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With a foreword by
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Practicing Positive Psychiatry

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Contents

Foreword

The current times present unprecedented challenges to individual and societal well-being. We are experiencing behavioral pandemics of suicides, opioid abuse, and loneliness on a scale that was never seen in human history, and they are severely and adversely impacting human well-being, health, and even longevity (Jeste, Lee, & Cacioppo, 2020). The rapidly increasing pace and demands of life, the competitive environment faced from early age, and the ever-changing nature of technology leave little time for meaningful pursuits but ample opportunities for failure. The breakdown of family and community structure not only damages the safety net, but it also denies access to conventional wisdom. Fueled additionally by obesity and sedentary lifestyle, the mental health pandemics are manifestations of these stressors. Loneliness, once experienced only by the abandoned old and possibly by young immigrants, is now an everyday reality for large swaths of the society (Lee et al., 2019). The COVID-19 pandemic has made the already dire situation worse.

At the same time, there are silver linings on the horizon. There is growing scientific literature on wisdom, a positive personality trait associated with well-being and health. A number of randomized controlled trials are being conducted to enhance components of wisdom like compassion, emotional regulation, and spirituality, as well as resilience and overall wisdom (Lee et al., 2020, Treichler et al., 2020). This is positive psychiatry. The origin of psychiatry is rooted in medicine's goal of alleviating mental illnesses, the diseases being its original and natural focus. Over recent decades, however, psychiatry, hand-in-hand with psychology, has undergone several changes in its perspective, shaped by behaviorism, existentialist and humanistic psychology, and, of course, biology which is at the core of medicine. Martin Seligman, following his earlier work on learned helplessness and pessimism developed an interest in quite the opposite: strength and optimism, the positive side of psychology. It was one of those ideas that aged well, it grew upon innate validity. The principles of positive psychology can be witnessed in action elsewhere – it propels the markets for self-help literature and motivational talks. Yet, it has taken centuries for organized medicine and psychiatry to accept the notions

of positive personality traits as targets of intervention, and well-being and happiness as outcomes. The first papers with positive psychiatry in their title were published in 2013 and 2015 (Jeste, 2013; Jeste & Palmer, 2013) and the first book on that topic in 2015 (Jeste & Palmer, 2015). Since then, the positive psychiatry movement has been spreading internationally (Machado & Matsumoto 2020; Messias, Peseschkian, & Cagande, 2020).

It is, therefore, with great enthusiasm that we welcome *Practicing Positive Psychiatry* by Fredrike P. Bannink and Frenk P.M.L. Peeters This book is a slightly modified English translation of the first book on positive psychiatry in Dutch published earlier this year. The authors aim at shifting the focus of psychiatry from reducing distress and surviving to successful living and flourishing. They combine the medical model in psychiatry with the synthesis paradigm or functional approach. We were struck by a beautiful sentence in the Introduction: "With this book, we invite you to apply positive psychiatry to not only repair the worst, but also to create the best in your patients, your colleagues, and yourself." The intent to go beyond treating diseases and disabilities and expanding the mission to bringing out the best not only in the patients but also in the therapists (and readers from all walks of life) is laudable and noteworthy.

The authors have achieved professional eminence and have authored several other important books in the field. Fredrike Bannink, MDR, is a clinical psychologist and lawyer, whereas Frenk Peeters is a psychiatrist and Professor of Clinical Psychology at the Maastricht University in the Netherlands. They have adopted and adapted the ideas from our and others' work (Jeste, Palmer, Rettew, & Boardman, 2015), shaping them with their valuable firsthand experience.

The book is very well written and the concepts are conveyed very clearly, making it accessible even to lay readers. For those who are interested in research, the book is interspersed with important references to the larger body of work they draw from. The book is structured into five well thought out chapters following the Introduction. The first chapter discusses two paradigm shifts in the field: moving the focus from the disease to the person and adding synthesis to analysis. The second chapter explains the various constructs involved in positive psychiatry. By increasing patients' intrinsic motivation, the proposed solution-focused model enables shorter interventions, greater autonomy for patients, and less burnout among professionals. The third chapter describes the recovery-oriented approach. The fourth chapter describes various applications. The authors discuss 41 applications, which are summarized at the end of the book. The remarkable fifth chapter titled "Reflection" is a fascinating discourse on professionals' reflection along with feedback from patients, and a presentation of future vision. Finally, there is a chapter with 31 FAQs.

