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ARTICLE

The application of positive psychological interventions in the context of trauma: A scoping review

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Abstract: The experience of trauma seems to have become endemic, highlighting the need for interventions to reduce the adverse psychological effects of trauma and promote positive mental health. Positive psychological interventions (PPIs) may address this need and have gained increased research attention in diverse settings and among diverse populations. The objective of this scoping review was to provide an overview of available research on the application of PPIs in the context of trauma. The review considered studies that focused on implementing a PPI and involved participants who were exposed to trauma. Studies were identified through bibliographic databases and a manual search of relevant reference lists. Following screening of titles, abstracts and full text, 30 records were included in the study. Results indicated that PPIs have been implemented with people who experienced trauma-related distress following different forms of trauma. Most interventions focused on enhancing positive emotions, thoughts, experiences, relationships and resources; developing character strengths; or fostering mindfulness, and incorporated various positive psychological activities and techniques. Interventions were mostly conducted in group format, by a mental health practitioner at out-patient centres or clinics, over the course of four to eight sessions. Findings suggested that PPIs may be useful in decreasing trauma-related psychopathology and promoting wellbeing in the aftermath of trauma. However, more research is needed to confirm the efficacy, acceptability and feasibility of these interventions among people who have experienced trauma.

Keywords: intervention, positive psychology, PTSD, scoping review, trauma

1. Introduction

The experience of trauma seems to have become endemic with 70% of the general population being exposed to a traumatic event at some point in their lifetime and more than one third exposed to four or more traumatic events (Benjet et al., 2016). Exposure to trauma can produce a wide spectrum of adverse psychological responses, ranging from mild and temporary disequilibrium to severe and chronic distress (American Psychiatric Association [APA], 2022). According to Benjet et al. (2016), over 8% of those exposed to trauma will subsequently develop posttraumatic stress disorder (PTSD), a complex and debilitating psychological disorder. PTSD is characterized by intrusions (e.g. distressing memories or flashbacks), avoidance of trauma reminders (e.g. objects associated with the traumatic event), negative alterations in cognition and mood (e.g. negative view of the self, others, or the world) and changes in arousal and reactivity (e.g. hypervigilance). However, clinical presentation varies and some individuals may also experience dissociative symptoms (e.g. depersonalization or derealization) (APA, 2022).

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Individuals with PTSD are more likely than those without PTSD to have a comorbid mental disorder such as depression, anxiety, or substance use (APA, 2022; Hogg et al., 2023). Trauma is further associated with increased suicidal ideation and attempted suicide (Akbar et al., 2023) as well as lower wellbeing and overall satisfaction with life (Volgenau et al., 2023).

Consequently, enormous effort has been invested over the past few decades to develop intervention strategies to reduce the adverse psychological effects of trauma. Despite the demonstrated effectiveness of psychological treatments, including exposure therapy, cognitive behavioral therapy, eye movement desensitization and reprocessing, many treatment-seeking individuals still experience residual symptoms after treatment completion (Cusack et al., 2016; Paintain & Cassidy, 2018). Traditional trauma interventions have also been criticized for primarily focusing on pathology, disregarding the client's natural resiliency, being time-consuming and having high drop-out rates (Cusack et al., 2016; Paintain & Cassidy, 2018). However, positive psychological interventions (PPIs) may address these shortcomings.

Positive psychology shifted the traditional focus of psychology from investigating pathology and treating mental disorders to also studying human strengths and promoting mental health, positive functioning, and wellbeing among individuals, groups, and institutions (Seligman & Csikszentmihalyi, 2000; Sheldon & King, 2001). Over the past few decades, research on positive psychology has shown rapid growth and its application has expanded across various disciplines (Rusk & Waters, 2013). This is supported by literature recognising that wellbeing and psychopathology are two related, yet independent dimensions and that the absence or amelioration of symptoms of mental disorders does not necessarily contribute to positive mental health (Keyes, 2002, 2005; Keyes & Lopez, 2002). As such, the development and evaluation of interventions aimed at enhancing wellbeing has been central to the study of positive psychology (Hendriks et al., 2020).

1.1 Positive psychological interventions (PPIs)

Sin and Lyubomirsky (2009) first described positive psychology interventions as any intervention with the primary aim of increasing positive feelings, positive behaviors, or positive cognitions through pathways that are consistent with positive psychology theory. For example, pathways associated with Seligman's (2011) PERMA theory of wellbeing include promoting savoring of pleasurable experiences, fostering engagement in absorbing skillful activities, enhancing relationships, promoting meaning and purpose, and supporting accomplishments. The development of character strengths (e.g. zest, kindness, and hope) is central to Peterson and Seligman's (2004) theory of virtues and strengths, while Frederickson's (2000) broaden and build theory involve broadening thought action repertoires and building psychological resources. Ng and Lim (2019) further expand the definition by including activities that are not necessarily regarded as inherently positive, but that contribute to psychological functioning and enhance human flourishing. Given the fact that PPIs encompass a range of pathways and techniques, Schueller et al. (2014) favor the term *positive psychological interventions* to provide an integrative and comprehensive description of practices that may impact wellbeing. In accordance with Keyes' (2002, 2005) dual continuum model, these authors argue that positive psychological interventions should not merely reduce psychological distress, but ultimately promote positive mental health (Schueller et al., 2014). This broad term is applied in the current study.

PPIs may range from brief, scripted, self-administered activities, to more long-term in-depth therapeutic interventions and may include, but are not limited to; gratitude activities, mindfulness exercises, loving-kindness meditation, savouring positive experiences, practicing random acts of kindness, and visualising one's best possible future self (Bolier et al., 2013; Carr

et al., 2021; Carr et al., 2024; Sin & Lyubomirsky, 2009). Various meta-analyses and systematic reviews have shown that PPIs can be effective in enhancing wellbeing, improving strengths and quality of life and decreasing depression, anxiety and stress, in both clinical settings and the general population (Bolier et al., 2013; Carr et al., 2021; Carr et al., 2024; Hendriks et al., 2020; Sin & Lyubomirsky, 2009). PPIs may therefore be a valuable adjunct therapeutic approach for the prevention and treatment of mental illness and the promotion of mental health in various contexts (Bolier et al., 2013; Carr et al., 2021; Waters et al., 2022). This is particularly relevant to the context of trauma as PPIs are typically brief, cost-effective, flexible and easy to implement.

1.2 Positive psychological interventions (PPIs) in the context of trauma

The mechanism of change underlying PPI's render it particularly relevant to address trauma-related distress. Through enhancing positive emotions, PPI's may broaden trauma survivors' attention, creativity, and thinking which enable more effective coping and buffer against negative emotions and thoughts (Fredrickson et al., 2003). Meaning-making processes may also assist people to develop new and acceptable ways of understanding a traumatic situation which predicts better adjustment following trauma (Park, 2022). Similarly, practicing gratitude is associated with a more positive appraisal of trauma-related events which may reduce one's perceived threat level and subsequent symptoms of hypervigilance (Emmons & McCullough 2003). Furthermore, by promoting kindness and compassion, PPI's may help trauma survivors develop psychological flexibility, distance themselves from the trauma mindset, and consider other perspectives, which in turn reduce feelings of shame, guilt and blame (Kearney, 2013). Mindfulness, described as purposefully paying attention to the present moment without any judgement of the experience, may counteract ruminative tendencies which decrease anxious arousal and anhedonia. A nonjudgmental outlook may also promote a willingness to approach fear-provoking stimuli, leading to reduced avoidance (Boyd et al., 2018). In addition, the building of strengths and personal resources such as resilience and social support in the aftermath of trauma may be valuable as it is associated with better adjustment and greater adversarial growth (Tedeschi & Calhoun, 2004).

Several interventions, based on the principles of positive psychology, have been utilized in the context of trauma. For example, Radstaak et al. (2020) investigated the effect of well-being therapy, initially developed to prevent relapse of mental disorders and promote psychological wellbeing, among a group of participants previously exposed to various forms of trauma. Results suggested that participants who reported low levels of wellbeing at the start of the treatment benefitted more from well-being therapy than treatment as usual. However, well-being therapy was not more effective in increasing wellbeing or decreasing PTSD symptoms when compared to treatment as usual (Radstaak et al., 2020). Interventions aimed at increasing forgiveness and self-forgiveness in trauma contexts provided more promising results (Ha et al., 2017; Wade & Worthington, 2005; Walton, 2005). Ha et al. (2017) found that a group of South Korean students exposed to sexual abuse experienced reduced shame and depression, and increased post-traumatic growth after exposure to forgiveness writing therapy when compared to a control group. Participants were not only able to forgive the self, but also reported forgiveness of the situation by reconstructing their malicious beliefs about the world; suggesting that forgiveness writing therapy may be an appropriate approach for treating survivors of sexual abuse (Ha et al., 2017).

Moreover, a scoping review (Boyd et al., 2018) suggested that mindfulness-based treatments are effective in reducing symptoms of PTSD, with medium to large within-group effect sizes and low dropout rates. The key mechanisms underlying treatment efficacy may be related to

reductions in avoidance, improvements in shame-based appraisals and self-blame cognitions; lending strong support to the potential utility of mindfulness-based treatment approaches. Loving-kindness meditation, a practice designed to enhance feelings of kindness and compassion for self and others, appears to be a particular promising treatment for trauma survivors. Kearney et al. (2013) found that loving-kindness meditation was associated with reduced symptoms of PTSD and depression as well as enhanced self-compassion among a group of veterans. When compared to cognitive processing therapy (CPT), this intervention provided similar reductions in PTSD symptoms, with change over time in depressive symptoms being even greater for loving-kindness meditation than for CPT. Loving-kindness meditation also had higher attendance relative to CPT, highlighting that this intervention may be appropriate for the treatment of PTSD (Kearney et al., 2021).

In addition, solution-focused brief therapy (SFBT) has been applied to clients managing different forms of trauma. Similar to PPIs, SFBT utilizes client strengths, hope and positive affect as vehicles for positive therapeutic change (Froerer et al., 2018). Joubert and Guse (2021) found that SFBT contributed towards a group of South African trauma survivors' experiences of hope and subjective wellbeing. In particular, the therapeutic conversation, empathy and acceptance in therapy, visualising a better future and focusing on strengths instead of the trauma facilitated these experiences. A review of the literature on SFBT in the context of trauma also showed that SFBT led to significant improvements in trauma symptoms, recovery and self-esteem (Eads & Lee, 2019). Compared to control groups, SFBT showed statistically significant improvements with large effect sizes on post-traumatic growth and sleep issues, but effect sizes for trauma symptoms were small and not statistically significant or varied greatly between different reporters.

Given the expanding use of PPIs in the context of trauma, a broader review of findings is warranted. However, to our knowledge, no published systematic reviews or meta-analyses have been conducted on the implementation of PPIs with people exposed to trauma. A scoping review will thus not only assist in mapping the extent and nature of literature available on this broad topic, but may also identify gaps and inconsistencies in the current knowledge base and inform further research in the field (Arksey & O'Malley, 2005; Peters et al., 2021). This may ultimately guide clinicians in developing and implementing effective and contextually relevant PPIs in the aftermath of trauma.

The objective of this scoping review was to provide an overview of available research on the application of PPIs in the context of trauma. Specifically, we aimed to answer the following research questions: (a) What PPIs are applied in the context of trauma?; (b) How are PPIs applied in the context of trauma?; and (c) What is the outcome of PPIs in the context of trauma?

2. Method

In order to ensure methodological rigor, this scoping review was conducted and reported in accordance with the Joanna Briggs Institute's (JBI) methodology for scoping reviews (Peters et al., 2020) as well as the Preferred Reporting Items for Systematic Reviews and Meta-Analysis extension for Scoping Reviews (PRISMA-ScR) guidelines (Tricco et al., 2018).

2.1 Inclusion and exclusion criteria

Based on Schueller and colleagues' (2014) broad definition of PPIs, our scope included interventions rooted in positive psychology theory or tradition and interventions whose primary goal was to increase positive feelings, positive cognitions, or positive behavior through pathways that are consistent with positive psychology theories. Interventions that were mindfulness-based

or strength-focused and aligned with the principles of positive psychology were also included. We excluded studies that focused primarily on activity-based interventions, interventions not explicitly rooted in positive psychology, and studies that only focused on reducing distress.

With regards to trauma, studies involving participants exposed to traumatic events or suffering from trauma-related disorders (e.g. PTSD) were included. Studies primarily focusing on cancer- or other medical-related traumas were excluded due to the specific nature of these experiences and previous systematic reviews investigating the effectiveness of PPIs in this context (e.g. Casellas-Grau et al., 2014; Tian et al., 2024).

Given that scoping reviews aim to determine the types of available evidence, the inclusion criteria were not limited by a specific type of research design (Peters et al., 2021). Original, peer-reviewed articles and book chapters were included along with published theses or dissertations. Abstract-only texts, conference papers and newspaper articles were excluded due to the limited information provided by these sources. Due to resource and time constraints, papers not available in full-text were also excluded from this scoping review. Studies were therefore included if they: (a) focused on a PPI; (b) aimed to promote positive mental health or wellbeing; (c) involved participants exposed to trauma or diagnosed with trauma-related distress; (d) were written in English; and (e) were available in full text.

2.2 Search strategy

In August 2024 the following bibliographic databases were searched for studies which met the inclusion criteria: PsycINFO, PubMed, Scopus, EBSCOhost, MEDLINE, ProQuest, Africa-Wide Information and Web of Science. Each data source was searched by combining terms that refer to the three conceptual domains, namely *positive psychology (*e.g. "positive mental health", "wellbeing" or "well-being"), *intervention* (e.g. "therapy", or "treatment") and *psychological trauma* (e.g. "posttraumatic stress", "post-traumatic stress" or "PTSD"). Reference lists of systematic reviews, meta-analyses and scoping reviews were also scanned for applicable literature. The search was limited to work published since 2005, as literature on positive psychology rapidly increased from the early 2000s (Rusk & Waters, 2013).

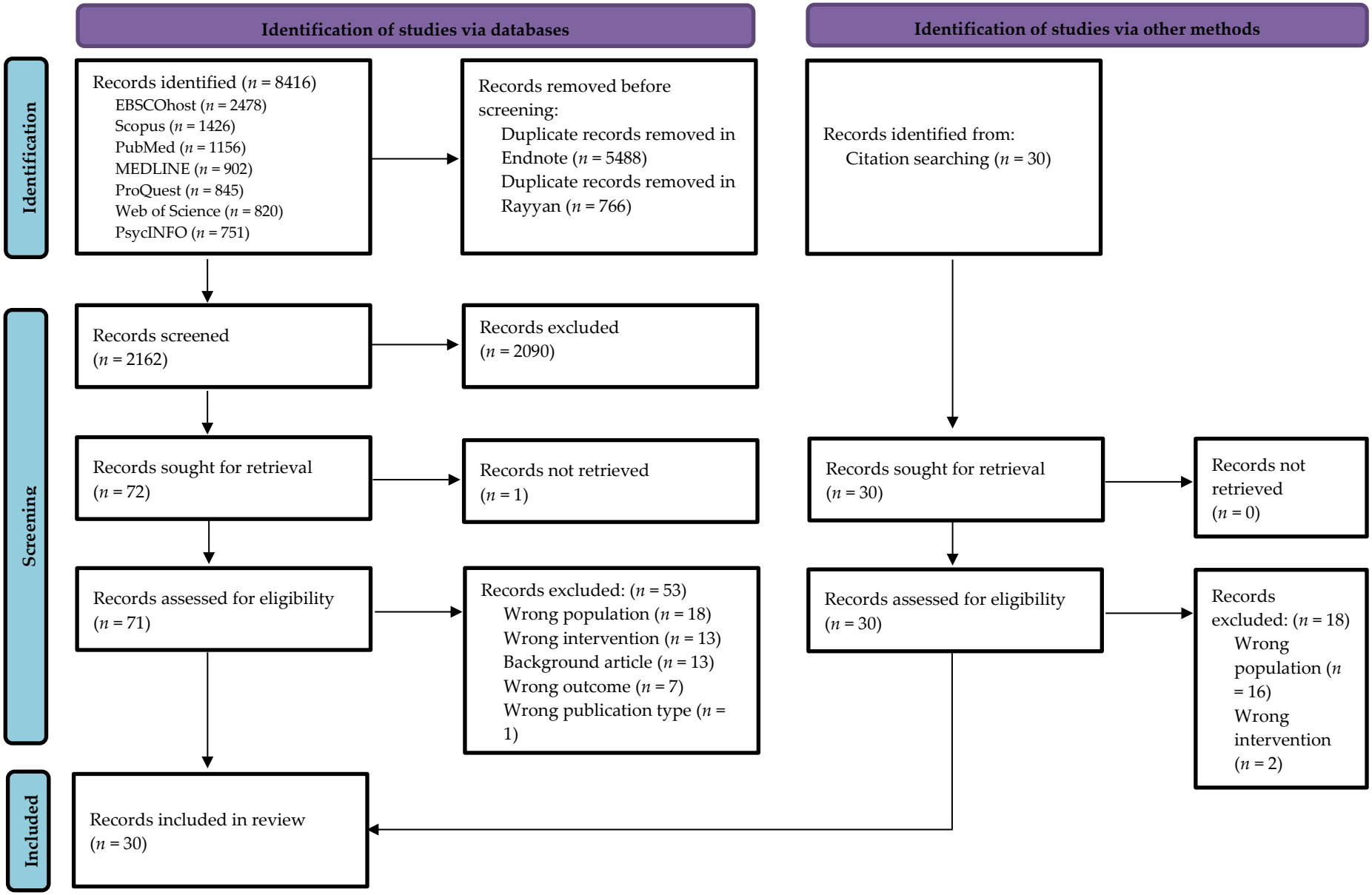
2.3 Source of evidence selection

The citation details of retrieved records were uploaded to an EndNote Version 21 (The EndNote Team, 2013) library where duplicates were removed and then imported into Rayyan systematic review software (Ouzzani et al., 2016) where deduplication again took place. The authors screened both the title and abstract as well as the full text against the inclusion criteria. Reasons for exclusion of full text sources were recorded and any disagreements that arose were resolved through discussion. The results of the search and the study selection process are presented in a PRISMA flow diagram, as reflected in Figure 1. At the end of the reviewing process, 30 studies were identified for analysis.

2.4 Data extraction and charting

We developed a data extraction tool which assisted in charting specific details about the study, methodology, population, intervention and outcome of the intervention. The draft data extraction tool was modified and revised as necessary during the process of extracting data from each included evidence source.

Figure 1: PRISMA flow diagram of the study selection process



3. Results

The 30 included studies are presented in Tables 1 and 2. The findings will be discussed along the following dimensions: study characteristics, population, intervention, and outcomes.

3.1 Study characteristics

As noted in Table 1, the vast majority of studies (n = 25, 83.3%) were published journal articles, while the remaining (n = 5, 16.7%) were doctoral theses or dissertations. There has been a steady increase in the number of studies since 2005, with only two (6.7%) studies published between 2005 and 2009 and 14 (46.7%) studies published in the last four years (2020 – 2024). Most of the studies reported on interventions implemented in North-America (n = 20, 66.7%) or Europe (n = 7, 23.3%), while a few (n = 3, 10%) interventions were implemented in South Korea (Chang et al., 2024), Iran (Daneshvar et al., 2022), and South Africa (Joubert, 2020). Various researchers conducted the studies, and only three authors (Ahmadi et al., Kearney et al., Müller-Engelmann et al.) had more than one publication. In terms of research design, the majority of studies (n = 23, 67.7%) utilised a quantitative approach, followed by mixed-methods (n = 6, 20%), and qualitative (n = 1, 3.3%) studies. Most interventions comprised of relatively small samples, ranging from 7 to 200 participants. The majority of studies (n = 26, 86.7.%) focused on individuals, however, three studies (Ahmadi et al., 2020; Ahmadi et al., 2022; Hoskins et al., 2018) involved youths and their parents or caregivers while another (Kahn et al., 2016) considered partner dyads.

3.2 Population

Table 1 indicates that most interventions were implemented among adults (n = 26, 86.7%) and only four (13.3%) studies included children or adolescents. Among the studies with adults, eight specifically focused on Veterans, two involved students and one study included refugees (Chang et al., 2024). Six (20%) studies exclusively comprised women. Moreover, except for studies involving Veterans, all samples consisted of more females than males. Although not all studies reported racial or ethnic background, half (n = 15, 50%) of the interventions were primarily implemented with White/Caucasian participants. In only two studies (Hoskins et al., 2018; Joubert, 2020), non-White participants comprised the majority of the sample.

With regards to the type of trauma, several (n = 11, 36.7%) interventions involved participants exposed to various traumatic events. Some interventions also focused exclusively on sexual trauma (n = 3, 10%), combat-related trauma (n = 3, 10%) and intimate partner violence/abuse (n = 3, 10%). More than half (n = 18, 60%) of the studies included clinical populations, with participants meeting the criteria for or showing symptoms of PTSD. Among these studies specifically, three involved participants with a comorbid diagnosis of either attention-deficit/hyperactivity disorder (ADHD), substance use disorder or suicidality. Two (6.7%) interventions were applied with trauma-survivors experiencing any mental or physical health problem and 10 (33.3%) studies did not specify a formal diagnosis. However, a large number of studies excluded participants with serious mental health problems (e.g., psychosis or mania) (n = 23, 76.7%), suicidality (n = 15, 50%), or substance use (n = 13, 43.3%).

Table 1: Summary of characteristics and population of included studies.

Study Characteristics			Population		
Author(s) & Year	**Publication Type & Country**	**Research Design**	**Sample**	**Type of Trauma**	**DSM Diagnosis**
Ahmadi et al. (2020)	Journal article (USA)	Quantitative	Adolescents (n = 8) & parents Female = 55%; male = 45%	Not specified	PTSD & ADHD **Excluded:** psychiatric disorder; substance use disorder
Hogue (2024)	Doctoral dissertation (USA)	Quantitative	Adults (n = 8) Female = 87.5%; male = 12.5% White = 87.5%	Sexual	Probable PTSD **Excluded:** high suicide risk, mania/psychosis
Kent et al. (2011)	Journal article (USA)	Quantitative	Veterans (n = 39) Female = 33%; male = 67%. Caucasian = 76%	Various	Moderate PTSD symptoms **Excluded:** suicidality, alcohol/substance abuse, psychosis
Bein (2014)	Doctoral dissertation (USA)	Quantitative	Veterans (n = 8) Male = 100% Experimental Group: White/ Caucasian = 75%	Not specified	PTSD & substance use disorder (SUD) **Excluded**: psychotic disorder
Müller-Engelmann et al. (2019)	Journal article (Germany, Europe)	Quantitative	Adults (n = 14) Female = 78.6%; male = 21.4%	Inter-personal violence	PTSD **Excluded**: psychotic disorder, bipolar disorder, suicidality, substance use disorder
Lawrence & Lee (2014)	Journal article (UK)	Qualitative	Adults (n = 7) Female = 71.4%; male = 28.6%	Various	PTSD
Kearney et al. (2012)	Journal article (USA)	Quantitative	Veterans (n = 92) Female = 24%; male = 76% Caucasian = 84%	Not specified	Mental and physical health problems **Excluded**: psychotic disorder, mania/poorly controlled bipolar disorder, borderline/antisocial personality disorder, suicide risk, substance use disorder
Grodin et al. (2019)	Journal article (Canada)	Quantitative	Veterans (n = 22) Female = 4%; male = 96%. Caucasian/ non-Hispanic = 82%	Military-related	PTSD **Excluded:** suicidal ideation, substance use disorder, symptoms of psychosis

Study Characteristics			Population		
Author(s) & Year	**Publication Type & Country**	**Research Design**	**Sample**	**Type of Trauma**	**DSM Diagnosis**
Lang et al. (2019)	Journal article (USA)	Quantitative	Veterans (n = 28) Female = 25%; male = 75%. Caucasian = 50%	Various	PTSD **Excluded:** high risk of suicide, untreated substance use disorders, serious mental illness
Au et al. (2017)	Journal article (USA)	Quantitative	Adults (n = 10) Female = 80%; male = 10%; non-binary = 10% European-American = 70%	Various	Elevated PTSD symptoms **Excluded**: suicidal ideation and intent, psychosis, bipolar disorder, substance use disorder
Chang et al. (2024)	Journal article (South Korea)	Quantitative	Refugees (n = 60) Female = 85%; male = 15%	Defection experience	Not specified **Excluded:** mental disorder
Dumarkaite et al. (2021)	Journal article (Lithuania, Europe)	Quantitative	Students (n = 70) Female = 87.1%; male = 12.9% Lithuanian = 94%	Various	High levels of PTSD & C-PTSD symptoms **Excluded:** acute case of psychiatric care, abuse of alcohol/drugs
Daneshvar et al. (2022)	Journal article (Iran)	Quantitative	Females (n = 42)	Intimate partner violence	PTSD **Excluded:** major depression disorder, dysthymic disorder, bipolar disorder, psychosis, alcohol/ other drug abuse
Joubert (2020)	Doctoral thesis (South Africa)	Mixed-methods	Black females (n = 7)	Various	Not specified **Excluded:** acute presentation of trauma-related symptomology, psychosis, or suicidality
Murn & Schultz (2024)	Journal article (USA)	Mixed-methods	Females (n = 8) White = 75%	Sexual violence	Not specified **Excluded:** Mental health needs beyond the scope of the group
Kearney et al. (2013)	Journal article (USA)	Quantitative	Veterans (n = 42) Female = 40.5%; male = 59.5% White = 83.3%	Not specified	PTSD **Excluded:** psychotic disorder, mania/poorly controlled bipolar disorder, borderline/antisocial personality disorder, suicidal ideation, active substance use disorder

Study Characteristics			Population		
Author(s) & Year	**Publication Type & Country**	**Research Design**	**Sample**	**Type of Trauma**	**DSM Diagnosis**
Kimbrough et al. (2009)	Journal article (USA)	Quantitative	Adults (n = 27) Female = 89%; male = 11% White = 78%	Childhood sexual abuse	Not specified **Excluded:** Major psychiatric illness, dissociative identity disorder, alcohol/drug dependency
Hernandez (2019)	Doctoral dissertation (USA)	Mixed-methods	Women	Inter-personal violence	Not specified
Müller-Engelmann et al. (2017)	Journal article (Germany, Europe)	Mixed-methods	Adult patients (n = 14) Female = 71%; male = 29%	Various	PTSD **Excluded:** schizophrenia, schizoaffective disorder or bipolar disorder, suicidality
McGuire et al. (2023)	Journal article (USA)	Mixed-methods	Veterans (n = 48) Female = 19%; male = 81 % White = 43%; Black/ African American = 44%	Combat exposure	PTSD **Excluded:** psychosis, substance/alcohol use disorder, suicide risk
Hoskins et al. (2018)	Journal article (USA)	Quantitative	Youth (n = 16) & caregivers Female = 63%; male = 37%. Mexican = 62.5%	Various	Clinically significant symptoms of PTSD
Kahn et al. (2016)	Journal article (USA)	Quantitative	Veteran-partner dyads (n = 160) Veterans: Female = 18.8%; male = 81.2% White = 51.9%	Deployment	Not specified
Foka et al. (2021)	Journal article (Greece, Europe)	Mixed-methods	Children (n = 72) Female = 64.8%; male = 35.2%	Transit	Not specified
Roepke et al. (2018)	Journal article (USA)	Quantitative	Adults (n = 112) Female = 64%, male = 36% White/ Caucasian = 53.54%	Loss of a loved one	Not specified **Excluded:** high levels of depression/PTSD symptoms, suicidal ideation, psychotic disorder

Study Characteristics			Population		
Author(s) & Year	**Publication Type & Country**	**Research Design**	**Sample**	**Type of Trauma**	**DSM Diagnosis**
Ahmadi et al. (2022)	Journal article (USA)	Quantitative	Youth (n = 200) & parents Intervention Group: Female = 56%; male = 44%	Not specified	PTSD & suicidality **Excluded**: major psychiatric disorders, prior suicide attempts
Li et al. (2024)	Journal article (USA)	Quantitative	Female immigrants (n = 50)	Intimate partner violence (IPV)	Not specified **Excluded:** substance use, suicidality, treatment for severe mental illness
Müller-Engelmann et al. (2024)	Journal article (Germany, Europe)	Quantitative	Adult patients (n = 32) Intervention Group: Female = 100%	Various	Mental disorder **Excluded**: substance abuse/use disorder, suicide attempts/life-threatening self-injury, schizoaffective disorder, schizophrenia or bipolar-I disorder
Reed & Enright (2006)	Journal article (USA)	Quantitative	Females (n = 20) European Americans = 90%	Emotional abuse from partner	Symptoms of PTSD **Excluded:** significant ongoing psychiatric illness (e.g. suicidal ideation or psychosis)
Radstaak et al. (2020)	Journal article (Netherland, Europe)	Quantitative	Adults (n = 64) Female = 59.4%; male = 40,6%. Dutch = 76.6%	Various	Residual symptoms of PTSD **Excluded:** DSM-IV-TR PTSD diagnosis
Dadouch (2021)	Doctoral dissertation (USA)	Quantitative	Students (n = 38) Female = 76%; male = 24%. White = 39.5%; African American = 28.0%; Hispanic = 26.5%; Asian = 5.3%	Various	Sub-threshold PTSD

Table 2: Summary of interventions and outcomes of included studies.

Intervention Characteristics					Intervention Outcomes	
Citation	**Format & Setting**	**Facilitator & Duration**	**Nature & Aim**	**Positive Activities/ Techniques Applied**	**Outcome Measures**	**Key Findings**
Ahmadi et al. (2020)	Group & individual Psychiatry clinic	Therapists Twice-weekly sessions (75 min) for 6 weeks	Reminder-focused positive psychiatry (RFPP) Shifting attention from intrusive memories to a focus on positive feelings, thoughts, goals, and choices.	Express gratitude, encourage social connectedness, savour the present moment.	**Mental Illness:** ADHD symptoms (SNAP), PTSD symptoms (CAPS-CA-5), traumatic reminders (UCLA-TRI). **Wellbeing:** positive emotion, engagement, relationships, meaning, and accomplishment (PERMA scale), gratitude (GRAT), posttraumatic growth (PTGI), resilience (CD-RISC). **Other:** Vascular function measured as temperature rebound, C-reactive protein, homocysteine. Acceptability, feasibility, fidelity.	RFPP is associated with improvement in core PTSD and ADHD symptoms, decrease in inflammation, and increase in well-being (PERMA, gratitude, resilience), vascular function, and PTG, as well as a favourable long-term clinical outcome.
Hogue (2024)	Online in a video conference room	Graduate students Weekly sessions (30 min) for 5 weeks	Brief self-compassion intervention Fostering a more compassionate attitude toward oneself and others.	Mindfulness practices, compassionate meditation, practicing self-kindness (e.g. writing a letter of compassion to self).	**Mental Illness:** Experiential avoidance (BEAQ), shame (TRSI), posttraumatic cognitions (PTCI-9), psychological distress (PDS–5 & BSI). **Wellbeing**: self-compassion (SCS), psychological flexibility (Psy-Flex), general psychological wellbeing (Flourishing Scale).	Significant decreases in trauma symptoms, trauma-related shame, experiential avoidance, and posttraumatic cognitions. No statistically significant changes in self-compassion, general psychological distress, psychological flexibility, or overall well-being. Self-compassion approached significance in pre-posttest analyses and was the only variable that was statistically significant at one-month follow-up.
Kent et al. (2011)	Group Veterans Affairs Health Care System	Psychologist 12 weekly (90 min) sessions	Resilience-oriented treatment Fosters resilience resources (e.g., awareness of positive emotions, social connectedness).	Activities focused on building positive emotional experiences and social bonds.	**Mental Illness:** PTSD symptoms (PDS), depressive symptoms (BDI-II), anxiety level (STAI). **Wellbeing**: positive emotional health (subscales of RAND-36), psychological wellbeing (subscales of Ryff's Psychological Well-Being Scale). **Other**: executive function, memory.	The intervention, but not the waitlist control group, showed improvements for affective symptoms (depression and anxiety), positive emotional health, memory and executive function.

Intervention Characteristics					Intervention Outcomes	
Citation	**Format & Setting**	**Facilitator & Duration**	**Nature & Aim**	**Positive Activities/ Techniques Applied**	**Outcome Measures**	**Key Findings**
Bein (2014)	Group In-patient treatment facility	Mindfulness instructor Weekly sessions (60 min) for 8 weeks	Classical mindfulness intervention + treatment as usual (TAU) Fosters sustained attention and a non-judgmental, non-controlled awareness.	Mindfulness and concentration practices.	**Mental Illness:** Impulsivity (UPPS-P), posttraumatic symptoms (PCL-M), symptoms of depression (PHQ-9). **Wellbeing**: mindfulness skills (FFMQ).	Compared to a control group (TAU), the experimental group had more significant improvements in mindfulness skills, PTSD symptoms, impulsivity, and overall mood.
Müller-Engelmann et al. (2019)	Individual Outpatient centre	Clinical psychologists 8 weekly (90 min) sessions	Mindfulness + loving-kindness meditation Develop and use mindfulness and loving-kindness skills.	Mindfulness-based exercises (e.g. body scan, sitting mediation), loving-kindness meditation (e.g. imaginary compassionate self).	**Mental Illness:** PTSD symptoms CAPS-5), depressive symptoms (BDI-II), psychological distress (BSI). **Wellbeing:** mental well-being (WHO-5), mindfulness skills (FFMQ), self-compassion (SCS).	Significant reduction of PTSD symptoms, depression and psychological distress. A significant increase in well-being, complimented by relevant increases in mindfulness skills and self-compassion.
Lawrence & Lee (2014)	Group & individual	Clinical psychologists	Compassion-focused therapy (CFT) Development and strengthening of compassion.	Not specified	Helpful and difficult aspects of CFT, feelings throughout therapy, barriers experienced during therapy, changes participants had experienced as a result of therapy.	Despite initial aversive responses to self-compassion, participants experienced increasingly positive affective responses to self-compassion and described a changed outlook on life including an increased sense of hopefulness for the future. They reported the therapeutic relationship as an important factor making this possible.

Intervention Characteristics					Intervention Outcomes	
Citation	**Format & Setting**	**Facilitator & Duration**	**Nature & Aim**	**Positive Activities/ Techniques Applied**	**Outcome Measures**	**Key Findings**
Kearney et al. (2012)	Group Veterans medical centre	MBSR instructors 8 weekly sessions (2.5hr) + 7 hr retreat	Mindfulness meditation-based stress reduction (MBSR) + TAU Enhancing non-judgmental attention to present-moment experiences.	Mindfulness meditation (e.g. body scan, sitting meditation) and gentle yoga.	**Mental Illness:** PTSD symptoms (PCL-C), depression (PHQ-9), behavioural activation (BADS), experiential avoidance (AAQ-2). **Wellbeing:** mindfulness (FFMQ). **Other:** health status.	Significant improvements in PTSD, depression, experiential avoidance, and behavioural activation as well as mental and physical health. In addition, mindfulness skills increased significantly over the course of the study.
Grodin et al. (2019	Group Outpatient clinic	Clinical psychologists 12 sessions	Compassion-focused therapy (CFT) Helping individuals learn about their emotions and develop compassion.	Compassion cultivation exercises, loving kindness/compassion meditation.	**Mental Illness:** PTSD symptoms (PCL-5), anger (STAXI-2). **Wellbeing:** self-compassion (SCS), fears of compassion (FCS). **Other:** Relevance, utility and acceptability.	The intervention demonstrated preliminary effectiveness in decreasing PTSD symptoms, anger symptoms, and fears of compassion, while increasing self-compassion.
Lang et al. (2019)	Group Outpatient clinic	Clinical psychologist 10 weekly (90 min) sessions	Compassion meditation (CM) Develop a sense of common humanity and generate compassion for self and others.	Present–moment awareness, contemplative practices to increase well-being and compassion.	**Mental Illness:** PTSD symptoms (CAPS-5 & PCL-5), emotional distress (BSI), anger (STAXI-2), depression (PHQ-9), problematic drinking (AUDIT – C), impairment of functioning (SDS). **Wellbeing:** life satisfaction (SWLS). **Other:** Feasibility, acceptability.	A more substantive reduction in PTSD symptoms in the CM condition than in the control condition (relaxation programme). The study demonstrated the feasibility of CM.
Au et al. (2017)	Individual Centre for Anxiety & Related Disorders	Master's-level clinician Six weekly (60–90 min) sessions	Compassion based therapy Focused on practicing self-compassion	Experiential exercise (e.g., loving kindness meditation), mindfulness & self-compassion exercises.	**Mental Illness:** PTSD symptoms (PCL-5), shame (ISS), self-blame (self-blame subscale of PTCI). **Wellbeing:** self-compassion (SCS). **Other:** Acceptability, tolerability.	Reliable decreases in PTSD symptom severity and reductions in shame. Also, improvements in self-compassion and self-blame. Participants reported high levels of satisfaction with the intervention.

Intervention Characteristics					Intervention Outcomes	
Citation	**Format & Setting**	**Facilitator & Duration**	**Nature & Aim**	**Positive Activities/ Techniques Applied**	**Outcome Measures**	**Key Findings**
Chang et al. (2024)	Group Community welfare centres	Twice-weekly (120min) sessions for 5weeks	Posttraumatic growth promoting (PTGP) programme Enhance posttraumatic growth.	Mindfulness exercises (e.g., loving kindness, body scan meditation), praying (contemplating positive aspects of a traumatic experience), writing & storytelling.	**Mental Illness:** Anxiety (Korean version of the SAI), depression (CES-D). **Wellbeing:** mindfulness (Mindfulness Scale), post-traumatic growth (PTGI). **Other:** cortisol levels.	The programme was effective in significantly increasing post-traumatic growth and decreasing anxiety, depression and cortisol level.
Dumarkaite et al. (2021)	Online intervention	Self-help 8 weeks - participants were encouraged to practice at least one exercise/day	Mindfulness-based intervention Focused on mindfulness training.	Mindfulness exercises	**Mental Illness:** Symptoms of PTSD and complex PTSD (C-PTSD) (ITQ), depression (PHQ-9), anxiety (GAD-7). **Wellbeing:** positive mental health (PMHS). **Other: u**ser satisfaction and program usability.	The intervention reduced C-PTSD disturbances in self-organization symptoms, reduced symptoms of PTSD sense of threat and promoted positive mental health. High user satisfaction and good usability of the intervention were reported.
Daneshvar et al. (2022)	Group	8 sessions (2 hr)	Compassion focused therapy (CFT) Teaching empathy, sympathy, compassion, acceptance, tolerance, responsibility, and self-worth.	Not specified	**Mental Illness:** Experiential avoidance and psychological flexibility (AAQ). **Wellbeing:** meaning in life (MLQ), sense of coherence (SOC-13).	A greater reduction in experiential avoidance and a significant rise in meaning-in-life compared to a no-treatment control group. No change in the level of sense of coherence.

Intervention Characteristics					Intervention Outcomes	
Citation	**Format & Setting**	**Facilitator & Duration**	**Nature & Aim**	**Positive Activities/ Techniques Applied**	**Outcome Measures**	**Key Findings**
Joubert (2020)	Individual Community clinics	Clinical psychologist 1-4 sessions – depending on patient (60min)	Solution Focused Brief Therapy (SFBT) Focused on eliciting positive goals, positive emotions, hope and resources.	Eliciting a desired outcome (goal), describing the preferred future, amplifying resources/strengths.	**Mental Illness:** depression (PHQ-9), PTSD symptoms (PCL-5). **Wellbeing:** Hope (AHS), subjective well-being (SPANE, SWLS). **Other**: Experience of hope and SWB after exposure to SFBT, specifically focusing on the aspects of SFBT that contributed to their experiences.	Increase in hope, positive affect, and life satisfaction as well a decrease in negative affect and psychopathology, after exposure to SFBT. In particular, the therapeutic conversation, empathy and acceptance in therapy, visualising a better future and focusing on strengths instead of the trauma facilitated these experiences.
Murn & Schultz (2024)	Group University counselling centre	Psychologist 8 weekly sessions (90min)	Peer support group Provide empowerment in a safe, compassionate environment.	Self-compassion and mindfulness techniques, expressive and creative therapeutic activities, and building peer connections.	**Mental Illness:** PTSD symptoms (PDS-5). **Wellbeing:** general wellbeing (subscales of SGWB), protective factors of resilience (SPF-24), self- compassion (SCS). **Other**: Experiences, level of trust, and belonging throughout the group.	Preliminary results suggesting it is an effective group therapy model for improving post-traumatic stress symptoms, well-being, resilience, and self-compassion. Nearly all members identified universality (e.g., "knowing I'm not alone") and coping skill development as important healing factors of this group.
Kearney et al. (2013)	Group Veteran hospital	Meditation teachers 12 weekly sessions (90 min)	Loving-kindness meditation + TAU Enhance feelings of kindness and compassion for self and others.	Mindful meditation, loving-kindness meditation.	**Mental Illness:** PTSD symptoms (PTSD-SS-I), depression (PROMIS). **Wellbeing:** compassionate or altruistic love (CLS), mindfulness (FFMQ).	Overall, loving-kindness meditation appeared safe and acceptable and was associated with reduced symptoms of PTSD and depression.
Kimbrough et al. (2009)	Group	MBSR teacher 8 weekly (2.5–3hr) classes + 5-hr retreat + 3 refresher classes over 4 months	MBSR + TAU Focused on staying present to experiences, building on strengths and cultivating compassion for self and others.	Sitting meditation, body scan, walking meditation, gentle yoga.	**Mental Illness:** Depressive symptoms (BDI-II), PTSD symptoms (PCL), anxiety (BSI). **Wellbeing:** mindfulness (MAAS).	At 8 weeks, depressive symptoms were reduced by 65%. Statistically significant improvements were observed in all outcomes post-MBSR. Improvements were largely sustained until 24 weeks.

Intervention Characteristics					Intervention Outcomes	
Citation	**Format & Setting**	**Facilitator & Duration**	**Nature & Aim**	**Positive Activities/ Techniques Applied**	**Outcome Measures**	**Key Findings**
Hernandez (2019)	Group Crisis centre	Psycho-therapist 4 weekly sessions (1 hr)	Mindfulness meditation (MM) Changing ruminative thinking to focusing on the present moment.	Mindfulness exercises (e.g. body scan meditation)	**Mental Illness:** Stress (PSS). **Wellbeing:** positive emotions (SPANE), optimism (LOT-R), mindfulness (KIMS). **Other:** What participants found challenging or helpful, whether they anticipate continuing with mindfulness practices, and improvement in stress reduction, well-being, and positive mood.	There were no significant differences from pre to posttest on stress, well-being, and optimism. However, qualitative data revealed a feeling of relaxation or balance, improved self-awareness, and improved intentionality.
Müller-Engelmann et al. (2017)	Group PTSD outpatient centre	MBSR instructor 8 weekly sessions (2.5 hr) + daylong retreat	MBSR To establish present-moment awareness.	Body scan, yoga, sitting and walking meditation.	**Mental Illness:** PTSD symptoms (DTS), depressive symptoms (BDI-II). **Wellbeing:** mindfulness (FFMC). **Other:** Applicability & helpfulness of the program.	Patients considered the exercises to be applicable and helpful. Results confirmed the efficacy of MBSR in reducing PTSD symptoms. In the qualitative interviews, the patients reported an augmentation of wellbeing and improvement regarding the handling of difficult situations and more distance from the traumatic event. Interviews also suggest that the intervention should be better adapted to the needs of PTSD patients (e.g., more information regarding exercises, including shorter exercises)

Intervention Characteristics					Intervention Outcomes	
Citation	**Format & Setting**	**Facilitator & Duration**	**Nature & Aim**	**Positive Activities/ Techniques Applied**	**Outcome Measures**	**Key Findings**
McGuire et al. (2023)	Online intervention	Self-help Twice-weekly sessions for 4 weeks	Moral Elevation Online Intervention for Veterans Experiencing Distress Related to PTSD and Moral Injury (MOVED) Instil strong, positive experiences.	Elevation induction (exposure to stimuli depicting others engaging in a virtuous action/display of character strength), goal setting, reflection exercise (journaling).	**Mental Illness:** PTSD symptoms (PCL-5), moral injury distress (EMIS). **Wellbeing:** quality of life (WHOQOL-BREF), prosocial behaviour (The Prosocialness Scale). **Other:** Acceptability & satisfaction. Initiation or enrolment into the treatment, engagement, session and treatment experiences, and suggested revisions.	The intervention was largely feasible, acceptable and satisfactory. Veterans who completed MOVED reported decreases in PTSD symptoms and increases in physical and psychological domains of quality of life, compared to a no treatment condition. MOVED veterans reported no decrease in moral injury distress and no changes in prosociality. Qualitative feedback supported positive treatment outcomes across a range of domains. Veterans recommended adaptations to enhance engagement and maximize the impact of intervention content.
Hoskins et al. (2018)	Group Community clinic	Psychology interns & trainees 10 (90 min) weekly sessions	Positive Adaptations for Trauma and Healing (PATH) Focuses on social competence, problem-solving skills, critical consciousness, autonomy, a sense of purpose and positive affect skills.	Noticing positive events, amplifying and gratitude, mindfulness, acts of kindness, positive reappraisal, and setting attainable goals.	**Mental Illness:** Trauma symptoms (TSCC & UCLA-RI), depression (CDI-S), internalizing and externalizing problems (CBCL), stress (PSS). **Wellbeing:** resilience (IPFI), positive and negative emotions (PANAS-X).	At pretest, 56% of the youth endorsed clinically significant PTSD symptoms which dropped to 0% at posttest. Participants reported reductions in depression and externalizing and internalizing behaviour

Intervention Characteristics					Intervention Outcomes	
Citation	**Format & Setting**	**Facilitator & Duration**	**Nature & Aim**	**Positive Activities/ Techniques Applied**	**Outcome Measures**	**Key Findings**
Kahn et al. (2016)	Online intervention	Self-help 16-weeks	Mission Reconnect (MR) program Mindfulness-related stress reduction focused on supporting psychological, social, and physical outcomes.	Gratitude exercises; mindfulness instruction; eliciting appreciation, compassion, and forgiveness for one's partner and oneself; practicing being present with one's partner.	**Mental Illness:** Stress (PSS), depression (BDI), PTSD symptoms (PCL-C). **Wellbeing:** self-compassion (SCS), perceived social support (MSPSS), adjustment (RDAS). **Other**: pain (PainUsual & PainBest), sleep quality (Pittsburgh Index).	Significant improvements were seen at 8 and 16 weeks in posttraumatic stress disorder, depression, sleep quality, perceived stress, resilience, self-compassion, and pain.
Foka et al. (2021)	Group Refugee camps	Trained facilitator & local refugee interpreter Daily (2-hr) sessions for 6 days	A resilience-building intervention (Strengths for the Journey [SFJ]) Focused on positive emotions, optimistic thinking and hope, character strengths, and positive relationship.	Positive emotions activities, (experiencing and recalling), best possible self-exercise, gratitude exercise, mindfulness activities.	**Mental Illness:** Depressive symptoms (CES-DC). **Wellbeing:** mental well-being (WHO-5), self-esteem (LSE), optimism (YLOT). **Other:** Participants' experiences in the intervention, components they found useful or not, how the intervention affected them, and what they would change about the intervention.	Improvements in well-being, self-esteem, optimism, and depressive symptoms, compared with the wait-listed group. Focus group participants highlighted the importance of SFJ in developing a sense of togetherness and building their strengths.
Roepke et al. (2018)	Group University centre	Ph.D. candidates Single session (6 hr) + optional 1-hr booster session offered 2 weeks later	Psychosocial intervention (SecondStory) Helping individuals experience greater psychological growth, greater well-being, and less distress after adversity.	Identifying strengths, new possibilities for the future, setting and pursuing goals, writing a message to future participants.	**Mental Illness:** Depression symptoms (PHQ-9), posttraumatic stress symptoms (PCL-C). **Wellbeing:** posttraumatic growth (C-PTGI), life satisfaction (SWLS), psychological well-being (Ryff's Psychological Well-Being Scale).	Participants did not show significantly greater improvements than control (expressive writing) participants on measures of PTG, posttraumatic stress, or life satisfaction, but they did show greater decreases in depression symptoms by the first follow-up.

Intervention Characteristics					Intervention Outcomes	
Citation	**Format & Setting**	**Facilitator & Duration**	**Nature & Aim**	**Positive Activities/ Techniques Applied**	**Outcome Measures**	**Key Findings**
Ahmadi et al. (2022)	Not specified In-patient psychiatric rooms	10 min twice daily for 2 consecutive days	Reminder-focused positive psychiatry and suicide prevention (RFPP-S) Shifting attention from intrusive memories to positive feelings, thoughts, goals, and choices.	Self-compassion, gratitude and engagement exercises.	**Mental Illness:** Suicidal ideation (C-SSRS), PTSD symptoms (CAPS-CA-5), trauma reminders (UCLA-TRI), parent-child interactions (PACHIQ-R). **Wellbeing:** wellbeing (PERMA scale), positive psychiatric indicators (gratitude survey, CD-RISC, PTGI).	RFPP-S group showed a greater reduction in PTSD symptoms (55%) and reactivity to trauma and loss reminders (80%) compared with the TAU control group. Significantly greater reduction in suicide severity and increases in well-being, flexible thinking, and coping skills. Hospital readmission due to suicidality 1 month after discharge was 0% for the RFPP-S group and 20% for the control group.
Li et al. (2024)	Online	Introduction session by interventionalist followed by self-care resources 7 weekly sessions (practicing exercises at least four/week.)	Empowerment-based intervention (self-compassion, health, and empowerment; SHE) Providing mental health self-care resources.	Self-compassion, mindfulness, and loving-kindness.	**Mental Illness:** depressive symptoms (PHQ-9), anxiety symptoms (GAD-7), PTSD symptoms (PCL-5). **Wellbeing:** self-compassion (SCS-SF) **Other:** Frequency of intimate partner violence, safety behaviours.	The intervention group showed consistent trends toward improvements in most outcome measures, including specific types of IPV, depressive and PTSD symptoms, self-compassion, and certain components of self-compassion (i.e., isolation and over identification) when compared to the control group (psycho-education).
Müller-Engelmann et al. (2024)	Individual University outpatient centre	Therapists 6 weekly (100 min) sessions + a 4-week practice phase	Cognitive techniques + loving-kindness meditations (C-METTA) Focused on promoting positive emotions and well-being.	Loving-kindness meditation	**Mental Illness:** PTSD symptoms (CAPS-5 & PCL-5), trauma-related guilt and shame (TRGI, TRSI & SGATS), depressive symptoms (BDI-II), psychological distress (BSI), self-criticism (SCS). **Wellbeing:** mental well-being (WHO-5), self-compassion (SCS).	Greater reductions in C-METTA versus waitlist (WL) control in PTSD symptoms, guilt, shame, psychopathology and self-criticism.

Intervention Characteristics					Intervention Outcomes	
Citation	**Format & Setting**	**Facilitator & Duration**	**Nature & Aim**	**Positive Activities/ Techniques Applied**	**Outcome Measures**	**Key Findings**
Reed & Enright (2006)	Individual	Psychiatric nurse Weekly (1hr) sessions (min= 5 months, max= 12 months). Duration was self-determined by participants.	Forgiveness therapy (FT) Promotes valued personal qualities (e.g. compassion).	Explore empathy and compassion, practicing goodwill, finding meaning in suffering, finding a new purpose in life of helping others.	**Mental Illness:** PTSD symptoms (PTSS), anxiety (STAI), depression (BDI-II). **Wellbeing:** interpersonal forgiveness (EFI), self-esteem, environmental mastery (subscale of Ryff's Psychological Well-Being Scale), finding meaning in suffering (FMIS). **Other:** Psychological abuse. The participant's current perspective about the role that spousal psychological abuse has in her life story.	Participants in FT experienced significantly greater improvement than control (alternative treatment) participants in depression, trait anxiety, posttraumatic stress symptoms, self-esteem, forgiveness, environmental mastery, and finding meaning in suffering, with gains maintained at follow-up.
Radstaak et al. (2020)	Individual Outpatient care centre	Psychologists 6 sessions over a period of ±3 months	Well-being therapy (WBT) Increase psychological well-being (e.g. purpose in life, environmental mastery, personal growth, autonomy, self-acceptance, positive relationships).	Positive emotions diary, write down three things that went well each day, think of a place where you feel safe and positive.	**Mental Illness:** Residual PTSD symptoms (PTSD-SS), depressive symptoms (HADS-D). **Wellbeing:** well-being (MHC-SF) posttraumatic growth (PTGI).	WBT was not more effective than TAU in increasing levels of well-being or posttraumatic growth, nor in decreasing PTSD symptoms. However, for participants with low levels of well-being at baseline, WBT was more effective than TAU in increasing ratings of well-being and posttraumatic growth.
Dadouch (2021)	Individual	Graduate student & research assistants Two 15-minute writing tasks on 2 consecutive days	Positive Writing Identify the perceived benefits of a traumatic experience.	Write about how you have changed/grown as a person as a result of a traumatic experience.	**Mental Illness:** PTSD symptoms (PCL-5). **Wellbeing:** life satisfaction (SWLS), positive affect (PANAS).	Significant improvement in PTSD symptomatology at the two-week follow-up. Life satisfaction overall did not change over time, however, male participants and those in the positive writing group improved significantly more at the two-week follow-up. The classic condition led to greater reduction in positive mood compared to the positive writing task.

Note. AAQ = Acceptance and Action Questionnaire/ AAQ-2 = AAQ – version 2; AHS = The Adult Hope Scale; AUDIT - C = The Alcohol Use Disorders Identification Test; BADS = The Behavioral Activation for Depression Scale; BDI/ BDI-II = Beck's Depression Inventory; BEAQ = The Brief Experiential Avoidance Questionnaire; BSI = The Brief Symptom Inventory; CAPS-5 = Clinician-Administered PTSD Scale for DSM-5/ CAPS-CA-5 = CAPS-5 Child/Adolescent Version; CBCL = The Child Behavior Checklist; CDI-S - The Children's Depression Inventory: Short Version; CD-RISC = Connor-Davidson Resilience Scale; CES-D = The Centre for Epidemiological Studies Depression Scale; CES-DC = The Center for Epidemiological Studies. Depression Scale for Children; CLS = Compassionate Love Scale; CSEI = Coopersmith Self-Esteem Inventory; C-SSRS = The Columbia-Suicide Severity Rating Scale; DTS = The Davidson Trauma Scale; EFI = The Enright Forgiveness Inventory; EMIS = The Expressions of Moral Injury Scale; FCS = The Fears of Compassion Scale; FFMQ = Five Facet Mindfulness Questionnaire; FMIS = Finding Meaning in Suffering Scale; GAD-7 = The Generalized Anxiety Disorder 7-item; GRAT = Gratitude Resentment and Appreciation Test; HADS-D = The Hospital Anxiety and Depression Scale Depression subscale; IPFI = The Individual Protective Factors Index; ISS = Internalized Shame Scale; ITQ = The International Trauma Questionnaire; KIMS = Kentucky Inventory of Mindfulness Skills; LOT-R = Revised Life Orientation Test; LSE = The Lifespan Self-Esteem scale; MAAS = The Mindful Attention Awareness Scale; MHC-SF = Mental Health Continuum-Short Form; MLQ = The Meaning-in-Life Questionnaire; MSPSS = The Multidimensional Scale of Perceived Social Support; PACHIQ-R = Parent-Child Interaction Questionnaire–Revised; PANAS = Positive and Negative Affect Scale/ PANAS-X = Modified PANAS; PCL = PTSD CheckList/ PCL- 5 = PCL for DSM-5/ PCL-M = PCL - Military Version/ PCL-C = PCL - Civilian Version; PDS = The Posttraumatic Diagnostic Scale/ PDS-5 = The Posttraumatic Diagnostic Scale for DSM–5; PHQ-9 = Patient Health Questionnaire; PMHS = Positive Mental Health Scale; PROMIS = The Patient-Reported Outcomes Measurement Information System; PSS = The Perceived Stress Scale; PT = The Shame and Guilt After Trauma Scale; PTCI-9 = Posttraumatic Cognitions Inventory–9 Item**;** PTGI = Posttraumatic Growth Inventory/ C-PTGI = Current-Standing PTGI**;** PTSD-SS = PTSD Symptom Scale/ PTSD-SS-I = PTSD-SS -Interview Version; PTSS = Post-Traumatic Stress Disorder checklist; RDAS = Revised Dyadic Adjustment Scale; SCS = Self-Compassion Scale/ SCS-SF = SCS-Short Form; SDS = The three-item Sheehan Disability Scale; SGWB = Scales of General Well-Being; SNAP = Swanson, Nolan, and Pelham (SNAP) Rating Scale; SOC-13 = Short form of the Sense of Coherence scale; SPANE = Scale of Positive and Negative Experience; SPF-24 = Scale of Protective Factors; STAI = The State-Trait Anxiety Inventory; STAXI-2 = The State-Trait Anger Expression Inventory; SWLS = The Satisfaction with Life Scale; TRGI = Trauma-Related Guilt Inventory; TRSI = The Trauma-Related Shame Inventory; TSCC = The Trauma Symptom Checklist for Children; UCLA-RI = The UCLA Posttraumatic Stress Disorder Reaction Index; UCLA-TRI = UCLA Trauma Reminder Inventory; UPPS-P = The Urgency, Premeditation, Perseverance, Sensation Seeking, and Positive Urgency Impulsivity Scale; WHO-5 = WHO-Five Well-Being Index; WHOQOL-BREF = WHO – Quality of Life – Brief; YLOT = The Youth Life Orientation Test.

3.3 Intervention

Interventions were delivered in various formats, as reflected in Table 2. Half (*n* = 15, 50%) of the interventions were conducted in groups, followed by individual in-person (*n* = 7, 23.3%), online (*n* = 5, 16.7%) and a combination of individual and group (*n* = 2, 6.7%) formats. Considering the online interventions, one (Hogue, 2024) was delivered by graduate students via video conferencing, one (Li et al., 2024) provided a telephonic introduction followed by online self-care resources, and the remaining three (Dumarkaite et al., 2021; Kahn et al., 2016; McGuire et al., 2023) were web-based self-help programmes.

With regards to the interventions that were delivered in person, most were offered at out-patient centres or clinics (*n* = 9), university counselling/treatment centres (*n* = 3), and veteran medical centres (*n* = 3). Interventions were also implemented at in-patient facilities (Ahmadi et al., 2022; Bein, 2014) and trauma-focused contexts, such as a crisis centre (Hernandez, 2019), community welfare centres (Chang et al., 2024), and refugee camps (Foka et al., 2021). However, not all studies specified the setting in which the intervention was conducted. Several (*n* = 13, 43.3%) interventions were implemented by a mental health professional (e.g. psychologist, psychiatric nurse), while some interventions were also facilitated by mindfulness/meditation instructors (*n* = 5, 16.7%) or graduate students (*n* = 4, 13.3%). One intervention (Foka et al., 2021) was implemented by a trained lay counsellor and a local refugee interpreter. The duration of interventions ranged from a single session, with an optional one-hour booster session offered two weeks later (Roepke et al., 2018), to weekly, one-hour, sessions for a minimum of five months (Reed & Enright, 2006). However, the majority (*n* = 16, 53.3%) of interventions were conducted over the course of four to eight sessions. Three studies (Kearney et al., 2012; Kimbrough et al., 2010; Müller-Engelmann et al., 2017) included a mindfulness day retreat in addition to the group sessions. Two studies (Joubert, 2020; Reed & Enright, 2006) were less structured and based the duration of the intervention on the needs of the participants.

Table 2 indicates that the nature and content of interventions differed substantially. Almost a third (*n* = 9, 30%) of the interventions were rooted in traditional positive psychology theory, focused on enhancing positive emotions, thoughts, experiences, relationships and resources in the aftermath of trauma. Several (*n* = 9, 30%) interventions focused on developing character strengths such as compassion, kindness and forgiveness, and some (*n* = 6, 20%) also aimed to foster mindfulness. One intervention explicitly promoted post-traumatic growth (Chang et al., 2024), while the remainder (*n* = 5, 16.7%) appeared to be integrative, incorporating various aspects of positive psychology theory. However, five (16.7%) of the interventions were not delivered as standalone treatments, but were provided in conjunction with other approaches (e.g. treatment as usual or cognitive techniques).

The most common positive techniques and activities included mindfulness practices (e.g. mindfulness meditation, body scan) (*n* = 17, 56.7%), loving kindness meditation (*n* = 6, 20%) and some form of writing (e.g. positive journaling, writing compassionate letters) (*n* = 6, 20%). Some interventions also applied gratitude exercises (*n* = 5, 16.7%), self-compassion activities (*n* = 4, 13.3%), compassion activation techniques (*n* = 4, 13.3%), activities to identify meaning, purpose or strengths (*n* = 4, 13.3%), goal setting (*n* = 4, 13.3%) or techniques to foster social bonds (*n* = 3, 10%). A few interventions implemented acts of kindness (Hoskins et al., 2018; Reed & Enright, 2006), the 'three good things' exercise (Radstaak et al., 2020), imagining the 'best possible self' (Foka et al., 2021) or savoring the present moment (Ahmadi et al., 2020). Three interventions (Kearney et al., 2012; Kimbrough et al., 2009; Müller-Engelmann et al., 2017) incorporated yoga as part of the intervention, while one (Chang et al., 2024) made use of praying to contemplate positive aspects of the traumatic experience and another (Murn & Schultz, 2024) used expressive

and creative therapeutic activities. However, the majority (n = 23, 76.7%) of interventions incorporated more than one positive activity or technique to reach the intended outcome.

3.4 Outcomes

As outlined in the criteria, all the interventions aimed to promote positive mental health or wellbeing and thus included a positive outcome measure, as seen in Table 2. However, all studies, except the qualitative study (Lawrence & Lee, 2014), also investigated mental illness or psychopathology outcomes, such as PTSD symptoms (n = 24, 80%), depression (n = 16, 53.3%), and anxiety (n = 5, 16.7%). Studies furthermore evaluated emotional or psychological distress (n = 4, 13.3%), experiential avoidance (n = 3, 10%), trauma-related shame and guilt (n = 3, 10%), traumatic reminders (n = 2, 6.7%), anger (n = 2, 6.7%) and perceived stress (n = 2, 6.7%) as outcomes. A few studies (n = 4, 13.3%) considered physical health outcomes, such as vascular function (Ahmadi et al., 2020), health status (Kearney et al., 2012), cortisol levels (Chang et al., 2024), or pain and sleep quality (Kahn et al., 2016); while another study (Kent et al., 2011) measured executive functioning and memory.

In terms of positive mental health, a variety of outcomes were investigated. Nearly half (n = 14, 46.7%) of the studies explicitly measured some form of wellbeing or positive mental health outcome. However, the conceptualisation of wellbeing varied widely, with some studies focusing on Ryff's (1989) psychological wellbeing (e.g. Roepke et al., 2018), others defining wellbeing according to Seligman's (2011) PERMA theory (e.g. Ahmadi et al., 2022) and yet others referring to wellbeing in more general terms (e.g. Murn & Schultz, 2024). This was also evident in the diverse range of scales used to measure wellbeing or positive mental health. Besides wellbeing, several studies also measured self-compassion (n = 8, 26.6%) and mindfulness skills (n = 8, 26.6%) as outcomes. Furthermore, studies considered post-traumatic growth (n = 5, 16.7%), resilience (n = 4, 13.3%), life satisfaction (n = 3, 10%), positive and negative emotions (n = 3, 10%), optimism (n = 2, 6.7%), gratitude (n = 2, 6.7%), self-esteem (n = 2, 6.7%), and psychological flexibility (n = 2, 6.7%). Given the relatively few studies conducted on the application of PPIs in the context of trauma, it is not surprising that some (n = 7, 23.3%) studies focused on feasibility, acceptability, or satisfaction of study components. Mixed-methods and qualitative studies in particular explored how participants experienced the interventions, which aspects of the intervention they found helpful, and whether they recommended any changes (e.g. Lawrence & Lee, 2014).

Although the aim of this scoping review was not to assess and report on the effectiveness of PPIs in the context of trauma, we have identified trends, as indicated in Table 2, suggesting that the majority (n = 21, 70%) of interventions contributed to both increased wellbeing and decreased psychopathology following trauma. Six (20%) studies only noted improvement in trauma symptoms, while two (6.7%) only reported improvement in positive affective responses (Lawrence & Lee, 2014) or wellbeing and posttraumatic growth (Radstaak et al., 2020). Although Hernandez (2019) found no significant changes in stress, wellbeing, and optimism, qualitative data revealed that participants experienced feelings of relaxation or balance, improved self-awareness, and improved intentionality. Overall, participants reported satisfaction with the interventions (Au et al., 2017; Dumarkaite et al., 2021) and interventions appeared to have favourable long-term clinical outcomes, with some improvements sustained up to 24 weeks (Kimbrough et al., 2009). Additionally, qualitative findings identified the therapeutic relationship (Joubert, 2020; Lawrence & Lee, 2014), creating a sense of togetherness or universality (e.g., "knowing I'm not alone") (Foka et al., 2021; Murn & Schultz, 2024), and building strengths (Foka et al., 2021; Joubert, 2020) as important components of healing. However, participants recommended that some interventions may be better adapted to the needs of patients (e.g.,

provide more information regarding exercises, include shorter exercises) (Müller-Engelmann et al., 2017) and to enhance engagement and maximize the impact of intervention content (McGuire et al., 2023). Some (n = 9, 30%) interventions also showed more favourable outcomes, when compared to no treatment (Daneshvar et al., 2022; McGuire et al., 2023), waitlist control groups (Foka et al., 2021; Kent et al., 2011), treatment as usual (Ahmadi et al., 2022; Bein, 2014), alternative treatment (Reed & Enright, 2006), psychoeducation (Li et al., 2024), or a relaxation programme (Lang et al., 2019). Although not all studies reported the attendance or completion rates, it appeared to be relatively high (> 60%), with three studies indicating no drop outs (Chang et al., 2024; Hoskins et al., 2018; Müller-Engelmann et al., 2024).

4. Discussion

The aim of this scoping review was to provide an overview of available research on the application of PPIs in the context of trauma. Our review identified 30 studies which met the inclusion criteria and we noted a steady increase in the number of studies over the past few years. PPIs were mostly applied in Westernized countries with adults who were exposed to various forms of trauma and experiencing trauma-related symptomology (e.g. PTSD). These interventions were rooted in traditional positive psychology theory and primarily focused on enhancing positive emotions, thoughts, experiences, relationships and resources; developing character strengths; or fostering mindfulness. This is consistent with previous systematic reviews investigating PPIs in clinical samples with psychiatric or somatic disorders (Chakhssi et al., 2018) as well as patients with cancer (Tian et al., 2024). The interventions included in our review also involved pathways that aligned with positive psychology theory. For example, Müller-Engelmann et al. (2024) argued that positive emotions, through loving-kindness meditation, may broaden people's perception, enhance openness to new experiences and counteract negative emotions including shame and guilt in the aftermath of trauma. Character strengths, such as forgiveness, compassion and kindness, also played an essential role when individuals faced stressors as it assisted them to reorientate emotions, thoughts and/or actions toward the self and others, facilitated the repair of supportive close relationships, and led to self-acceptance (Kearney et al., 2013; Müller-Engelmann et al., 2019; Reed & Enright, 2006). This is especially relevant considering the many difficulties trauma survivors experience, including anger, self-criticism, feelings of shame, and interpersonal problems. Furthermore, mindfulness was associated with the acceptance of difficult experiences which may lead to a decrease in avoidance, emotional numbing, hypervigilance, and rumination, symptoms often seen in patients with PTSD (Kearney et al., 2012).

We found that a broad range of positive psychological activities and techniques were utilized, ranging from meditation and yoga to gratitude exercises and compassion or self-compassion activities. However, most interventions made use of more than one positive psychology activity, targeting various components of wellbeing. This is not unique as Hendriks et al. (2020) found a significant increase in the number of multi-component positive psychology interventions over the past few years. According to the synergistic change model, interventions targeting multiple domains of positive psychological and social functioning may decrease the risk of relapse and increase the likelihood of spill-over effects and synergy between the various activities (Rusk et al., 2018). This is supported by meta-analyses indicating that positive psychology interventions that incorporate multiple positive activities may be more effective than those implementing only one activity (Carr et al., 2021; Sin & Lyubomirsky, 2009). However, further research is necessary to better understand the specific elements essential for effective positive change in the context of trauma. It is also important to explore the interaction between different activities or techniques

to determine what works for whom and in which situations. Since most interventions included in this review comprised of relatively small, homogenous samples, future studies should include larger, more diverse samples and be conducted with various populations. Further, although most studies in this review utilised PPIs as a standalone approach, future studies may explore whether it is best suited as an independent approach or as an adjunct to other evidence-based trauma treatments.

Results from this review indicated that interventions were mostly conducted in group format, by a mental health practitioner at out-patient centres or clinics, and over the course of four to eight sessions. Literature confirms that guided positive psychology interventions, offered face-to-face in an individual or group format, are more effective than unguided self-help interventions in both clinical and non-clinical samples (Bolier et al., 2013; Carr et al., 2021; Chakhssi et al., 2018). This is particularly relevant in the context of trauma therapy where social cohesion and social support are highly valued components in the recovery process (Richins et al., 2020). Ellis et al. (2018) also suggested that trauma clinicians should consider the importance of building rapport, showing warmth, genuineness, and goal consensus in therapy as the therapeutic alliance was associated with a reduction in trauma-related distress among adults. This is echoed by our findings which identified the therapeutic relationship and experiencing a sense of togetherness between group members as essential healing factors in treatment. However, considering the rapid technological advancements and increased interest in online therapy, more studies are needed to investigate the application of positive psychological trauma interventions in this format. With regards to intervention duration, previous studies found that positive psychology interventions consisting of multiple sessions and of longer duration (more than eight weeks) are effective (Carr et al., 2021; Chakhssi et al., 2018; Sin & Lyubomirsky, 2009). According to Sin and Lyubomirsky (2009), longer durations gave participants an opportunity to convert the positive activities they learned into habits. However, for cancer patients, positive interventions with a shorter duration (less than eight weeks) appear more effective due to cancer-related challenges, such as fatigue (Tian et al., 2024). Studies should thus focus on determining the optimal intervention dose, including intervention duration and session length, to maximize the impact of therapy for trauma survivors.

Consistent with our review, a previous scoping review on community-level positive psychology interventions found that few interventions were participatory and collaborative in nature and that the expert model, where professionals taught or guided structured programmes, was mainly retained (Montiel et al., 2021). This is concerning, given the rising incidence of trauma and the shortage of trained, specialised mental health workers in many developing countries. Task-shifting, which involves training non-specialist health professionals to administer mental health treatments, may not only expand access to mental healthcare services in low- and middle-income countries, but may also embrace the diverse needs of the population (Rathod et al., 2017). However, it is of critical importance that non-specialist health professionals receive the necessary training, support, and supervision to ensure that treatment is delivered in an ethical, culturally sensitive, and efficient manner. Given the nuanced professional skills required to work with individuals exposed to trauma, it is recommended that these initiatives be implemented only following an assessment of their suitability and appropriateness, and within a broader healthcare system (Le et al., 2022; Mbouamba et al., 2023). Furthermore, our findings highlighted the importance of considering the needs of participants, as Müller-Engelmann et al. (2017) recommended that interventions should be better adapted to the needs of PTSD patients. Future research is therefore essential to determine the feasibility and acceptability of PPIs in the context of trauma. It may also be valuable to explore interventions that utilise task-shifting as an

implementation approach in resource-constrained contexts. Qualitative studies, in particular, may shed light on these aspects.

The studies included in this review suggested that PPIs may be useful in decreasing trauma-related psychopathology, including PTSD, depression, and anxiety, as well as promoting various forms of wellbeing following trauma exposure. This is supported by previous meta-analyses which found that PPIs improved wellbeing and reduced distress for both clinical and non-clinical samples (Carr et al., 2021; Chakhssi et al., 2018; Sin & Lyubomirsky, 2009) as well as for patients with cancer (Tian et al., 2024). Further systematic reviews and meta-analyses are thus needed to rigorously assess the effectiveness of PPIs in the context of trauma. Although some interventions (e.g. Kimbrough et al., 2009) included in our review showed positive long-term clinical outcomes, more longitudinal studies are needed to investigate the long-term impact of these interventions. A few studies (e.g. Ahmadi et al., 2022) also found more favourable outcomes for PPIs, compared to other treatments, suggesting that randomised controlled trials should be conducted to compare these interventions with existing evidence-based practices for PTSD and trauma.

Although studies in this review showed some consensus with regards to the specific aspects of trauma-related distress that was targeted and measured, this was not the case for wellbeing as various conceptualisations and components of wellbeing were included and measured. In some cases, interventions also did not provide a clear theoretical alignment between the aim, the activities and the outcomes measured. Montiel et al. (2021) made a similar observation regarding community-level positive psychology interventions as they found a lack of cohesion and reasoning behind activities implemented and target outcomes measured. Various authors have criticised positive psychology for having little or no consensus as to what constitutes wellbeing and how it should be measured (Cooke et al., 2016; Ryff, 2022; van Zyl & Rothmann, 2022). Unfortunately, the inconsistent use of terminology and definitions may create confusion among researchers, clinicians, and policy makers who investigate mental health and wellbeing. