal and experiencing positive emotions and increased agency as a result of their success (Feldman & Dreyer, 2012).

In their 90-minute hope-based intervention, Feldman and Dreher (2013) employed goal-directed activities such as ‘goal mapping’ and visualisation with the aim of increasing university students’ hopeful goal-directed thinking. This hope-based intervention generated short-term enhancements in hope, life purpose, and vocational calling. Additionally, individuals assigned to the hope intervention reported significantly greater progress on self-nominated goals at one-month follow-up.

3.6.4 Conclusion

The researched literature evidenced strong support for the use of PPIs in adult and youth populations. More specifically, interventions that targeted the cultivation of positive emotions concerning adolescents’ past, present, and future characteristics and circumstances enhanced levels of hope, wellbeing, positive affect, self-worth, self-esteem, self-confidence, and
empathy in these youths. In addition, adolescents who participated in these PPIs experienced improvements in life satisfaction, cognitive hardiness, school engagement and achievement, goal-directed activity, motivation to achieve, popularity and acceptance, relatedness, and social skills. Furthermore, adolescents in these studies benefitted from decreased negative affect and problem behaviour as well as reduced symptoms of depression and anxiety. It is notable however, that as reported, a minority of studies revealed contradictory and less favourable findings as a result of the implementation of PPIs.

Nevertheless, these studies predominantly demonstrate the usefulness of PPIs in youths. As such, by employing PPIs to identify and enhance character strengths, build resilience, and increase wellbeing of vulnerable youths in CYCCs, PPIs could buffer susceptible adolescents against adverse and stressful life conditions.

3.7 Concluding Summary

Adolescence is a period of significant change, a time during which a child develops into an adult. Throughout this tumultuous period of life adolescents are faced with numerous developmental tasks, conflicts, and challenges that require successful negotiation. Physical, biological, and cognitive developmental changes impact on transforming youths. Additionally, adolescents’ home, school, and social environments also contribute to, and influence the transformation process. Suboptimal, neglectful, and hostile environments and circumstances place youths at risk of following undesirable developmental trajectories. As such, adolescents residing in CYCCs hailing from difficult and demanding home and social environments, face greater stressors and challenges than youths in general. Consequently, these youths are vulnerable to increased developmental complications, high levels of psychopathology and negative affect, as well as low levels of hope, goal-directed behaviour, positive affect, and wellbeing.

However, adolescence is also an age of opportunity, a period of growth where youths are at an optimal phase of cognitive development. Consequently, adolescence presents a pivotal opportunity to positively effect, influence, and enhance capacities for growth and development, to cultivate wellbeing, to assist vulnerable youths to navigate risks, and to guide them on the path to fulfilling their potential. Positive psychology and more specifically interventions within the positive psychology framework, offer tools and exercises aimed at
identifying and enhancing the positive attributes and strengths within these impressionable youths.

Research within the field of positive psychology offers a new avenue to understand and enhance mental health. When applied, positive psychology, offers the potential to enrich lives by enhancing wellbeing and positive affect rather than solely focusing on minimising symptoms of psychological distress. As such, mental health is conceptualised as more than just the absence of mental illness and rather more holistically it includes one’s ability to benefit from the good life, to function productively both in personal and social capacities, to self-actualise, and ultimately to flourish. Therefore, in a state of complete mental health, individuals are free of mental illness and experience high levels of wellbeing.

Enhanced levels of wellbeing can be achieved through focusing on cultivating various strengths, behaviours, emotional states, and traits. Hope is one such construct, a character strength, which involves goal-directed cognition, motivation, and behaviour. As such, persons with high levels of hope consider the future, engender positive expectations, and take action towards achieving their desired goals. Consequently, individuals high in hope generally experience narratives of successfully dealing with stressors and accomplishing their chosen objectives. Both the perceptions of successful goal pursuit as well as goal achievement contribute towards enhanced positive emotions, zest, and confidence in individuals with high levels of hope (Lopez et al., 2003). From this perspective, not only do enhanced levels of hope increase positive affect, but also allow individuals to live more meaningful, productive, and connected lives. Conversely, individuals low in hope have histories of unsuccessful stressor negotiations and resultant negative emotions and affective flatness, frequently giving rise to experiences of low self-worth, anhedonia, and low expectations for future success.

As a consequence of their suboptimal environments, youths residing in CYCCs frequently experience low levels of hope and demonstrate fewer character strengths than youths in general. Notably, this is not indicative of the absence of strengths or capabilities of these youths, but rather of an inadequate environment incapable of engendering the development of these skills. As such, identifying and developing character strengths (including hope) in vulnerable adolescents may offer these youths the opportunity to experience enhanced mental health and wellbeing through living more effective, productive, socially connected, and
meaningful lives whilst experiencing enhanced levels of positive emotions. Additionally, enhancing their strengths and cultivating positive attributes may buffer these adolescents against negative life circumstances and the development of psychological maladies. PPIs offer a means to identify, foster, and enhance character strengths.

Positive psychology interventions encourage focusing attention towards the past, present, and future elements in one’s life. Engendering positive emotions through this focused attention facilitates mental health and wellbeing (Seligman, 2002a). Gratitude exercises have proved successful in cultivating positive emotions towards past aspects of one’s emotional life. Identifying and utilising one’s character strengths as well as partaking in kind acts, savouring moments, and indulging in loving-kindness meditation are practices that have successfully created enjoyment in the present moment. Positive emotions have also been fostered through future-oriented practices of stimulating hopeful expectations as well as nurturing goal-directed thoughts and activities. Research in adolescent populations has confirmed the beneficial effects of these PPIs including among others improved positive affect, life satisfaction, scholarly achievement, and social competencies. However, this body of research has primarily focused on adolescents out of care facilities and within an American or European context. The current study attempted to contribute to the knowledge base by examining the effect of a six-week PPI on adolescents residing in the South African CYCC. The research methodology implemented to execute this study is explicated in the following chapter.
Chapter 4: Research Methodology

4.1 Introduction

The current chapter delineates the methodology employed in this study and commences with a formulation of the research question and aims. Thereafter, the quasi-experimental research design is explicated and the sampling technique and participant composition described. The procedures implemented prior to, during, and following the intervention as well as the content of the intervention are explored, following which, the measuring instruments and the statistical techniques applied to the collected data are discussed. Finally, the ethical considerations pertaining to the study are summarised.

4.2 Research Question and Aims

This study implemented a positive psychology intervention (PPI), which as explicated in the literature review, included activities designed to focus the participants’ attention and generate positive emotions towards the past, present, and future elements of their lives. These theoretically based activities included exercises focused on character strengths in general and also specifically on gratitude, kindness, and hope. As such, the broad research question was to investigate the effect of a PPI on hope and wellbeing among adolescents living in a Child and Youth Care Centre (CYCC). The research question, therefore asked: What is the effect of a PPI on hope and wellbeing among adolescents living in a Child and Youth Care Centre (CYCC)? Following this research question, the specific research aims were:

- To investigate whether there were significant differences in levels of hope, between and within the experimental and control groups, one week after the implementation of a PPI when compared to the baseline levels of hope accrued before the intervention.
- To investigate whether there were significant differences in levels of hope, between and within the experimental and control groups, five weeks after the implementation of a PPI when compared to the baseline levels of hope accrued before the intervention.
- To investigate whether there were significant differences in levels of wellbeing (as indicated by a presence of positive functioning and an absence of mental illness), between and within the experimental and control groups, one week after
the implementation of a PPI when compared to the baseline levels of hope accrued before the intervention.

- To investigate whether there were significant differences in levels of wellbeing, between and within the experimental and control groups, five weeks after the implementation of a PPI when compared to the baseline levels of hope accrued before the intervention.

The following paragraphs delineate the procedures and statistical analysis employed to reach these aims.

4.3 Research Design

A quantitative quasi-experimental research design was employed to investigate the effect of a PPI, the independent variable, on the dependent variables of hope and wellbeing among adolescents residing in a CYCC. Non-equivalent control group designs are frequently employed to evaluate the effectiveness of treatment programmes by comparing the dependent variables between the experimental and control groups (Campbell & Stanley, 1963; Goodwin, 2010). A repeated measures, non-equivalent control group design strategy was implemented in this study (Cook & Campbell, 1979; Goodwin, 2010). As explicated in the paragraph below addressing sampling, random assignment was not possible in the context of the CYCC. Consequently, to help minimise potential bias and erroneous third variable influences due to non-randomisation, participants in the experimental and control groups were matched on an individual level (Goodwin, 2010; Morling, 2012). Correspondingly, to control for non-equivalent groups, pre-test data were collected (Cook & Campbell, 1979). A discussion detailing the sampling procedure and matching strategy follows.

4.4 Sampling

The sample was composed of adolescents within a single care facility recruited according to availability and accessibility. A convenience strategy was employed, whereby a non-random sample of 29 adolescents was purposively selected from this expedient setting (Goodwin, 2010). Notably, although the sample was recruited from a single CYCC, the facility comprises numerous campuses. The purposive sample was selected from two such campuses, where 23 participants were residents of Campus A and six resided in Campus B. Furthermore, the total sample included male and female youths aged between 14 and 18 years. Intellectually challenged youths were excluded from the sample. Such exclusion was
specified as these adolescents may have experienced difficulties understanding and completing the measuring instruments and intervention exercises.

Small sample size as well as placement limitations based on the two residential campuses from which the participants originated, dictated non-random assignment to the experimental or control groups. Consequently, a matched-groups design was employed to control for potential selection effects (Morling, 2012). Notably, as adolescence is a period of significant cognitive development, 14-year-old youths differ considerably in cognitive ability to their 18-year-old counterparts (Berger, 2011; Harris & Butterworth, 2010). Research has also shown that gender and ethnicity may moderate the outcomes of hope and character strengths-based interventions (Chamberlain & Reid, 1994; Froh, Yurkewicz, & Kashdan, 2009; Marques et al., 2011; Owens & Patterson, 2013; Proctor et al., 2011; Snyder, Lopez, Shorey, Rand, & Feldman, 2003). Therefore, in order to mitigate potential third variable influences regarding age, gender, and ethnicity, participants were allotted to the experimental or control groups in as parsimonious a match as possible (Wilson & MacLean, 2011). Participant grouping and demographic details follow.

4.5 Demographic Characteristics of Participants

The total sample comprised 29 adolescents aged between 14 and 18 years ($M = 16.31; SD = 1.37$). The majority of the sample were female (59%) and of Black ethnicity (62%). Table 4.1 below details the participant particulars of the groups following matched allocation.
Table 4.1
Demographic Characteristics of Participants

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>15</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>16</td>
<td>4</td>
<td>29</td>
</tr>
<tr>
<td>17</td>
<td>4</td>
<td>29</td>
</tr>
<tr>
<td>18</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>Group Total</td>
<td>14</td>
<td>100</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>8</td>
<td>57</td>
</tr>
<tr>
<td>Male</td>
<td>6</td>
<td>43</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>7</td>
<td>50</td>
</tr>
<tr>
<td>Coloured</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>White</td>
<td>5</td>
<td>36</td>
</tr>
</tbody>
</table>

4.6 Procedures

4.6.1 Procedural Overview
All necessary ethical and statutory permissions were obtained and will be discussed in detail in the ethical considerations section below. Due to logistical restrictions, separate introductory sessions were held with the participants from Campus A and Campus B. In these sessions participants were introduced to the researcher and informed of their rights regarding the study (as detailed under ethical considerations). Additionally, participants were given a broad outline of the study and it was indicated that they would be invited to partake in intervention exercises during group sessions as well as in their private capacity. The researcher also explained that due to the nature of the study, the sample group would be
divided into experimental and control groups. It was clarified that all participants would have the opportunity to participate in the intervention; however, participants in the control group would partake in the programme after all research data had been collected. After consenting to participation, the adolescents completed a paper-and-pencil survey that included biographical information, as well as measures of hope, anxiety and depression, and optimal psychological functioning.

For a period of six weeks following the introductory meetings, the researcher met with participants from the experimental group for one-hour sessions on a weekly basis. As a consequence of behavioural limitations experienced by troubled adolescents residing in CYCCs, intervention groups were restricted to a maximum of seven youths per group (Yalom & Leszcz, 2005). As such, the 14 participants in the experimental group were assigned to one of two weekly group sessions. Additionally, as a corollary of logistical limitations, all participants in the experimental group originated from Campus A.

One week after the conclusion of the six-week intervention, the researcher met separately with each experimental and control group. During these post-intervention sessions the participants completed the original measures implemented in the introductory sessions. Four weeks thereafter, both experimental and both control groups completed the final follow-up measures. Follow-up measures were included to investigate whether any significant effects of the intervention were stable over time.

4.6.2 Intervention Content and Implementation

The PPI was composed of six structured one-hour sessions conducted over a six-week period. The intervention programme drew from research and interventions conducted by, among others, Suldo and Michalowski (2007), Proctor et al. (2011), and Feldman and Dreher (2012). Based on these interventions, each of the six sessions, detailed below, carried a major theme. In addition to the focal exercises drawn from the above-mentioned interventions, a ‘loving kindness meditation’ and a savouring exercise were practiced in each session. The meditation was introduced in order to promote and enhance compassion, empathy, social connectedness, and positive affect, as indicated by research. Likewise, the savouring exercise was introduced in order to stimulate positive affect in the moment and to cultivate self-esteem and life satisfaction.
All but the fist intervention session opened with a recapitulation of the previous week’s intervention activities and a reflection on the homework exercises. The week’s review was followed by a brief savouring exercise to facilitate focusing the group’s attention on the present moment. Thereafter, group discussions centred on the week’s principal topic were facilitated. These discussions were followed by the focal exercise. Finally, each session closed with a five-minute ‘loving kindness meditation’. A concise explanation of each weekly themed exercise follows.

4.6.2.1 Gratitude – ‘Counting Blessings’

As a means of self-reflection, the group members were asked to rate their levels of gratitude on a scale of one to 10. These scores were obtained by reflecting on how often they had experienced gratitude in the past month. Thereafter, the exercise of ‘counting blessings’ (Emmons & McCullough, 2003) was explained. During the session, the participants were invited to share their levels of gratitude with the group. They were also encouraged to share their counted blessings, three things they felt grateful for. Additionally, they were asked to note how these events, items, relationships, or attributes, which they felt grateful for, positively affected their lives. As a homework exercise, the participants were asked to repeat the ‘counting blessings’ exercise daily over the next week. After the first week, the exercise was repeated once a week for the remaining five weeks.

4.6.2.2 Kindness – ‘Acts of Kindness’

The second focal exercise centred on ‘acts of kindness’ (Lyubomirsky et al., 2004). In this session the participants were asked to self-reflect on the role kindness played in their lives, as well as to identify whom they felt benefitted from their own voluntary acts of kindness. In addition, participants each received a card with another group member’s name on it and were asked to write, and later share with the group, something kind about that person. Linked to the sharing of the kind words, participants were asked to self-reflect on how they felt after receiving words of kindness. Thereafter, an explanation was given regarding the homework exercise of performing five kind acts in a single day during the following week. This exercise was then repeated weekly for the duration of the intervention.
4.6.2.3 Character Strengths – ‘You at Your Best’

The third session introduced the character strengths-based practices and more specifically addressed the exercise ‘you at your best’ (Seligman et al., 2005). This exercise necessitated that each participant thought of a time or an event when they felt that they were at their best. Once they had recalled a relevant experience, they were asked to write about it and then create a drawing depicting that time when they felt they were at their best. Once they had completed these tasks, in an effort to strongly identify with and engage in the experience, they were asked to recollect how they felt and what strengths they employed at the time of their success. They were also asked to think about the amount of time, effort, and creativity that comprised such an accomplishment. Thereafter, they were invited to share their stories with the group and to discuss the strengths they utilised to realise their success and also the impact the achievement had on their emotions and self-esteem. Group members were also encouraged to offer up unidentified strengths or qualities employed in each story. As a homework activity, it was recommended that the participants re-read and elaborated on their stories throughout the week that followed.

4.6.2.4 Character Strengths – ‘Strength Spotting’ and ‘Using Character Strengths in a New Way’

The central task in the fourth session gave focus to strength identification and utilisation. Employing Proctor et al.’s (2011) method for ‘strength spotting’, the participants each received a worksheet listing the 24 character strengths identified in Peterson and Seligman’s (2004) Values in Action (VIA) classification. The listed character strengths were paired with age appropriate descriptions. Participants took turns reading the character strength descriptions out loud. Following each description, the group engaged in a discussion that served to identify new ways to exercise the specified character strength. Once group members had an understanding of the 24 character strengths, they were asked to go through the list individually and identify and rank their top five character strengths. Thereafter, participants received cards on which another group member’s name was printed; the adolescents were asked to identify and later share with the group one or more character strengths of the person whose name card they had received. In turn, within a group conversation each participant compared and reflected on their self-identified and participant-identified character strengths. They also considered and discussed whether they had utilised these character strengths in their ‘you at your best’ stories. The participants were then asked
to employ at least one of their top five character strengths in a new way every day for the
duration of the week.

4.6.2.5 Hope – ‘Best Possible Future Self’

In the fifth session the participants were introduced to a hope-based exercise that focused on
writing about one’s life goals and aspirations. In this exercise known as the ‘best possible
future self’ (King, 2001), participants were asked to think about their lives in the future; a
future where everything progressed as well as possible, where individuals worked hard and
achieved their desires and reached their life goals. Subsequently, participants were asked to
write about their ‘best possible future self’. On completion of the written exercise, the
participants were guided through a visualisation process; they were asked to use all their
senses to create a rich visualisation of their ‘best possible future self’. This process was
followed by a creative drawing task of illustrating the image of their visualisation and written
story. Thereafter, participants were invited to share their ‘best possible future selves’ with the
group. The homework exercise involved reviewing and enriching their writing, visualisation,
or illustration of their ‘best possible future self’.

4.6.2.6 Hope – ‘Goal Mapping’

The final session focused on hope-based ‘goal mapping’ (Feldman & Dreher, 2012). The
focal discussion and psycho-education in this session centred on hope-directed goal-setting
with reference to pathways and agentic thought. Following the group discussion, participants
were asked to select personally relevant short to medium term goals they wanted to achieve.
Once the goals were selected, the adolescents were asked to complete a worksheet detailing a
three-staged pathway required to achieve the desired goal. On the worksheet they were also
required to identify roadblocks that could obstruct each progressive phase of the planned
route to accomplishment. Finally, to complete the worksheet, they needed to create
alternative pathways around the perceived obstacles. After a group discussion focused on
motivational techniques, the participants were asked to identify and list various methods of
maintaining a sense of agency required to achieve their desired goals. These tasks were
followed by a visualisation exercise; participants were encouraged to use all five senses to
imagine traversing the three-staged pathway and negotiating the obstacles whilst remaining
motivated. As a final step, they were asked to visualise themselves accomplishing their
desired goals and to experience the emotions of success.
4.7 Measuring Instruments

Self-report questionnaires served as the medium for collecting data. A section detailing biographical information was completed in the introductory session. Additionally, the researcher compiled a booklet that incorporated three psychometric instruments measuring depression and anxiety, positive mental health (wellbeing), and hope. The questionnaires in this booklet were completed before the intervention, one week after the intervention, and at a follow-up five weeks after the completion of the intervention. Brief descriptions of these instruments follow.

4.7.1 Biographical Questionnaire

The biographical questionnaire was designed to gather relevant demographic information including the participants’ age, school grade, gender, home language, and ethnicity.

4.7.2 Mental Health Continuum Short Form (MHC-SF) (Keyes, 2005b)

4.7.2.1 Rationale

Keyes (2002) posited that positive mental health includes emotional, psychological, and social wellbeing. Prior to the development of the Mental Health Continuum Short Form (MHC-SF), instruments measuring wellbeing were lengthy in nature, did not measure all three aspects of wellbeing, or included measures of psychopathology (Lamers, Glas, Westerhof, & Bohlmeijer, 2012; Lamers, Westerhof, Bohlmeijer, ten Klooster, & Keyes, 2011). Consequently, the Mental Health Continuum Long Form that comprised 40 items, measuring all three facets of wellbeing, was refined; resulting in a brief questionnaire (MHC-SF) focused only on the three dimensions of positive mental health (Lamers et al., 2012). An aim of the current research was to investigate any changes in wellbeing among the adolescents after partaking in a PPI. To this end, the MHC-SF was employed.

4.7.2.2 Nature and Administration

The MHC-SF consists of 14 items, comprising a three-factor structure measuring emotional (items 1-3), psychological (items 9-14), and social wellbeing (items 4-8). Using a six-point Likert scale, the participants are asked to rate the frequency with which they experienced symptoms of positive mental health over the past month (never, once or twice a month, about once a week, two or three times a week, almost every day, every day). The MHC-SF takes
approximately 10 minutes to complete (Simmons & Lehmann, 2013) and has been confirmed in representative samples of adolescents aged 12 to 18 years (Keyes, 2005b, 2009; Lamers et al., 2011).

4.7.2.3 Scoring and Interpretation

The MHC-SF has continuous or categorical scoring options. The continuous scores are determined by adding individual item scores, with higher scores indicating higher levels of complete mental health. These continuous scores can be calculated for the total scale (total score range 0 – 70) as well as for the three subscales (emotional wellbeing 0 – 15; psychological wellbeing 0 – 30; social wellbeing 0 - 25). Additionally, the categorical scoring system delineates three categories: flourishing, languishing, and moderate health. A diagnosis of flourishing can be given if an individual reports ‘almost every day’ or ‘everyday’ for at least seven of the 14 items, with at least one item coming from the domain of emotional wellbeing. Conversely, an individual is said to be languishing if at least seven of the 14 items, including at least one emotional wellbeing item, are reported as ‘never’ or ‘once or twice a month’. Moderate health is diagnosed if the individual does not meet the criteria for either flourishing or languishing (Keyes, 2009).

4.7.2.4 Reliability and Validity

Multiple studies have evidenced the MHC-SF to show high internal consistency ($\alpha > .80$) among adults (United States, South Africa, and Netherlands) and adolescents aged between 12 and 18 years (Keyes, 2005b, 2006, 2009; Keyes et al., 2008, Westerhof & Keyes, 2010). Temporal stability was demonstrated with positive test-retest correlations reported over three and nine months at .68 and .65 respectively (Lamers et al., 2012). Likewise, numerous studies have reported good convergent, discriminant, criterion, and construct validity (Keyes, 2005b, 2006, 2009; Keyes et al., 2008, Westerhof & Keyes, 2010). Within the South African context, the MHC-SF replicated the three-factor structure of emotional, psychological, and social wellbeing (Keyes et al., 2008). Moreover, within this context, the MHC-SF showed convergent, criterion, and construct validity as well as good internal reliability with Cronbach’s alpha reported as >.73 (du Plessis, 2014; Guse & Vermaak, 2011; Keyes et al., 2008; van Schalkwyk & Wissing, 2010).
4.7.3 Children’s Hope Scale (CHS) (Snyder et al., 1997b)

4.7.3.1 Rationale

The foundational premise of the CHS is that children are goal oriented, and more specifically, their goal directed thoughts comprise two components, those of agency and pathways. Thoughts of agency are reflected in individuals’ initiative, motivation, determination, and commitment to embark on and to achieve their desired goals. The thoughts pertaining to creating possible routes to accomplish goals are reflective of pathways thinking. Snyder’s hope theory (1997b) suggests that hope entails the combination of goal directed pathways and agentic thinking. As such, the CHS measures the construct of hope, and also independently evaluates the components of agency and pathways. Consequently, the CHS was deemed appropriate to measure the levels of hope in the adolescents participating in this study.

4.7.3.2 Nature and Administration

The CHS is a six-item self-report questionnaire assessing dispositional hope that can be applied to youths between the ages of eight and 16 years. The six items are divided equally to measure the bi-faceted construct of hope; the odd numbered items represent agentic thought, while the even numbered items represent pathways thinking. Examples of questions include the agentic thought “I think I am doing pretty well” and the pathways thought “I can think of many ways to get the things in life that are important to me”. This brief, pencil and paper instrument can be administered within three minutes.

4.7.3.3 Scoring and Interpretation

The CHS is hand-scored on a six-point Likert scale ranging from one (none of the time) to six (all of the time). The total hope score is calculated by adding each item score. As such, this score can range between six reflecting low levels of hope and 36 indicating high levels of hope. Additionally, the subscales of agency and pathways demonstrate scores ranging between three (low hope) and 18 (high hope).

4.7.3.4 Reliability and Validity

The CHS yielded Cronbach’s alpha coefficients ranging from .72 to .86, with a median alpha of .77 (Snyder et al., 1997b), indicating good internal consistency. As a measure of dispositional hope, the test-retest correlations were positive and significant (.71 to .73), thus
indicating temporal stability. Snyder et al. (1997b) reported that parent’s ratings of children’s hope correlated positively with the children’s actual CHS scores, indicating convergent validity. Furthermore, Snyder et al. (1997b) established discriminant, predictive, and incremental validity. The CHS was advanced to be a valid measure of hope among South African adolescents (Guse & Kok, 2013).

4.7.4 Revised Child Anxiety and Depression Scale - Short Version (RCADS-SV) (Ebesutani et al., 2012)

4.7.4.1 Rationale

The Revised Child Anxiety and Depression Scale – Short Version (RCADS-SV; Ebesutani et al., 2012) is a concise form of the 47-item Revised Child Anxiety and Depression Scale (RCADS; Chorpita, Yim, Moffitt, Umemoto, & Francis, 2000). The original 47-item measure was developed in response to the scarcity of scales available that measured symptoms specific to pathological anxiety and depressive disorders in child populations. In particular, it was developed to assist with the clinical diagnosis of anxiety and depression as stipulated in the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition [DSM-IV]; American Psychiatric Association [APA], 1994). As such, the 47-item RCADS assesses both anxiety and depressive symptoms (Ebesutani et al., 2012). Although the 47-item RCADS proved valid and reliable, and demonstrated strong utility in both clinical and research contexts (Chorpita et al., 2000; Chorpita, Moffitt, & Gray, 2005), additional demands for instrument efficiency, including time required to complete the measure, were necessitated. To this end, the 25-item RCADS-SV was developed (Ebesutani et al., 2012). The measure of both anxiety and depression in a single scale combined with the brevity of the scale advance the RCADS-SV suitable for this study.

4.7.4.2 Nature and Administration

The RCADS-SV (Ebesutani et al., 2012) is a self-report questionnaire consisting of 25 items, with two subscales corresponding to the DSM-IV classification criteria for anxiety and depression in children and adolescents (ages six – 19). On a four-point Likert scale ranging from ‘never’ to ‘always’ children rate how often each item applies to them. Items representative of the anxiety scale include: “I feel afraid that I will make a fool of myself in front of people” and “I worry that something bad will happen to me”. Examples of statements reflecting depression include: “I feel sad or empty” and “I feel worthless”.
4.7.4.3 Scoring and Interpretation

The RCADS-SV offers both manual and automated scoring options. Manually, the RCADS-SV is scored on a four-point Likert scale with numerical values ranging from 0 – 3, where 0 = ‘never’, 1 = ‘sometimes’, 2 = ‘often’, and 3 = ‘always’. As such, the anxiety and depression total scale raw score ranges between 0 – 75, while the subscale raw scores for anxiety and depression range between 0 – 45 and 0 – 30, respectively. The RCADS-SV is normed according to gender and grade level. Consequently, to accommodate comparison of individuals across gender and grades, the raw scores are manually converted to $t$-scores. Alternatively, a programme for automated scoring is available at www.childfirst.ucla.edu/resources.html. The programme calculates the raw scores and converts them to $t$-scores once the user has entered the individual item scores (0 – 3) in the specified cells.

4.7.4.4 Reliability and Validity

Research demonstrated the 47-item RCADS to have good internal consistency as well as high convergent and discriminant validity in both non-referred and clinical populations (Chorpita et al., 2000, 2005; Esbjørn, Sømhovd, Turnstedt, & Reinholdt-Dunne, 2012). More recently, the RCADS-SV was reported as an efficient assessment of anxiety and depression. More specifically, the anxiety subscale of the RCADS-SV yielded Cronbach’s alpha coefficients of .86 and .91 in non-referred and clinical samples, respectively. Likewise, the depression subscale advanced Cronbach’s alpha coefficients of .79 in the non-referred sample and .80 in the clinical sample. As such, good internal consistency was indicated in both non-referred and clinical samples. Additionally, the RCADS-SV displayed good convergent and divergent validity as well as acceptable concurrent validity with clinical diagnostic groups (Ebesutani et al., 2012).

4.8 Data Analysis

Descriptive statistics were employed for the scale scores and demographics of the sample. The means of the dependent variables within and between the control and experimental groups before, after, and five weeks following the completion of the intervention were compared utilising inferential statistics. Specifically, independent-samples $t$-tests were conducted for between group comparisons before and after the intervention as well as at a five-week follow-up. Additionally, paired-samples $t$-tests compared the outcomes of the
within group repeated measures before the intervention and one and five weeks after the intervention. Parametric assumptions were tested in order to determine the appropriate tests of difference; these are reported on in the results chapter.

The data were captured and analysed using the Statistical Package for the Social Sciences (SPSS), version 22.

4.9 Ethical Considerations

Both the Higher Degrees Committee and the Ethics Committee at the University of Johannesburg granted permission for this study. Permission to conduct the study at the participating CYCC was also obtained from the facility’s Childcare Services Manager. Further to this, the Childcare Services Manager also signed guardian consent for each participant. Additionally, all the participating adolescents signed assent forms, agreeing to partake in the intervention and the study. The adolescents were advised that all information provided would remain confidential, that the study was not compulsory, and that they were allowed to withdraw from the programme at any time without any consequences. Confidentiality pertaining to the CYCC and the participating adolescents was maintained throughout the study. Identifying details were removed from biographical questionnaires and measuring instruments. Adolescents in the control group had the opportunity to take part in the intervention after follow-up measures were completed. In accordance with the principle of beneficence, every effort was made to provide benefit to the adolescents involved in the study, moreover each exercise and group session was considered with the core focus of doing no intentional or unintentional harm to the participants of the study. Although provisions were made for referring adolescents to the institution’s counsellor if deemed necessary, this service was not required.

Feedback on the results of this study, in the form of the completed dissertation will be made available to the participating CYCC.

4.10 Summary

This chapter detailed the methodology employed in the current study. The research question and aims were stated, following which, the research design and sampling technique were described. Procedures for the intervention were explored, detailing the contents of the six
intervention sessions as well as the in-session and homework exercises. Thereafter, the instruments used to measure the dependent variables were discussed, the process of data analysis explicated, and ethical precautions considered. The following chapter will present the results of the data analysis delineated in this chapter.
Chapter 5: Results

5.1 Introduction
The results of the empirical study are presented and interpreted in this chapter. The reliability indices and descriptive statistics for scales implemented in the study are provided. Thereafter, the results corresponding to the specific aims of the study are presented.

5.2 Descriptive Statistics
Descriptive statistics for the instruments employed in this study are summarised in the section below.

5.2.1 Reliability Indices of Measuring Instruments
Cronbach alpha (α) reliability coefficients are provided in Table 5.1. All of the reliability values reported in Table 5.1 below are greater than .70, with two measures yielding values greater than .8. Values greater than .8 suggest very good internal consistency, however, self-report scales with values above .70 are deemed acceptable for research purposes (Pallant, 2010; Nunnally, 1978).

Table 5.1
Cronbach’s Alpha Reliability Coefficients for all Measuring Instruments

<table>
<thead>
<tr>
<th>Scale</th>
<th>Number of items</th>
<th>α</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHS</td>
<td>6</td>
<td>.71</td>
</tr>
<tr>
<td>MHC-SF</td>
<td>14</td>
<td>.86</td>
</tr>
<tr>
<td>RCADS-SV</td>
<td>25</td>
<td>.86</td>
</tr>
</tbody>
</table>

Note. CHS = Children’s Hope Scale; MCH-SF = Mental Health Continuum – Short Form; RCADS = Revised Child Anxiety and Depression Scale – Short Version.

5.2.2 Means, Standard Deviations, Kurtosis, and Skewness of Measuring Instruments
Parametric techniques require that certain assumptions about the data be met. Specifically, in order to execute independent- and paired-samples t-tests the data must be interval/ratio and assumptions of normality need to be satisfied. Additionally, independent-samples t-tests assume homogeneity of variance (Pallant, 2010; Wilson & MacLean, 2011).
Skewness and kurtosis values give an indication of how the data are distributed. Perfectly normal distributions exhibit skewness and kurtosis values of zero, however, absolute values of less than two are deemed acceptable to meeting the normal distribution criteria (Heppner & Heppner, 2004). Additionally, the Shapiro-Wilk test is a commonly utilised formal normality test exhibiting good power properties (Razali, & Wah, 2011). The statistic has been shown to be an effective measure of normality in small samples (Shapiro & Wilk, 1965). The Shapiro-Wilk statistic lies between zero and one, where values of .01 or less indicate that assumptions of normality have not been met (Razali, & Wah, 2011; Shapiro & Wilk, 1965; Tabachnick & Fidell, 2007).

Prior to the main analysis, scale scores examined using the latest version of SPSS indicated the assumptions of homogeneity had been met (Field, 2005; Pallant, 2010). Specifically, Levene’s test for equality of variances yielded non-significant results for each of the measures at each time interval; indicating equal variances in the control and experimental groups.

Table 5.2 represents the means, skewness, kurtosis, and results from the Shapiro-Wilk normality test scores for the criterion (dependent) variables. With the exception of two kurtosis values, all skewness and kurtosis scores reported in Table 5.2 below fell within the modulus of two, indicating towards normality. Moreover, all but one of the criterion variables yielded Shapiro-Wilk statistic values greater than .01, reflecting the assumptions of normality were satisfied (Wilson & MacLean, 2011; Razali, & Wah, 2011; Shapiro & Wilk, 1965). As such, we can assume normal distribution of scores. Subsequently, since the assumptions for parametric techniques and specifically for independent- and paired-samples t-tests were met, these parametric tests were applied to analyse the data.
Table 5.2  
*Means, Standard Deviations, Skewness, Kurtosis, and Normality Distribution of All Measures for the Experimental and Control Groups*

<table>
<thead>
<tr>
<th>Scale</th>
<th>Group</th>
<th>Mean</th>
<th>SD</th>
<th>Skewness</th>
<th>Kurtosis</th>
<th>Shapiro-Wilk</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHS</td>
<td>Pre-Exp.</td>
<td>25.86</td>
<td>5.57</td>
<td>.32</td>
<td>-.38</td>
<td>.62</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pre-Cont.</td>
<td>21.87</td>
<td>5.81</td>
<td>.28</td>
<td>1.06</td>
<td>.59</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Post-Exp.</td>
<td>22.50</td>
<td>5.29</td>
<td>-.66</td>
<td>-.21</td>
<td>.09</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Post-Cont.</td>
<td>24.07</td>
<td>5.12</td>
<td>.53</td>
<td>-.05</td>
<td>.69</td>
<td></td>
</tr>
<tr>
<td></td>
<td>F-Up-Exp.</td>
<td>24.14</td>
<td>4.98</td>
<td>.45</td>
<td>-.31</td>
<td>.32</td>
<td></td>
</tr>
<tr>
<td></td>
<td>F-Up-Cont.</td>
<td>22.40</td>
<td>6.22</td>
<td>-.49</td>
<td>.19</td>
<td>.84</td>
<td></td>
</tr>
<tr>
<td>MHC-SF</td>
<td>Pre-Exp.</td>
<td>48.43</td>
<td>12.68</td>
<td>-1.19</td>
<td>1.60</td>
<td>.15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pre-Cont.</td>
<td>47.90</td>
<td>9.35</td>
<td>-1.15</td>
<td>-.57</td>
<td>.99</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Post-Exp.</td>
<td>48.21</td>
<td>11.81</td>
<td>-1.06</td>
<td>.96</td>
<td>.11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Post-Cont.</td>
<td>47.6</td>
<td>8.39</td>
<td>-.06</td>
<td>.80</td>
<td>.85</td>
<td></td>
</tr>
<tr>
<td></td>
<td>F-Up-Exp.</td>
<td>48.71</td>
<td>14.72</td>
<td>-.62</td>
<td>-1.19</td>
<td>.05</td>
<td></td>
</tr>
<tr>
<td></td>
<td>F-Up-Cont.</td>
<td>43.80</td>
<td>14.53</td>
<td>-.77</td>
<td>-.69</td>
<td>.06</td>
<td></td>
</tr>
<tr>
<td>RCADS-SV</td>
<td>Pre-Exp.</td>
<td>60.36</td>
<td>12.45</td>
<td>.81</td>
<td>-.15</td>
<td>.23</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pre-Cont.</td>
<td>55.67</td>
<td>9.06</td>
<td>-.54</td>
<td>-.82</td>
<td>.17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Post-Exp.</td>
<td>56.71</td>
<td>13.36</td>
<td>.53</td>
<td>-.84</td>
<td>.55</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Post-Cont.</td>
<td>54.93</td>
<td>10.74</td>
<td>1.60</td>
<td>3.75*</td>
<td>.03</td>
<td></td>
</tr>
<tr>
<td></td>
<td>F-Up-Exp.</td>
<td>55.29</td>
<td>11.53</td>
<td>.29</td>
<td>.12</td>
<td>.60</td>
<td></td>
</tr>
<tr>
<td></td>
<td>F-Up-Cont.</td>
<td>58.07</td>
<td>18.15</td>
<td>1.78</td>
<td>3.58*</td>
<td>.01**</td>
<td></td>
</tr>
</tbody>
</table>

*Note. * kurtosis > |2| ** p value < .01 (2 tailed)*

ChS = Children’s Hope Scale; MHC-SF = Mental Health Continuum – Short Form; RCADS-SV = Revised Child Anxiety and Depression Scale – Short Version; Pre-Exp. = Pre-Experimental Group; Post-Exp. = Post-Experimental Group; F-Up-Exp. = Follow-Up-Experimental Group; Pre-Cont. = Pre-Control Group; Post-Cont. = Post-Control Group; F-Up-Cont. = Follow-Up-Control Group.

5.3 Inferential Statistics

Independent- and paired-samples *t*-tests were employed to examine the mean differences between and within the experimental and control groups. To guard against alpha inflation, a
Bonferroni correction was used to establish the alpha level at .025 for all paired-samples $t$-test results. Results will be reported on in the following section.

### 5.3.1 Comparison of Pre-Test Scores between the Experimental and Control Groups

In view of the fact that complete random assignment of participants to the control and experimental groups was not possible, a comparison of the pre-test scores was necessary to determine whether the two groups’ baseline measures of hope and wellbeing were equal. As the assumptions of normality were satisfied for the data set, these continuous variable scores were compared by means of independent-samples $t$-tests. As can be seen in Table 5.3, no significant differences were found between the control and experimental groups on all three pre-test measures.

#### Table 5.3

<table>
<thead>
<tr>
<th>Scale</th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>CHS</td>
<td>25.86</td>
<td>5.57</td>
</tr>
<tr>
<td>MHC-SF</td>
<td>48.43</td>
<td>12.68</td>
</tr>
<tr>
<td>RCADS-SV</td>
<td>60.36</td>
<td>12.45</td>
</tr>
</tbody>
</table>

*Note. CHS = Children’s Hope Scale; MHC-SF = Mental Health Continuum – Short Form; RCADS-SV = Revised Child Anxiety and Depression Scale – Short Version.*

### 5.3.2 Significance of Differences in Hope One Week after the Intervention

#### 5.3.2.1 Significance of Differences in Hope within the Experimental Group before and One Week after the Intervention

Paired-samples $t$-tests were conducted to compare the mean hope scores within the experimental group before and one week after the intervention. A Bonferroni adjustment was applied to significance values to control for type 1 errors across multiple tests (Pallant, 2010); thus establishing the alpha level at .025. As reflected in Table 5.4, no significant differences were found within the experimental group before and one week after the PPI.
Table 5.4
Significance of Differences in Hope within the Experimental Group before and One Week after the Intervention

<table>
<thead>
<tr>
<th>Scale</th>
<th>Pre-Test</th>
<th>Post-Test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>CHS</td>
<td>25.86</td>
<td>5.57</td>
</tr>
</tbody>
</table>

*Note. CHS = Children’s Hope Scale.*

5.3.2.2 Significance of Differences in Hope within the Control Group before and One Week after the Intervention

Similarly, hope scores were compared within the control group. No significant differences were found within the control group from pre-test to post-test. The results are presented in Table 5.5.

Table 5.5
Significance of Differences in Hope Scores within the Control Group before and One Week after the Intervention

<table>
<thead>
<tr>
<th>Scale</th>
<th>Pre-Test</th>
<th>Post-Test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>CHS</td>
<td>21.87</td>
<td>5.81</td>
</tr>
</tbody>
</table>

*Note. CHS = Children’s Hope Scale.*

5.3.2.3 Significance of Differences in Hope between the Experimental and Control Groups One Week after the Intervention

Independent-samples t-tests were used to compare the mean differences in the hope scores between the experimental and control groups after the completion of the intervention. Unexpectedly, the experimental group showed a slight decrease in hope scores whilst the control group’s scores marginally increased; these differences, however, were not significant. The results are summarised in Table 5.6.
Table 5.6
Significance of Differences in Hope Scores between the Experimental and Control Groups One Week after the Intervention

<table>
<thead>
<tr>
<th>Time</th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>CHS Pre-Test</td>
<td>25.86</td>
<td>5.57</td>
</tr>
<tr>
<td>CHS Post-Test</td>
<td>22.50</td>
<td>5.29</td>
</tr>
</tbody>
</table>

*Note.* CHS = Children’s Hope Scale.

5.3.2.4 Conclusion

The independent-samples and paired-samples *t*-tests revealed no statistically significant differences between or within the experimental and control groups one week after the intervention. These findings indicate no change in levels of hope one week after the implementation of the PPI when compared to baseline scores. With this conclusion, the first research aim was reached.

5.3.3 Significance of Differences in Hope Five Weeks after the Intervention

5.3.3.1 Significance of Differences in Hope within the Experimental Group before and Five Weeks after the Intervention

Corresponding to the one-week post-intervention comparison, paired-samples *t*-tests were utilised to compare mean hope scores within the experimental group from pre-test to follow-up-test five weeks after the completion of the PPI. As can be seen in Table 5.7, these comparisons revealed no statistically significant differences in hope within the experimental group from one week before to five weeks after the intervention.
Table 5.7
Significance of Differences in Hope within the Experimental Group before and Five Weeks after the Intervention

<table>
<thead>
<tr>
<th>Scale</th>
<th>Pre-Test Mean</th>
<th>SD</th>
<th>Follow-Up-Test Mean</th>
<th>SD</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHS</td>
<td>25.86</td>
<td>5.57</td>
<td>24.14</td>
<td>4.98</td>
<td>.22</td>
</tr>
</tbody>
</table>

Note. CHS = Children’s Hope Scale.

5.3.3.2 Significance of Differences in Hope within the Control Group before and Five Weeks after the Intervention

Likewise, mean hope score comparisons before the intervention and five weeks after the intervention revealed no significant differences in levels of hope within the control group. Results are detailed in Table 5.8.

Table 5.8
Significance of Differences in Hope within the Control Group before and Five Weeks after the Intervention

<table>
<thead>
<tr>
<th>Scale</th>
<th>Pre-Test Mean</th>
<th>SD</th>
<th>Follow-Up-Test Mean</th>
<th>SD</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHS</td>
<td>21.87</td>
<td>5.81</td>
<td>22.4</td>
<td>6.22</td>
<td>.65</td>
</tr>
</tbody>
</table>

Note. CHS = Children’s Hope Scale.

5.3.3.3 Significance of Differences in Hope between the Experimental and Control Groups Five Weeks after the Intervention

Finally, as can be seen in Table 5.9, no significant differences were found in the levels of hope between experimental and control groups five weeks after the PPI.
Table 5.9

Significance of Differences in Hope between the Experimental and Control Groups Five Weeks after the Intervention

<table>
<thead>
<tr>
<th>Time</th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>CHS Pre-Test</td>
<td>25.86</td>
<td>5.57</td>
</tr>
<tr>
<td>CHS Follow-Up-Test</td>
<td>24.14</td>
<td>4.98</td>
</tr>
</tbody>
</table>

Note. CHS = Children’s Hope Scale

5.3.3.4 Conclusion

At five weeks after the PPI, the experimental and control groups exhibited no statistically significant differences in levels of hope as measured by the CHS. These statistically non-significant findings were revealed both within groups and between the experimental and control groups. Consequently, it can be surmised that levels of hope five weeks after the intervention were not significantly affected by the implementation of the PPI. Thus fulfilling the second aim of the study.

5.3.4 Significance of Differences in Wellbeing One Week after the Intervention

5.3.4.1 Differences in Wellbeing within the Experimental Group before and One Week after the Intervention

Paired-samples t-tests were used to compare the mean scores of wellbeing within the experimental group before the intervention to one week after the intervention. Wellbeing, conceptualised as the presence of positive functioning and an absence of mental illness, was measured with the MHC-SF and the RCADS-SV. Bonferroni adjustments were applied to the values of significance to accommodate for several t-tests performed simultaneously on a single data set (Terry, Malekshahi, & Delva, 2012). Although the experimental group exhibited a slight decrease in the mean RCADS-SV score, no statistically significant differences were found within the experimental group on measures of psychopathology (RCADS-SV) or positive functioning (MHC-SF) after the intervention when compared to baseline scores obtained before the intervention. The results are presented in Table 5.10.
Table 5.10
Significance of Differences in Wellbeing within the Experimental Group before and One Week after the Intervention

<table>
<thead>
<tr>
<th>Scale</th>
<th>Pre-Test</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>MHC-SF</td>
<td>48.43</td>
<td>12.68</td>
<td>48.21</td>
<td>11.81</td>
</tr>
<tr>
<td>RCADS-SV</td>
<td>60.36</td>
<td>12.45</td>
<td>56.71</td>
<td>13.36</td>
</tr>
</tbody>
</table>

*p* = .95

Note. MHC-SF = Mental Health Continuum – Short Form; RCADS-SV = Revised Child Anxiety and Depression Scale – Short Version.

5.3.4.2 Differences in Wellbeing within the Control Group before and One Week after the Intervention

As indicated in Table 5.11, the control group also displayed no statistically significant differences in measures of psychopathology and positive functioning one week after the intervention when compared to pre-test scores accrued before the PPI.

Table 5.11
Significance of Differences in Wellbeing within the Control Group before and One Week after the Intervention

<table>
<thead>
<tr>
<th>Scale</th>
<th>Pre-Test</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>MHC-SF</td>
<td>47.07</td>
<td>9.35</td>
<td>47.60</td>
<td>8.39</td>
</tr>
<tr>
<td>RCADS-SV</td>
<td>55.67</td>
<td>9.06</td>
<td>54.93</td>
<td>10.74</td>
</tr>
</tbody>
</table>

*p* = .80

Note. MHC-SF = Mental Health Continuum – Short Form; RCADS-SV = Revised Child Anxiety and Depression Scale – Short Version.

5.3.4.3 Significance of Differences in Wellbeing between the Experimental and Control Groups One Week after the Intervention

Independent-samples *t*-tests were conducted to compare the experimental and control groups on measures of wellbeing one week after the PPI. No statistically significant differences were found between the groups’ mean scores on the MHC-SF or RCADS-SV. The results are shown in Table 5.12.
Table 5.12
Significance of Differences in Wellbeing between the Experimental and Control Groups One Week after the Intervention

<table>
<thead>
<tr>
<th>Scale</th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHC-SF</td>
<td>Mean 48.21 SD 11.81</td>
<td>Mean 47.60 SD 8.39</td>
</tr>
<tr>
<td>RCADS-SV</td>
<td>Mean 56.71 SD 13.36</td>
<td>Mean 54.93 SD 10.74</td>
</tr>
</tbody>
</table>

Note. MHC-SF = Mental Health Continuum – Short Form; RCADS-SV = Revised Child Anxiety and Depression Scale – Short Version.

5.3.4.4 Conclusion

The $t$-tests employed to compare mean scores realised by the experimental and control groups revealed no statistically significant differences within or between these groups. These results evidenced no significant changes in wellbeing, conceptualised as the presence of positive functioning (MHC-SF) and the absence of psychopathology (RCADS-SV), in either the experimental or control groups at one week after intervention. These results suggest that participating in the PPI did not lead to significant changes in wellbeing one week after the conclusion of the intervention; as such, the third aim of the study was realised.

5.3.5 Significance of Differences in Wellbeing Five Weeks after the Intervention

5.3.5.1 Significance of Differences in Wellbeing within the Experimental Group before and Five Weeks after the Intervention

The experimental group’s scores of wellbeing before the intervention were compared to scores accumulated at the five-week follow-up. The downward trend in psychopathology, as evidenced in levels of anxiety and depression, visible one week after the intervention continued at the five-week follow-up. However, as shown in Table 5.13, the difference in scores of both the RCADS-SV and the MHC-SF at the five-week follow-up were not statistically significant when compared to the baseline scores accrued one week before the intervention.
Table 5.13
Significance of Differences in Wellbeing within the Experimental Group before and Five Weeks after the Intervention

<table>
<thead>
<tr>
<th>Scale</th>
<th>Pre-Test</th>
<th></th>
<th>Follow-Up-Test</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
<td>p</td>
</tr>
<tr>
<td>MHC-SF</td>
<td>48.43</td>
<td>12.68</td>
<td>48.71</td>
<td>14.72</td>
<td>.94</td>
</tr>
<tr>
<td>RCADS-SV</td>
<td>60.36</td>
<td>12.45</td>
<td>55.29</td>
<td>11.53</td>
<td>.19</td>
</tr>
</tbody>
</table>

Note. MHC-SF = Mental Health Continuum – Short Form; RCADS-SV = Revised Child Anxiety and Depression Scale – Short Version.

5.3.5.2 Significance of Differences in Wellbeing within the Control Group before and Five Weeks after the Intervention

As detailed in Table 5.14, no statistically significant differences in measures of wellbeing were found within the control group from one week before to five weeks after the intervention.

Table 5.14
Significance of Differences in Wellbeing within the Control Group before and Five Weeks after the Intervention

<table>
<thead>
<tr>
<th>Scale</th>
<th>Pre-Test</th>
<th></th>
<th>Follow-Up-Test</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
<td>p</td>
</tr>
<tr>
<td>MHC-SF</td>
<td>47.07</td>
<td>9.35</td>
<td>43.80</td>
<td>14.53</td>
<td>.24</td>
</tr>
<tr>
<td>RCADS-SV</td>
<td>55.67</td>
<td>9.06</td>
<td>58.07</td>
<td>18.15</td>
<td>.53</td>
</tr>
</tbody>
</table>

Note. MHC-SF = Mental Health Continuum – Short Form; RCADS-SV = Revised Child Anxiety and Depression Scale – Short Version.

5.3.5.3 Significance of Differences in Wellbeing between the Experimental and Control Groups Five Weeks after the Intervention

Lastly, the experimental group’s mean scores of wellbeing five weeks after the intervention were compared to those of the control group at the five-week follow-up. As can be seen in Table 5.15, there were no significant differences in the mean scores of the MHC-SF and the RCADS-SV before and five weeks after the PPI.
Table 5.15
Significance of Differences in Wellbeing between the Experimental and Control Groups Five Weeks after the Intervention

<table>
<thead>
<tr>
<th>Scale</th>
<th>Experimental Group</th>
<th>Control Group</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>MHC-SF</td>
<td>48.71</td>
<td>14.71</td>
<td>43.80</td>
</tr>
<tr>
<td>RCADS-SV</td>
<td>55.29</td>
<td>11.53</td>
<td>58.07</td>
</tr>
</tbody>
</table>

Note. MHC-SF = Mental Health Continuum – Short Form; RCADS-SV = Revised Child Anxiety and Depression Scale – Short Version.

5.3.5.4 Conclusion

Five weeks after the intervention, as at one week post-intervention, no significant differences were found within or between the experimental and control groups with regard to measures of positive functioning or psychopathology. As such, it can be concluded that the PPI had no significant effect on levels of wellbeing, as measured by the MHC-SF and RCADS-SV, five weeks after the intervention, achieving the fourth and final aim of the study.

5.3.6 Summary of Inferential Statistics

The main aims of the study were to determine whether the implementation of a PPI would have a significant effect on 1) hope and 2) wellbeing of adolescents residing in a CYCC. Further, the aim was to determine whether these effects were stable over time. The results of the inferential analysis indicated that no significant differences were experienced in hope and wellbeing one week or five weeks after the intervention, when compared to baseline scores accrued before the intervention. As such, the results suggest that the PPI had no statistically significant effect on hope and wellbeing among adolescents residing in the CYCC.

5.4 Summary of the Results

This chapter showcased the outcomes of the study. More specifically, the reliability indices and central tendencies of the measuring instruments employed in this study were presented. Additionally, the results from the statistical analysis of data collected at three time intervals through the administration of self-report measures of hope and wellbeing were presented.
The descriptive statistics used to describe the scale scores, advanced all three measuring instruments acceptable with Cronbach’s alpha values greater than .70. In addition, the inferential statistics compared means between and within the experimental and control groups. These comparisons revealed no statistically significant changes in levels of hope or wellbeing after the implementation of a PPI among adolescents residing in a CYCC. A discussion of these results as well as an interpretation thereof against the backdrop of existing literature will follow in the next chapter.
Chapter 6: Discussion and Conclusion

6.1 Introduction

The main focus and broad aim of this study was to investigate the effect of a Positive Psychology Intervention (PPI) on hope and wellbeing among adolescents residing in a Child and Youth Care Centre (CYCC). Both the suboptimal context and the challenging period of adolescence lead to vulnerabilities and render youths living in care facilities susceptible to unsatisfactory developmental trajectories. However, as youths’ cognitive capacities such as hypothetical, abstract, critical, and logical reasoning are developed during adolescence, this developmental phase offers a timeous opportunity to introduce tools and exercises that may promote positive growth, cultivate strengths, and enhance wellbeing. Such an opportunity may be particularly valuable to vulnerable and impressionable youths exposed to complex and frequently maladaptive home, school, and social environments. Literature predominantly indicated that character strengths, including hope, were positively correlated with wellbeing. Research also demonstrated that PPIs employing character strengths-based exercises increased wellbeing, positive affect, and life satisfaction and reduced negative affect and depressive and anxious symptoms. In this light the broad research aim, as stated above, was conceptualised.

This chapter reviews the outcomes of the study with regard to the specific aims. Thereafter, the findings are discerned, interpreted, and discussed in the context of existing literature. Limitations of the current research project are reviewed followed by recommendations for future studies. Finally, concluding remarks highlighting the recommendation for qualitative components in future positive psychology intervention (PPI) studies are discussed.

6.2 Discussion of the Results

6.2.1 Results in Relation to the Aims of the Study

6.2.1.1 Differences in Level of Hope One Week after the Intervention

The first aim of this study was to investigate whether there were significant differences in levels of hope, between and within the experimental and control groups, one week after the implementation of a PPI, when compared to the baseline levels of hope accrued one week before the intervention. No significant differences in baseline scores were found between the experimental and control groups, indicating that the two groups were similar before the
intervention. Therefore, any subsequent differences found between the groups could be attributed to the effect of the intervention. However, all within and between group comparisons yielded results that were not statistically significant, suggesting that the PPI had no significant effect on levels of hope one week after the intervention.

6.2.1.2 Differences in Level of Hope Five Weeks after the Intervention

The second aim was to evaluate the long-term effect of the PPI on hope and specifically to identify any differences in hope between and within the experimental and control groups five weeks after the intervention. These follow-up results also showed no significant changes in levels of hope between the experimental and control groups when compared to baseline scores. Furthermore, no significant differences in levels of hope were found within either the experimental or control groups. These results suggest that there were no significant long-term increases in levels of hope among adolescents who partook in the PPI.

6.2.1.3 Differences in Level of Wellbeing One Week after the Intervention

For the purpose of this study, wellbeing was conceptualised as the presence of positive functioning, as measured by the short form Mental Health Continuum (MHC-SF) and the absence of psychopathology, as measured by the short version of the Revised Children’s Anxiety and Depression Scale (RCADS-SV). As such, when identifying differences within and between the experimental and control groups for wellbeing, scores for both the MHC-SF and RCADS-SV were compared.

Corresponding to the first aim, the third aim was to investigate the differences in wellbeing between and within the experimental and control groups one week after the intervention, when compared to baseline scores. Consistent with the pre-intervention hope scores comparison between the experimental and control groups, baseline levels of wellbeing were also compared. No significant differences were found on scores of positive functioning or psychopathology between the experimental and control groups a week before the intervention, offering an equal point of departure for the two groups, with subsequent differences revealing the effectiveness of the intervention. Again however, no differences were noted between or within the experimental and control groups, suggesting that the intervention had no significant effect on wellbeing among adolescents residing in the CYCC. More specifically, the results revealed no significant increases in positive functioning or
significant decreases in anxiety and depression. Notably, a downward trend was exhibited within the experimental group on levels of anxiety and overall levels of psychopathology; these reduced levels, however, were not statistically significant. This downward trend is in standing with existing literature indicating PPIs effectiveness in reducing psychopathology including depression (Cheavens et al., 2006; Gander et al., 2012; Pietrowsky & Mikutta, 2012; Seligman et al., 2005; Sin & Lyubomirsky, 2009), anxiety (Cheavens et al., 2006; Green, 2007; Seligman et al., 2009), alcohol misuse (Akhtar & Boniwell, 2010), and schizophrenia (Johnson et al., 2011; Meyer, Johnson, Parks, Iwanski, Penn, 2012).

6.2.1.4 Differences in Level of Wellbeing Five Weeks after the Intervention

The final aim of the study was to investigate the differences in scores of wellbeing between and within the experimental and control groups five weeks after the completion of the PPI, when compared to baseline scores. Similar to the outcome of hope among adolescents, no significant findings were revealed on the scales of positive functioning or psychopathology five weeks after the intervention. More specifically, although the downward trend in anxiety and overall psychopathology was still notable five weeks after the intervention, these differences were not significant. Moreover, scores measuring positive functioning remained unchanged five weeks after the intervention. As such, it can be concluded that adolescents enjoyed no significant long-term increases in wellbeing as a consequence of partaking in a PPI.

6.2.2 Results in the Context of Existing Literature

The fact that differences in levels of hope and wellbeing were not statistically significant was surprising. Although previous studies reported non-significant changes in levels of hope (Weis & Speridakos, 2011) and wellbeing (Owens & Patterson, 2013; Parks et al., 2012; Rashid et al., 2013), such reports were scant in the burgeoning body of knowledge focused on the effect of PPIs. Moreover, the results of the current study were even more surprising when taking into consideration the context within which the study was executed. Literature indicated that adolescents residing in CYCCs may experience low levels of hope and wellbeing, and as such, may benefit from exercises aimed at enhancing these positive attributes. However, the results of the study refuted this expectation. Consequently, it was important to examine existing literature to help identify factors that theoretically may have contributed towards these unanticipated findings. The following section initially qualifies the
baseline levels of hope and wellbeing exhibited by the participants. Thereafter, other factors that may have contributed to the findings of this study are identified and discussed.

6.2.2.1 Baseline Levels

6.2.2.1.1 Hope

Levels of hope were measured using the Children’s Hope Scale (CHS; Snyder et al., 1997). Contrary to the expectation, the mean baseline score obtained from the CHS by adolescents in the experimental group was relatively high ($M = 25.9$, $SD = 5.57$); falling in the top third CHS score range. This score indicated that the adolescents felt hopeful somewhere between “a lot of the time” and “most of the time”, as implied by the mean item score of $M_i = 4.3$.

Only one published study was identified employing the CHS among adolescents residing in a CYCC (McNeal et al., 2006). This study evaluated changes in levels of hope among 155 adolescents (Mean age = 14.5, $SD = 1.5$) who had recently been placed in a residential care facility in the Midwestern United States. The CHS was administered within a week of each adolescent’s arrival and follow-up measures were taken between four and seven months thereafter. McNeal et al. (2006) reported lower mean baseline levels of hope ($M = 22.5$; $M_i = 3.8$) than the current study, these levels significantly improved across the six-month period of residency ($M = 25.5$; $M_i = 4.3$).

In a broader context, the CHS has been administered to referred (Snyder et al., 1997) and non-referred (Gilman et al., 2006; Valle, Heubner, & Suldo, 2004; Valle et al., 2006) American youths with varying levels of physical health (Snyder et al., 1997), and socio-economic status (Gilman et al., 2006; Valle et al., 2004, 2006) as well as youths attending schools in rural districts (Valle et al., 2006). Snyder et al. (1997) and Gilman et al. (2006) reported similar levels of hope for their samples with baseline means ranging between $25.4 < M < 26.4$ and mean item scores ranging between $4.2 < M_i < 4.4$. The mean scores obtained for the rural (Valle et al., 2006) and Southeastern State (Valle et al., 2004) participants were $28.9$ ($M_i = 4.8$) and $28.6$ ($M_i = 4.8$) respectively. Notably, these scores are higher than those reported in the current study, however they still indicate that the youths feel hopeful between “a lot of the time” and “most of the time”.

88
The CHS has also been administered across cultures with English-speaking Mexican American adolescents (Edwards et al., 2007) experiencing similar levels of hope to the adolescents reported on in the above-mentioned studies ($M = 26.1; M_i = 4.4$), while Portuguese youths (Marques et al., 2007, 2011) revealed slightly lower levels of hope ($M = 24.1, 22.4; M_i = 4.0, 3.7$). Within the South African context, two large samples of adolescents from various socio-economic and ethnic backgrounds experienced similar levels of hope ($M = 25.04, 25.14; M_i = 4.2, 4.2$) to the participants of the current study (Guse & Vermaak, 2011).

In conclusion, based on the literature reviewed and the studies reported on diverse samples and various cultures, it appears evident that youths among different populations experience similar and generally high levels of hope. Moreover, the adolescents participating in the current study exhibited higher levels of hope than expected, considering the suboptimal environment from which they originate. Furthermore, these results are surprising when compared to the lower levels of hope initially experienced by youths placed in a residential care facility in the Midwestern United States. However, the results are very similar to those expressed by the same Midwestern adolescents six months after their initial placement. Therefore, it could be hypothesised that placement in CYCCs may help increase levels of hope experienced by the vulnerable youths. A hypothesis that appears to be a contradiction to current literature that suggests youths residing in CYCCs may exhibit low levels of hope in general and towards positive outcomes in the future (e.g., Dumain, 2010; Milkman & Wanberg, 2012). Therefore, taking the higher than expected levels of hope of this vulnerable population into consideration, PPIs focusing on identifying and building character strengths in general with the aim of enhancing wellbeing may produce more significant findings than those employing hope-based activities.

6.2.2.1.2 Wellbeing

For the purpose of this study, wellbeing was conceptualised according to Keyes’ model of complete mental health (2002). Accordingly, two instruments were administered to measure the four facets of wellbeing. The MHC-SF was employed to measure positive functioning encompassing emotional, psychological, and social wellbeing, whilst low scores on the RCADS-SV indicated an absence of psychopathology.
The total possible score for the MHC-SF is 70; thus mean baseline scores \((M = 48.4; SD = 12.68)\) obtained by the experimental group indicated moderate levels of positive functioning. This score reflected that adolescents in the experimental group experienced levels of positive functioning somewhere between one and three times a week. These reported levels are slightly higher than those indicated in other South African adolescent samples. For example, multicultural non-referred adolescent samples achieved the following mean scores on the MHC-SF: 42.7 \((SD = 11.62)\) (Guse & Vermaak, 2011), 42.9 \((SD = 5.68)\) (van Schalkwyk & Wissing, 2010), 43.4 \((SD = 11.4)\) (Kruger, 2013), and 45.6 \((SD = 11.3)\) (van Schalkwyk & Wissing, 2013). As such, when compared to scores obtained by general South African adolescent populations, the mean scores measuring positive functioning in vulnerable youths residing in CYCCs were unexpectedly high.

Scores on the RCADS-SV are dependent on gender and age categories; therefore to allow for comparisons across ages and gender, raw scores are converted to \(t\)-scores. The baseline \(t\)-scores were therefore calculated to a mean \(t\)-score of 60.4 \((SD = 12.45)\) for adolescents in the experimental group. According to Ebesutani and his colleagues (2012), \(t\)-scores above 65 enter the borderline clinical threshold and those above 70 enter the clinical threshold. Consequently, the scores obtained by the susceptible youths residing in the CYCC were well below the clinical threshold and indicated an absence of psychopathology; another outcome that was in contradiction to expectations. Interestingly, one week after the intervention these scores decreased \((M = 56.71; SD = 13.36)\) and the downward trend continued at the five-week follow-up \((M = 55.29; SD 11.53)\). Although these differences were not significant, it is noteworthy that the mean scores dropped substantially below the clinical threshold, suggesting the possible benefits of PPIs in decreasing psychological distress.

6.2.2.1.3 Conclusion

All measures administered to the adolescents prior to partaking in the intervention yielded results comparable to and generally better than those of their referred and non-referred peers. These relatively positive baseline scores were unexpected, as research indicated that youths placed in CYCCs frequently had histories of trauma, deprivation, and abuse (Kjelsberg & Nygren, 2004; Rushton & Minnis, 2002; Stanley et al., 2003); placing them at increased risk of experiencing low levels of hope and wellbeing combined with a high incidence of psychopathology. Therefore, that these adolescents should have hopeful views of their lives and experience positive functioning and low levels of mental illness is somewhat surprising.
It could be hypothesised, that in contrast to the bleak reports of neglect and abuse in residential care, these facilities offer caring and supportive environments that serve both as a protective factor and a positive living alternative for young, impressionable, and vulnerable youths (Gilman & Handwerk, 2001). Additionally, the adolescents’ harsh life experiences and the mere fact that they survived such complexities pays tribute to their resilience, an attribute that may also enhance their experience of hope and wellbeing. Another hypothesis for understanding the initial high levels of hope and wellbeing exhibited by the youths residing in the CYCC involves hedonic adaption (see Frederick & Loewenstein, 1999, for a review). This theory suggests that regardless of initial boosts or decrements in happiness resulting from positive or negative life experiences, individuals return to their happiness baseline. As a consequence of hedonic adaption, the adverse life circumstances endured by vulnerable youths dissolve into an unnoticed background, thereby reducing the long-term negative impact of such undesirable and frequently traumatic events on their victims.

Although these hypotheses are plausible, the adolescents who partook in the intervention enjoyed no significant improvements in levels of hope or wellbeing. As such, theoretical factors contributing to these torpid results must be considered. A discussion thereof follows.

6.2.2.2 Ceiling effect

When compared to youths of most general referred and non-referred samples, and particularly when compared to South African non-referred samples, the looked-after adolescents in the experimental group initially exhibited slightly higher levels of hope and wellbeing. Additionally, it was noted that several participants rated their hope, for example, at the maximum level of “all of the time” during the initial assessment. As such, it could be argued that the high baseline levels of hope and wellbeing allowed little scope for improvement on subsequent assessments. Stated differently, the non-significant effects of the intervention on levels of hope and wellbeing among adolescents residing in CYCCs could be attributed to ceiling effects of these constructs (Goodwin, 2010).

6.2.2.3 Methodological Moderators

Although mounting evidence suggests the efficacy of PPIs, recent research has highlighted the importance of various moderating factors in the outcomes of these interventions (Lyubomirsky, Dickerhoof, Boehm, & Sheldon, 2011; Lyubomirsky & Layous, 2013, Nelson
& Lyubomirsky, 2012; Seear & Vella-Brodrick, 2012; Sheldon & Lyubomirsky, 2007; Sin & Lyubomirsky, 2009). The contribution of these moderating factors to the non-significant findings reported will now be explored.

6.2.2.3.1 Measuring Instruments

Although due diligence was given regarding the selection of instruments employed to measure wellbeing, research has indicated that nations and cultures may well differ in orientations of happiness and that a single measure may have underestimated the complexities of positive functioning in this sample (Park et al., 2009). Admittedly, the MHC-SF incorporates both hedonic and eudaimonic wellbeing, and more specifically encompasses items measuring emotional, social, and psychological wellbeing; however it might be that not enough emphasis was placed on the more transient and malleable facets of wellbeing. In other words, it may be that the complex construct of wellbeing as measured by the MHC-SF, which incorporates elements of meaning and engagement in life in addition to three items measuring affect, is less susceptible to changes over a shorter period of time compared to the transient elements of mood and emotions (Seear & Vella-Brodrick, 2012). In addition, given that nations differ with respect to orientations of happiness and that Park and her colleagues (2009) reported that South Africans scored the highest out of 27 nations on an orientation towards pleasure, it may have been that the scale employed did not fully tap into the more ephemeral, malleable, and affect based facets of wellbeing, arguably pertinent in this particular sample (Park, Peterson, & Ruch, 2009). Potentially, additional scales of wellbeing assessing positive and negative affect may have produced more substantial changes among the impressionable adolescents.

6.2.2.3.2 Duration of the Intervention

Another methodological moderator that deserves mention is that of the duration of the intervention. In their meta-analysis of 74 interventions, Sin and Lyubomirsky (2009) reported that interventions of longer durations produced larger gains in wellbeing. The current six-week intervention fell within the second shortest of four temporal categories described in the meta-analysis; the intervention categories ranged from four weeks (or shorter) to longer than 12 weeks. Research suggested that longer interventions supported skill improvement through increased practice of the assigned tasks and also provided opportunity for the rehearsed positive activities to develop into habitual practices (Lyubomirsky et al., 2009; Seligman et
al., 2005; Sheldon & Lyubomirsky, 2006). Therefore, it is possible that a longer intervention may have yielded greater increases in wellbeing. In addition to these methodological moderators, research has repeatedly indicated individuals’ behaviours, circumstances, and characteristics also may contribute to the efficacy of interventions. These factors concerning participants are considered in the following section.

6.2.2.4 Participatory Moderators

6.2.2.4.1 Self-Selection, Motivation, and Effort

Interventions conducted with individuals who self-selected participation in exercises with the publicised aim of enhancing wellbeing (e.g., Fordyce, 1977; Seligman et al., 2005) proved more effective than those interventions where members were unaware of the true purpose of the study (e.g., Lyubomirsky et al., 2005; Sheldon & Lyubomirsky, 2006; Sheldon et al., 2013)(Lyubomirsky, 2011; Sin & Lyubomirsky, 2009). In the second category of interventions, participants were recruited to complete exercises without being informed that changes in wellbeing and happiness were the major focus of the studies. As such, individuals were neither aware of the expected outcomes nor had they chosen to partake in the interventions driven by the desire to increase their levels of happiness. Consequently, they were not intrinsically motivated to fully embrace and complete the exercises with expectations of enhancing wellbeing.

According to Lyubomirsky and her colleagues (Lyubomirsky et al., 2011; Sin, Della Porta, & Lyubomirsky, 2011; Sin & Lyubomirsky, 2009), studies that recruited their participants as opposed to self-selection studies yielded weaker and less robust effects. Therefore, these scholars suggested that self-selection driven by the conscious knowledge of the purpose of the intervention and the motivation to achieve this purpose and thereby enhance levels of wellbeing might moderate the effectiveness of PPIs. In other words, the desire to enhance levels of wellbeing and happiness motivates individuals to partake in positive interventions and to execute activities with the intention of increasing positive functioning and emotions. Notably, motivation also allows the effortful practice to persistently continue over time, which is paramount in yielding positive outcomes (Layous et al., 2013a; Lyubomirsky et al., 2011; Seear & Vella-Brodrick, 2012; Seligman, 2005; Sheldon & Lyubomirsky, 2006). Moreover, the mere expectancy of increased positive affect and wellbeing might influence the individuals’ subjective experience and enhance motivating cognitions such as demand
effects, self-fulfilling prophecy effects, or simple positive response biases (Lyubomirsky et al., 2011). Arguably, motivation and increased effort placed on completing the required exercises combined with positive expectations result in stronger and more durable outcomes.

Although participation in the current study was voluntary and adolescents were offered the opportunity to withdraw at any time throughout the intervention, they did not personally pursue the programme nor were they informed that the aim of the intervention was to enhance levels of hope and wellbeing. As such, this study falls within the second category of interventions mentioned above. It could therefore be hypothesised that the participants may have experienced a lack of motivation and made little effort when completing the tasks within the sessions. Furthermore, away from the sessions and the influence of the researcher it is possible that motivation and effort levels were further reduced, resulting in lowered performance on homework tasks. Minimal effort and motivation in executing tasks combined with the possibility that the youths neither took the exercises seriously nor believed that they served a purpose may have contributed to the non-significant effects of the intervention. The prospect that the adolescents did not complete their homework with effortful motivation (if at all) is discussed in more detail in the limitations of the study. The level of support felt by adolescents can also influence motivation and commitment to task engagement and completion; the following section investigates the effect of social support or the lack thereof on task performance.

6.2.2.4.2 Social Support

Researchers have suggested that engaging in positive activities yields better results when those performing positive tasks receive social support and encouragement (Layous, Sheldon, & Lyubomirsky, 2014; Lyubomirsky et al., 2011, Sin et al., 2011). Volitional acts, regardless of the purported benefits can be difficult to execute; however, interpersonal support and reassurance can aid individuals to initiate and maintain performance on positively focused activities (Layous et al., 2014). For example, Layous et al. (2012a) found that reading out loud a peer testimonial expressing the benefits experienced by the said peer as a result of partaking in the positive activity (thereby offering participants reassurance regarding the task) bolstered the efficacy of the intervention. Similarly, participants who received virtual social support via text messaging when performing acts of kindness, enjoyed greater increases in positive affect and significant boosts in happiness when compared to their controlled peers (Della Porta, Jacobs Bao, & Lyubomirsky, 2012). Moreover, social support, in and of itself
has been positively correlated with wellbeing in youths (Cattell & Herring 2002, Klineberg et al., 2006). Therefore, enjoying the support of important others while performing intentional positive activities may promote greater and more sustained levels of wellbeing (Layous et al., 2014).

Understanding the role social support plays in initiating and maintaining performance on selected tasks promotes the argument that youths lacking social support may not fully engage in positively charged exercises. Youths residing in CYCCs reported that they had fewer friends, felt less satisfied in relationships, and felt lonelier than their peers (Dinisman et al., 2012). Additionally, looked-after adolescents evaluated their friendships more negatively and experienced fewer good times and more unpleasant incidences with their friends when compared to adolescents in general (Dinisman et al., 2012). Further, children in care experienced less emotional and social support than their family-nurtured counterparts (Allen & Vacca, 2010). As such, it could be reasoned that the youths residing in the CYCC may have experienced lower levels of support, involvement, reassurance, and encouragement from others when performing the tasks required by the PPI. It follows then, that the discouraged adolescents may not have fully committed to the positive activities and consequently did not reap the benefits thereof. Accordingly, it is conceivable that reduced social support experienced by the youths residing in the CYCC may have played a role in the effectiveness of the PPI. Optimal timing and variation of tasks are two other frequently mentioned factors that have also been found to moderate intervention effectiveness. Consideration will now be given to the role they may have played in the current study.

6.2.2.4.3 Timing of and Variation in Exercise

In gratitude and kindness intervention studies, the frequency at which activities were practiced was reported to impact on the effectiveness of the interventions (Emmons & McCullough, 2003; Lyubomirsky et al., 2005). In a gratitude intervention, counting blessings daily for a period of two weeks produced greater benefit than performing the task once a week over a ten-week period (Emmons & McCullough, 2003). However, a second study contradicted these findings and reported that counting blessings once a week was found to be more effective than counting blessings three times a week (Lyubomirsky et al., 2005). Lyubomirsky and her colleagues (2005) reasoned that participants might have found the gratitude activity more rewarding and meaningful when focusing on it only once a week, arguing that participants may have become bored with the thrice-weekly repetitive listing
task and frustrated by trying to generate new aspects to be grateful for. Although conflicting evidence was reported in these studies, the research indicated the importance of timing.

Similarly, participants who performed five acts of kindness within one day enjoyed greater increases in wellbeing than those performing five kind acts throughout the week (Lyubomirsky et al., 2005). Performing multiple acts of kindness may have had a cumulative effect on boosting happiness, as experiencing more positive than negative emotions can give rise to an upward spiral (Fredrickson, 2001). Therefore each act of kindness performed in a single day may have generated positive emotions increasing the ratio of positive to negative emotions, precipitating an upward spiral and culminating in enhanced wellbeing.

Furthermore, varying the details of activities ensures that exercises remain intrinsically enjoyable, a factor that is conducive to experiences of flow and wellbeing (Csikszentmihalyi, 1990). Indeed, scholars reported larger gains in wellbeing for individuals who varied their acts of kindness throughout the ten-week interventions when compared to those who repeatedly committed the same acts of kindness over the same ten-week period (Sheldon & Lyubomirsky, 2012; Sheldon et al., 2013; Tkach, 2005). These studies deduced that keeping activities fresh and meaningful over the intervention period proved pivotal in enhancing wellbeing.

Participants in the current study were asked to perform the ‘counting blessings’ exercise daily during the initial week of the intervention and once weekly for the remaining five weeks (so designed to accommodate the contradictory findings with regard to timing effectiveness in gratitude interventions). Additionally, they were asked to perform five acts of kindness in a single day each week for the final five weeks of the intervention. Participants were also instructed to add variety to both their gratitude and kindness exercises. Although these instructions were given in accordance with empirical evidence, it appeared apparent in the weekly feedback discussions that neither variety nor timing of task performances were maintained, even with repeated encouragement. As such, it could be reasoned that failure to observe task instructions may have allowed participants to perform tasks in a manner contradictory to suggestions based on empirical findings. Therefore, it is possible that non-compliance in the weekly tasks may have contributed to the lack of change in hope and wellbeing among the participants. These moderators pertaining to the homework tasks will be addressed further in the limitations of the study.
Another postulate to consider when addressing the effectiveness of the intervention was whether the selected exercises were suitably matched to the vulnerable youths recruited for this study. Person-activity fit refers to the idea that certain positively focused activities are more suited to certain individuals. For example, the reflective exercise of ‘counting blessings’ may be more beneficial to introverts, whereas extroverts may find the socially connected acts of kindness more rewarding (Nelson & Lyubomirsky, 2012). Likewise, although older people may enjoy greater rewards through reflecting on their pasts by savouring happy times, youths may reap the greatest benefits by visualising their ‘best possible future selves’ (Lyubomirsky & Layous; 2013). Additionally, Parks and her colleagues (2012) indicated that although certain activities may be especially beneficial to depressed individuals, others might prove ineffective or even harmful. Higher levels of person-activity fit have been associated with greater benefits achieved when practicing activities (Nelson & Lyubomirsky, 2012; Schueller, 2011). In fact, participants practicing activities that were matched to their personalities, preferences, and interests experienced enhanced levels of wellbeing when compared to those who practised unmatched tasks (Dickerhoof, 2007; Schueller, 2011).

It is therefore possible that the current study inadvertently employed activities that may not have best suited participants’ personalities, values, strengths, interests, cultural preferences, or circumstances; however, this remains a question for future research. It is worth noting that enhanced knowledge of the sample population could assist in the activity selection process to ensure optimal person-activity fit. In other words, better understanding the idiosyncrasies of the vulnerable population may ensure that a selection of activities is offered that interest and motivate participant engagement. Such person-activity fit may ultimately allow for complete immersion in positively focused tasks providing optimal benefit to participants.

6.2.3 Conclusion

It was anticipated that hope and wellbeing would increase among adolescents residing in a CYCC after partaking in a PPI; however, the vulnerable youths experienced no significant improvements. Their baseline levels of hope and wellbeing were interpreted in the context of existing literature and it was revealed that the susceptible youths initially exhibited relatively high levels of these constructs, limiting the scope for significant improvements in the
bespoke areas. Additionally, although the bulk of empirical and theoretical evidence points towards the successful implementation of positive interventions, more recently research has been published highlighting the importance of various moderators in the outcomes of these interventions. An exploration of these moderators revealed various theoretical explanations for the findings of the study. More specifically, certain methodological and participatory moderators may have played a role in the efficacy of the intervention. Through identifying moderators that may have influenced the outcomes of the PPI, certain limitations of the study were brought to light; these are explicated below.

6.3 Limitations

In the context of the interesting and surprising findings the following limitations are considered as means by which to further the insights gained in the study with a view to developing into the effects of PPIs in respect of hope and wellbeing in adolescent populations. Firstly, the study was conducted among a relatively small group of adolescents from a single care facility within the Gauteng region. The findings cannot be generalised to all adolescents residing in CYCCs in South Africa or even in Gauteng, as the sample is not representative of such.

Secondly, due to logistical limitations, random allocation of participants to the experimental and control groups was not possible. Although all participants were residents of a single CYCC, the facility comprised multiple campuses, of which two were employed for the purpose of this study. As a result, taking logistical concerns into consideration, all experimental participants originated from a single campus, whilst the control group included youths from both campuses. As such, the environmental differences between as well as reasons for placement within the two campuses may have confounded the outcome variables.

Thirdly, in order to recruit a big enough sample to employ statistical techniques, youths aged between 14 and 18 years were included in the study. However, as adolescence is a period of intensive transformation including various cognitive developmental stages, it cannot be assumed that youths of different ages will have attained the same levels of cognitive abilities. Thus, older adolescents may have experienced the positive intervention in an entirely different manner to those, who as yet, had not attained comparable cognitive capacities. Although activities were developed taking the variance of age into consideration, it is possible that both younger adolescents and adolescents attending technical schools may have
battled with the content or execution of certain tasks. Similarly, although all instruments were validated for youths over 12 years of age, some of the adolescents may have had difficulty reading and fully comprehending some of the items listed in the measures. As such, youths’ age and cognitive capacities may have had an impact on the findings.

Levels of concentration and ease of distraction of the participants were taken into consideration when selecting the measuring instruments administered. Consequently, it was not appropriate to administer more than three scales to the adolescents. Although the MHC-SF addresses all three facets of wellbeing, positive and negative affect are only briefly attended to within the scale. Measuring these more transient and malleable facets of wellbeing may have produced more substantial results than the relatively stable facets measured by the MHC-SF. As such, additional measures (e.g., Positive and Negative Affect Schedule for Children (PANAS – C); Laurent et al., 1999) may have revealed significant differences among the youths. However, such measures were not administered, highlighting the fourth limitation of the study.

Finally, youths received verbal coaching as well as printed worksheets detailing instructions (including timing and variation of tasks) for completing homework activities. In performing these activities youths were trusted to complete them as requested. However, it was not within the researcher’s control to ensure that participants accurately followed instructions or completed tasks. Consequently, the possibility that youths did not effortfully complete the tasks with full motivation, whilst heeding instructions regarding timing and variation of activities, must be considered as a limitation of the study. Against the backdrop of contextual literature explicating possible moderators that may have contributed to the statistically non-significant outcomes of the PPI and ascertaining limitations of the study, possible directions for future research have been identified. A discussion of these recommendations follows.

6.4 Recommendations for Future Research

Following the findings of the study, several recommendations for further research are made. Firstly, a larger sample recruited from various residential care facilities distributed over a broader region would provide a greater representation of the looked-after population within South Africa. A larger sample would also offer greater normality in sample and scaled score distributions.
Although no statistically significant differences were found in baseline measures between the experimental and control groups, discrepancies in scores of hope and psychopathology were noted between the groups. Such differences may have been eliminated through random allocation of participants to groups. Thus a second recommendation concerns randomisation.

Thirdly, the research methods employed to assess the intervention could be enhanced. Additional measuring instruments could be included to ascertain changes in the more transient and malleable elements of wellbeing. Further, in order to achieve a deeper understanding of the intervention process and the outcomes thereof, it is recommended that PPIs be evaluated both quantitatively and qualitatively. Collateral information could also be collected from caregivers; this could be achieved through the completion of parent-report measures and interviews.

Considering research indicated that longer interventions are more efficient in producing favourable outcomes, a fourth recommendation addresses the duration of the PPI. Perhaps introducing the intervention as part of the weekly routine within residential care facilities may allow for semester long practices.

Finally, in order to address the self-selection process and thereby enhance motivation and dedication to the practice, it is recommended that youths be informed of the possible intrinsic rewards of partaking in the intervention. In addition, it may be of benefit to offer participants alternative positive activities thus giving them the opportunity to select tasks most suited to their interests, values, and circumstances; as a result affording them the greatest prospect of enhanced motivation. In relation to motivation and effort exerted in performing homework exercises, it is recommended that assignment worksheets be reviewed in sessions to encourage completion of tasks in accordance with activity instructions as well as to encourage peer support for positive practices.

6.5 Concluding remarks

The statistically non-significant outcomes of the study may not be a true reflection of the possible benefits of PPIs in the context of vulnerable adolescents residing in CYCCs. Although from a qualitative perspective improvements in communication, confidence, self-esteem, positive affect, and future-focused optimism were displayed by the youths; these improvements did not translate into statistically significant results. However, the researcher
feels confident that certain youths may have benefitted from the intervention exercises. A brief discussion detailing observable positive developments within this vulnerable population serves to highlight the importance of qualitative components in future PPI research.

Identifying and building character strengths observably enhanced levels of self-confidence and self-worth in a number of youths, with one vulnerable adolescent privately reporting the impact these exercises had on assertiveness, self-belief, and self-value. Additionally, several adolescents reported that practicing gratitude daily made them more aware of how much they had, as opposed to focusing on what was missing in their lives. Individuals mentioned that this practice, although ‘obvious’, was not within their regular behaviour and one student went so far as to be grateful for the gratitude exercise, whilst another stated gratitude towards the intervention process.

Youths also reflected on the weekly savouring process, expressing gratitude for the immediate experience of indulgence as well as for their newfound capacity of identifying novel ways of appreciating regular experiences. After savouring a piece of chocolate, for example, one youth mentioned that chocolate had never tasted as good. The adolescents generally eagerly anticipated the weekly savouring exercise, and it was extremely satisfying to observe one specific group savour the visual experience of bubbles. Whereafter, the group commented on the visual effects of light reflecting in the bubbles, their emotive reactions to the bubbles, and memories brought forward by savouring the bubbles.

The loving-kindness meditation was another aspect that was favourably mentioned; consensus was that it brought calm into their otherwise hectic lives. A few adolescents remarked that it brought them a sense of connectedness, warmth, and the prospect of offering help to others in situations where they were otherwise helpless. Again it was interesting for the researcher to observe the differences between groups with regard to the meditation practice. Although one group member would inevitably request the meditation when nearing the end of the session, some of the groups particularly immersed themselves in the meditation, opting to lie or sit on the floor for a more peaceful and complete experience, displaying full engagement in the process.

Although the ‘acts of kindness’ and ‘best possible future self’ exercises were well received on the whole, both activities are worth mentioning for the notably negative response
generated in a few individuals. Firstly, three members of one experimental group mentioned that they particularly did not like performing acts of kindness as they found that people either ridiculed them for their kind efforts or took advantage of their kindness. On the other hand, however, members of one control group expressed their pleasure in performing these acts of kindness, as the intrinsic reward received for practicing kindness far outweighed the effort they put into the practice. Moreover, it was specifically mentioned that performing kind acts brought joy and happy feelings to the benefactor. Secondly, during the ‘best possible future self’ exercise, one individual expressed reluctance to generate such an image, choosing not to look optimistically to the future so as to avoid the inevitable sadness of disappointment. According to the youth, this behaviour had been developed as a consequence of the individuals’ life lessons of bad experiences. Similarly however, this negative response was contrasted with a number of youths expressing vivid and sensual visualisations of seemingly achievable and desirable ‘best possible future self’ images, once again exhibiting complete immersion and belief in the activity and in themselves. Notably, these benefits and drawbacks of specific exercises within the intervention programme were not identified through quantitative methods employed in this study.

Finally, it was very encouraging that a particularly troubled youth from the experimental group voluntarily attended the control group sessions. Additionally, another adolescent who was not involved in the study asked to attend the sessions as a consequence of being interested in the process that had been discussed among adolescents within the CYCC. And yet another individual who had chosen not to partake in the study requested permission to attend the control group sessions as he felt he might benefit from the experience.

In conclusion, although the quantitative results of the study were not statistically significant, the process of the intervention and the researcher’s involvement in this vulnerable adolescent population was extremely rewarding and from a qualitative perspective positive growth within the majority of the participants was observed. Notably, the subtleties in positive behavioural and attitudinal changes noted by the researcher as well as information regarding the benefits and drawbacks of specific activities implemented were not assessed through the quantitative study; a qualitative component in future research may uncover such detail. The researcher feels that benefits are to be gained by PPIs within this setting and that future research in this field will be advantageous to vulnerable youths residing in CYCCs. Importantly, the qualitative experience, although not incorporated in the study, highlights an
above-mentioned limitation and reiterates the importance of a qualitative component as a recommendation for future research.

6.6 Conclusion

This study endeavoured to implement and evaluate the effect of a PPI among vulnerable adolescents residing in a CYCC. Contrary to expectations based on theoretical evidence, baseline scores achieved by the participants on measures of hope and wellbeing compared favourably to their referred and non-referred South African peers; indicating moderately high levels of hope and wellbeing among the susceptible youths. Surprisingly, scores accrued one week and five weeks after the intervention suggested no statistically significant changes in hope or wellbeing, although measures of psychopathology exhibited a downward trend.

Although the literature reviewed primarily reiterated the efficacy of PPIs in general and particularly in adolescent populations, more recent research sought to understand the role played by various moderating factors in the outcomes of positively focused interventions. Relevant methodological and participatory factors were considered for the possible role they played in contributing to the statistically non-significant findings of the current study. The exploration of moderating factors on the effect of PPIs also brought attention to further research possibilities and recommendations for future studies.

Finally, although this study produced findings that were not statistically significant within a positivistic lens, it is the researcher’s opinion that the statistical results underestimated the changes experienced by the youths who participated in the study. As such, it is felt that the vulnerable youths residing in the CYCC enjoyed gains in positive functioning and mental health. Moreover, it is the researcher’s belief that residents of care facilities in general will benefit from further studies in this field and specifically through the implementation of PPIs. Thus, further (mixed methods) research on positively focused interventions implemented in CYCCs is recommended in the hope of improving wellbeing among susceptible youths and providing them with tools that might assist in everyday functioning and serve to protect them against stressful life circumstances. Additionally, such interventions may not only provide vulnerable youths the opportunity to enhance their own wellbeing, but in doing so their positive mental habits and behaviours might influence those around them and consequently contribute to the community as a whole.
References


doi:10.1016/j.schres.2011.02.015


Proctor & P. A. Linley (Eds.), *Research, applications, and interventions for children and adolescents: A positive psychology perspective* (pp. 81-115). New York, NY: Springer.


Appendix

Declaration Regarding Plagiarism

• I understand what is meant by “plagiarism”. Plagiarism is using another’s work and pretending that it is one’s own. Not referencing one’s sources or not citing them accurately also constitutes plagiarism. I understand that plagiarism is wrong, and is contrary to the university’s regulations regarding intellectual property as stipulated in the general regulations manual.

• I have accurately cited all contributing authors and sources that have shaped my work.

• This assignment or proposal is my own work and does not appear anywhere else in previously published media (including internet based sources).

• I have not allowed anyone to copy my work with the intention of committing plagiarism.

Student Name: ________________________________________

Student Number: ________________________________________

Signature: ____________________________________________