The authors make a strong case that nothing short of a profound paradigm shift is warranted to successfully practice positive psychiatry. A focus on the patient must also be accompanied by a synthesis that involves patient participation. The book starts out by laying a strong groundwork explaining the envisioned paradigm shift to the intended audience of practitioners who seek better outcomes for their patients. The book is replete with stories, applications, and case studies, written in easily understandable language. The provided applications have considerable utility for the practitioner. These are templates for practioner–patient dialog. They include specific questions, often open-ended and always nudging toward the desired synthesis. The "Taxi Driver" application is foundational, highlighting the fact that where you are headed is relevant, not where you are coming from. Stories provide a meta commentary illustrating key ideas, often borrowing from a wider context, sometimes examples from very different fields, our favorite being "Lessons From the Bamboo". The case studies are in third person and intended to provide a perspective, connecting applications with patients, while taking care that the patient is never objectified and a disease is not the long-term focus, fitting with the overall paradigm of positive psychiatry.

While the paradigm and procedures are described in earlier chapters, the true spirit of positive psychiatry is captured by the chapter titled "Recovery-Oriented Approach". The possibility of recovery is first introduced to the practitioner while making her or him aware that it goes well beyond symptom relief and must include leading a meaningful life. This foundational paradigm shift is captured by a key sentence and highly resonates with our philosophy: *"One important recovery-oriented practice involves structuring the ethos and culture of mental health services around the premise that persons who experience mental illness can indeed recover."*

The final chapter includes FAQs, an essential companion to the applications provided throughout the book. The FAQs handle exceptions to scripted applications and often link back to the subject matter. What we particularly appreciated in this chapter is the emphasis on pragmatics rather than on high philosophy. For example, regarding a question on the role of diagnostics in positive psychiatry, the authors write that "The role of diagnostics is important, but diagnostics should not only be about problems, symptoms, disorders, and what is wrong in the patient's life, but also about their strengths, resources, and what is going well." We also applaud the authors' list of "What if" questions from the perspective of patients as well as treating clinicians. One rarely encounters a book with such varied scenarios accompanied by appropriate "how to" responses. This reflects on the authors' decades of thoughtful clinical experience and expertise.

We have long held the view that psychiatry is defined by the skill set possessed by mental healthcare providers (Jeste et al., 2015). These skills are shaped by expectations of outcomes held by psychiatrists and other practitioners. Pessimism on outcomes by a practitioner will certainly limit what can be achieved for the patients. The efficacy of psychosocial factors in enhancing patient well-being, including alleviation of today's greatest challenges such as obesity and hypertension, to promote health and longevity is well acknowledged (Diener & Chan, 2011; Schutte, Palanisamy, & McFarlane, 2016; Wiley, Bei, Bower, & Stanton, 2017). By shifting the focus away from disease and by inviting the patient to envision a desirable future, we can set up a gradual but positive trajectory for the outcomes reinforced by focusing on health and biology and refined over the course of the treatment. This promotion of positive psychosocial factors like resilience, optimism, social-engagement, and wisdom is the essential skill defining positive psychiatry.

This is indeed a timely book, and we are delighted and honored to write this Foreword. We congratulate the authors on having done an outstanding job in packaging a subject matter that we share as the core of psychiatry practice and research. It is our belief that positive psychiatry and a focus on wellness can produce lasting results, augmented by psychopharmacology and various other treatments. We also hope that this approach replaces less effective and limiting approaches. Since the days of William James, an educator and the father of American psychology, not only has psychiatry come a long way, but at many points, reset the direction of the field. This book defines a critical time point in the evolution of psychiatry.

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Introduction

From what's wrong to what's strong

Applying positive psychiatry in our daily practice – in times where we see standardized treatments and confection instead of customization – requires two paradigm changes as well as a culture change, and we are convinced it will undoubtedly enhance the quality and effectiveness of our treatments. With this book, we invite you to apply positive psychiatry to not only repair the worst, but also to create the best in your patients, your colleagues, and yourself. In doing so, we have high hopes that positive psychiatry may become a firm element of the psychiatry of the future.

Paradigm Changes

Until recently (mental) healthcare concentrated on reducing (psycho)pathology. Treatment providers focused primarily on treating diseases and were not, or virtually not, knowledgeable about promoting well-being. They were not used to looking beyond the imperfections of life. Fortunately, today we see two paradigms changes.

The *first paradigm change* places people at the center stage, instead of the disease. Mental healthcare should no longer be the place where only problems and disorders are discussed and treated, but also be the place where the focus is on what works in the lives of our patients, where their competences and resilience are discovered and developed, where positive emotions are strengthened, and where hope, gratitude, and optimism are nourished.

> If we want to flourish and if we want to have well-being, we must indeed minimize our misery; but in addition, we must have positive emotion, meaning, accomplishment and positive relationships. The skills and exercises that build these are entirely different from the skills that minimize our suffering. Seligman, cofounder of the positive psychology movement (2011, p. 53).

Today, competence-based work is integral in (mental) healthcare. It is a methodology that seeks to match the existing competences of patients, focusing on the discovery and expansion of their skills. *Competence* means patients have sufficient skills to be able to perform their daily tasks in an adequate manner. Basic principles of the competence model are to:

- connect with the strengths of patients and encourage them in the realization of their goals;
- listen to their needs, wishes, limitations, and norms – and take these seriously; and
- focus on creating new opportunities.

The *second paradigm change* is the addition of the synthesis paradigm to the analysis paradigm. In the philosophy of science, we can discern two ways of understanding the world and our lives: the analysis paradigm and the synthesis paradigm.

The reductionistic medical model (the analysis paradigm) can be complemented with the functional solution-focused approach (the synthesis paradigm),which involves designing an outcome that was not there before. This outcome is about our patients' new and better life. You can compare working from the medical model to the work of an archaeologist and working from the solution-focused approach to the work of an architect.

Symptom reduction does not work well when the complexity of a system increases, as is the case in a number of mental health issues; well-being is the result of a very large number of factors with interdependent interactions, which cannot be achieved purely by analyzing the individual parts.

In sum: A system is a whole that cannot be understood by analysis only. We also need the synthesis paradigm to be able to use the best of both worlds. We describe both paradigm changes in more detail in Chapter 1.

For Whom Is This Book Written?

Increasingly more psychiatrists and other practitioners working with psychiatric patients and the patients themselves are discovering the possibilities of employing a (more) positive focus. This focus is shaped by positive psychology, with an emphasis on patients' strengths; by the solution-focused approach, with an emphasis on their preferred futures and what works in their lives; and by the recovery-oriented approach, aimed at maximizing (remaining) possibilities.

This is the first book in which the analysis paradigm (the medical model) in psychiatry is supplemented by the synthesis paradigm (the solution-focused approach). It is also the first book where we address not only the *what*, but also the *how* of positive psychiatry, which led us to title this book *Practicing Positive Psychiatry*.

It is intended for all practitioners who are dissatisfied with the one-sided focus on psychopathology and would like to focus (more) on competences, possibilities, and what works in the lives of their patients. It is also aimed at all practitioners who wish to expand their repertoire of therapeutic techniques and wish to collaborate optimally with their patients. They will discover an approach that can significantly increase patient motivation and cocreate preferred outcomes as well as finding pathways to achieve this.

In addition to a description of positive mental healthcare and positive psychiatry, this book describes 41 applications; a list of the applications is included at the end of the book. Chapter 6 includes 31 frequently asked questions. We do not pretend to have all the right answers, but we hope you will find them useful. The 22 stories and 21 cases illustrate how positive psychiatry can be employed and how the use of a positive focus may make our work better, faster, lighter, and, yes, more fun. Not only for our patients, but also for ourselves.

Psychiatrist: After focusing nearly 20 years on everything that is wrong in the lives of my patients and in the organization, this approach feels like a breath of fresh air.

We think our field is ready to embrace positive psychiatry. Are you as well?

Fredrike Bannink, clinical psychologist and lawyer
Frenk Peeters, psychiatrist and psychotherapist

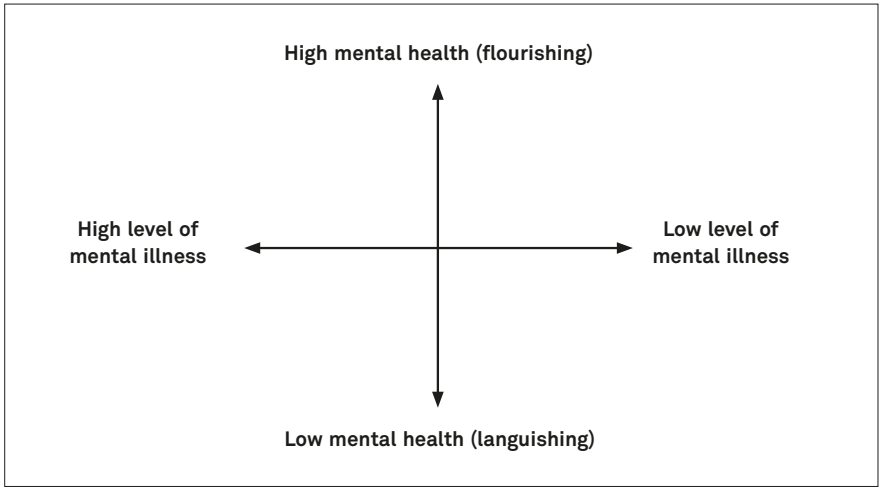

Figure 1.1 Two-continua model of mental health (Keyes, 2005).

Positive Mental Health

We would like to propose a form of *integral psychiatry*, whereby the use of a negative, problem-focused perspective is embedded in a positive strength-focused perspective, with an overall focus on well-being. Use of the patients' and their environment sources of strength must be applied to maximum effect, and their well-being should be the focus in diagnostics as well as in treatment. Another important point is that, whenever and wherever possible, patients should be provided assistance *within* society: An isolated life in a protective environment should be avoided.

The approach of positive health by Bannink and Jansen (2017), applied in the general practitioners' field, incorporates both the medical model and the solution-focused approach. The solution-focused approach is about designing the patients' preferred outcome and finding the road to achieving this goal. It is about building solutions instead of solving problems. The solution-focused approach concentrates not only on competences, but on everything that works in a patient's life, and thus has a broader focus than positive psychology has. The approach contains its numerous solution-focused questions and its language (*solution talk* instead of *problem talk*; see Chapter 2), whereas positive psychology and the recovery-oriented approach (still) lack these.

In the concept of positive health, Huber and colleagues suggest that the person takes center stage, not the disease. O'Hanlon and Rowan, both solu-

might be created. We need to design outcomes. I do not like saying design 'solutions' because this implies that there is a problem. Even when we cannot find a cause, or, after finding it, cannot remove it, we can always attempt to design an outcome.

Starting with the end in mind is also reflected in the arts and in music. Sculptor Michelangelo visualized and composer Mozart heard the final version of their masterpiece and then worked backward. This additional value is exactly what we, in our profession, should strive for (see Case 1.2).

> **Story 3. Michelangelo and Mozart**
>
> Michelangelo saw in a discarded block of marble the magnificence of David, and Mozart heard in the quiet of his studio the overpowering strains of the Requiem.
> Patients seek advice to cope with the future. Whether an advisor is a doctor or a lawyer, a financial consultant or a psychotherapist, his or her mission is to help the client make a better future (Salacuse, 2000, p. 43).

The two major solution-focused assumptions are:
1. If it works (better), do more of it.
2. If it does not work, stop and do something else.

This sounds very simple. But then, simple is not the same as easy. It takes a lot of practice to be able to maintain a positive focus. The solution-focused approach is easy to learn but hard to carry out. Not because it is complicated or difficult, but because it requires a disciplined mind-set and skill to remain simple.

We saw earlier that it is not always necessary to know the cause or the perpetuating factors of a problem in order to help our patients realize a new and better life. Rapid change or solution of the problem is possible. The solution-focused approach leads to three therapeutic principles:
1. Focus on solutions and possibilities instead of on pathology.
2. Invite the patient to take action.
3. Search for small positive changes and amplify them.

Case 1.2. From the Future Back

An English psychiatrist, MacAdam, once told this story. "A young girl I was working with had experienced abuse. She walked into my office... a very large girl with shaved hair, tattoos on her head and I don't think she'd showered in a week. I'd been asked to see her because she was so angry. She clearly didn't want to come and see a shrink. She'd been to a bunch of therapists before, social workers, psychologists, and school counselors. I just said, 'You've talked to everybody about your past; let's talk about your dreams for the future.' And her whole face just lit up when she said her dream was to become a princess.

In my mind, I couldn't think of two more opposite visions, but I took it very seriously. I asked her about what the concept of princess meant to her. She started talking about being a people's princess who would do things for others, who would be caring and generous and a beautiful ambassador. And she described the princess as slender and well dressed. Over the next few months, we started talking about what this princess would be doing. I discovered that while this girl was 14, she hadn't been attending school for 2–3 years. She'd refused to go.

The princess she described was a social worker. So I said, 'Okay, it's now 10 years' time and you've trained as a social worker. What university did you go to?' She mentioned one to the North of England and I asked, 'What books did you read... what did you study there?' She said, 'I don't know, psychology and sociology and a few other things like that.' Then I said, 'Remember when you were 14? You've been out of school for two or three years. Remember how you got back in school?'

She said, 'I had this psychiatrist who helped me.' And then I asked the important question: 'How did she help you?' And she started talking about how she made a phone call to the school and I followed up: 'Who spoke? Did you or she?' She replied, 'The psychiatrist spoke, but she arranged a meeting for us to go to the school.' 'Do you remember how you shook hands with that teacher when you went in? And how you looked and what you wore?' We went into these minute details about what that particular meeting was like, looking from the future back. She was able to describe the conversations they'd had, how confident she had been, and how well she had spoken.

About a month after this conversation, she said to me, 'I think it's about time we went to school, don't you? Can you ring and make an appointment?' I asked her if she needed to talk about it anymore and she said, 'No.' She knew how to behave. When we went to the school, she was just brilliant.

I first met that girl about 10 years ago. Now she's a qualified social worker. She fulfilled her dream, even though she attended a university different from the one she envisioned." (Bannink, 2012)

Problem Talk or Solution Talk

What we pay attention to grows. Solution-focused practitioners use principles from *learning theory*. *Operant conditioning* is about positive and negative reinforcement and positive and negative punishment to change behavior. Use is made of positive reinforcement of *solution talk* (as much attention as possible is given to conversations about the goal [the preferred future], exceptions to problems, possibilities, strengths, competences, possibilities, and resources) and the negative punishment of *problem talk* (as little attention as possible is given to conversations about problems, causes, limitations, impossibilities, and deficits). This does not mean patients are not allowed to talk about problems or that solution-focused practitioners are problem-phobic. They listen respectfully to the patient's story, but do not ask for any details of the problems. As a result, they do not reinforce their patients' problem talk (see Table 2.2).

Table 2.2 Differences between problem talk and solution talk

Problem talk	Solution talk
Conversations about problems, what patients do not want, what they want to get rid of, causes, negative emotions, disadvantages, deficits, risks, impossibilities, failures, and the undesired or feared future	Conversations about what patients want to have instead of problems, what patients do want, where they want to go to, exceptions, positive emotions, benefits, strengths, resources, possibilities, successes, and the preferred future

Thus, solution-focused practitioners should be experts not only in asking solution-focused questions, but also in the field of operant conditioning (Bannink, 2012). When patients think they should talk about problems, they make it clear to us that they have a theory of change about what may be helpful. When solution-focused practitioners accept the invitation to have problem conversations, they then look for ways to help them figure out what changes they hope will result from such conversations (in terms of their goal and solutions).

Solution-focused questions to examine the patients' theory of change are:

- How will talking about these problems help you realize the desired changes?
- How will you know we have talked long enough about the problems, so we can start focusing on where you want to go to instead of where you want to get away from?
- What would be the first small signs that will tell you that you can leave the past behind?

Application 4.6. Looking Through a Positive Lens

If patients can find little or no strengths at all, invite them to look at themselves through a more positive lens and answer the following questions:

- Where do you find the courage to change if you want to?
- How can you make it easier for yourself to change?
- How does change usually happen in your life?
- How do you get good ideas? How did you get these good ideas previously?
- How do you keep going in life? How do you keep your head above water?
- When was your last success? What did you do to make it happen?
- Which personal strengths do you have?
- When did you realize you have those strengths?
- When did others realize you have those strengths?
- How could you use those strengths (even) more than you already do?
- How would important others become aware that you use these strengths more often?
- What do you do with ease that others find difficult?
- What was easy for you when you were a child?
- If … (e.g., a deceased person) could see how you are living now, what would they be proud of?
- What would that person say about you if that were possible?
- What would they answer to the question of how you accomplished it?
- What is going well, even if only slightly?
- What are you pleased about in your life and would like to remain as it is?

Resilience

Resilience is one of the constructs of positive psychology. It refers to how people deal with setbacks in order to maintain their well-being. Resilience (Latin: *resilio* means I bounce back) is the ability to survive and persevere when there are obstacles and threats. Bonanno (2004) defines resilience as the human capacity to maintain a relatively stable healthy psychological and physical functioning level in situations where we are exposed to a potentially very disruptive event, such as the death of a person with whom we have an intimate relationship, or a violent or life-threatening situation. The ability to be sexually active and to experience positive emotions also remains intact. This is different from the traditional road to recovery, with its focus on symptom reduction, which usually takes at least a few months before returning to the baseline level the patient had before the traumatic experience.

Application 4.21. Fifty Positive Things

Do you remember the Paul Simon song Fifty Ways to Leave Your Lover? In this application, invite patients to make a list of 5 × 10 = 50 positive things to promote their well-being. It is nice to talk about these 50 things with their partner, children, or friends, and also to ask others for their 50 positive things:

1. Name 10 personal strengths
2. Name 10 successes in your life
3. Name 10 ways in which you are kind to others
4. Name 10 strokes of luck in your life
5. Name 10 ways in which others support you

Application 4.22. In 10 Years' Time

Invite patients to write down how they will be doing in ten years' time when everything has gone as smoothly as possible in their lives. They are doing well (at work), they are successful and other areas of their lives are also as good as can be.

Once they have described all the details, ask them to read everything again and set a goal or mission to work on daily. Finally, invite them to make a five- or ten-year plan to ensure their mission will succeed.

Story 8. Winnie-the-Pooh on Success

There are different definitions of success. Often success is equated with money and status. But real success is usually less about results, and more about the process of achieving goals and dreams. Not only do humans find that building success is important, some fictitious animals consider this to be "the most important subject of all."

In "Winnie the Pooh on Success" (Allen & Allen, 1997, p. 17) the Wise Stranger tells the animals how they can become successful. He writes the following acronym on a sheet of paper and shows it to his friends:

Select a Dream
Use your Dreams to set a Goal
Create a Plan
Consider Resources
Enhance Skills and Abilities
Spend Time Wisely
Start!

Feedback by Patients

Asking feedback from patients, inviting them to reflect on the treatment, is an excellent source of information. The Harvard Medical School stated as early as the 1970s that the most unused source of information in healthcare is the opinion of the patients themselves.

The assessment of the effectiveness of a treatment is usually delegated to practitioners, but proof of effectiveness is more accurately provided by the ideas of patients and their experiences as equal partners in treatment. Investigation of their thoughts has several advantages:

- It ensures patients are at the center of the treatment.
- It stimulates cooperation.
- It ensures patients have a positive experience with the practitioner.
- It structures the session and directs the change process.

As we stated earlier, patients should take center stage: their strengths and resources, cooperation, evaluation of the alliance, and ideas about the problem and possible solutions. Treatment interventions will only be useful when patients consider these as relevant and plausible.

- You may ask for patients' feedback using the following questions:
- What feedback would you like to give me about today's session?
- What did you find most useful today?
- What have you achieved with this session?
- What did you hope to achieve, but was not ultimately reached?
- How can we redress that?
- What is the best or most valuable thing you have noticed about yourself today?
- What are you taking away from this session that you can think about or work on in the near future?
- What are you taking away from this session that could help you in the coming week to ...?
- What are you taking away from this session that will ensure you can tell me things are going better at our next session?

The use of feedback is a good compass for registering change. Duncan (2010) calls this *practice-based evidence*: doing what works. According to him, treatment should be a discovery, anchored in feedback to handle uncertainties en route. About registering progress, the APA Presidential Task Force on Evidence-Based Practice (2006, p. 280) states:

Chapter 6
Frequently Asked Questions

The real voyage of discovery consists not in seeing new landscapes, but in having new eyes.

Marcel Proust, French writer

It is said that a wise person does not have the right answers, but asks the right questions. In this chapter we list our answers to 31 frequently asked questions. We do not pretend to have all the right answers. Your additions are welcome via solutions@fredrikebannink.com.

Question 1: *What if my patient cannot find a goal?*

- Sometimes patients have never thought about their preferred future, so give them time to think about it, sleep on it, and/or discuss it with their loved ones.
- Praise them for showing up and talking to you.
- Ask what the patient's best hopes are and what difference it would make if all best hopes were met.
- Ask what they want to be better tomorrow, if the *miracle question* (see Chapter 4) does not provide sufficient information (e.g., in the case of autism).
- Invite the patient to ask others (e.g., family or friends) what they think the patient's goal is.
- Ask for exceptions to the problem, when a glimpse of the preferred future is already present.
- Invite your patient to meet with you again in the future.
- Do not give homework suggestions.

About the Authors

Fredrike Bannink is a clinical psychologist, child psychologist, and lawyer. She is a trainer and supervisor of the Dutch Association for Behavioural and Cognitive Therapy (VGCt) and cofounder and chair of the Positive CBT section. She is also founder and chair of the Special Interest Group Positive CBT of the European Association for Behavioural and Cognitive Therapies (EABCT).

Fredrike has a therapy, training, coaching and mediation practice based in Amsterdam, The Netherlands. She is a pioneer in recognizing and describing the possibilities of working with a positive focus in many different fields, such as (mental) healthcare, education, and law. She is an international keynote speaker, trainer, and author of around 50 books.

Other publications by Fredrike Bannink for Hogrefe are:

- Handbook of Solution-Focused Conflict Management (2010)
- Handbook of Positive Supervision (2015)
- Praxis der Positiven Psychologie (2012)
- Lösungsfokussierte Fragen. Handbuch für die lösungsfokussierte Gesprächsführung (2015)
- Supervision und Intervision (2017)
- A prática da terapia cognitivo-comportamental positiva (2019)
- Positieve psychologie in de praktijk (2009)
- Positieve supervisie en intervisie (2012)

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Frenk Peeters is a psychiatrist and psychotherapist. He is Professor of Clinical Psychology at the Department of Clinical Psychological Science, Faculty of Psychology and Neuroscience, Maastricht University, The Netherlands. Frenk is specifically interested in improving and renewing treatments for mood disorders; his practice utilizes both the problem-focused as well as the solution-focused approach. He has (co)authored more than 150 peer-reviewed papers and book chapters, mostly in the field of mood disorders.

Peer Commentaries

This volume provides psychiatrists and other mental health practitioners with new ways to support recovery and well-being. Numerous stories and case studies illustrate how positive mental health and solution-focused approaches are used in practice, and the book is full of guidance underpinned by scientific evidence. This is a valuable book for anyone working to support people with mental health issues.

Mike Slade, PhD, Professor of Mental Health Recovery and Social Inclusion, University of Nottingham, UK

Fredrike Bannink and Frenk Peeters have created a practical resource where different perspectives putting the promotion of well-being before the reduction of symptoms are brought together. Starting by contextualizing paradigm shifts and formulating basic definitions, it continues with an excellent seminal chapter on positive psychiatry that, gathering previous works done in the last decade, acknowledges and clarifies common critiques to positive paradigms. Then, the founding pillars of positive psychiatry, namely positive psychology, the solution-focus approach, the recovery-oriented approach, and the nonspecific factors in psychotherapy, are presented. One of the most recent approaches that has had a tremendous impact on the involvement of mental health service users and their relatives, the recovery-oriented approach, is further developed by two heavyweights in the field. The book culminates with a chapter on applications and another two that are especially pertinent as well as innovative, on reflection and frequently asked questions.

The entire book is packed with useful clinical vignettes, cases, applications, and stories that help contextualize and apply its contents. It is an excellent tool to get introduced to this field in a practical way but without forgetting its theoretical foundations.

Francisco José Eiroa-Orosa, PhD, Ramón y Cajal researcher and Professor, Department of Personality, Evaluation and Psychological Treatment, University of Barcelona, Spain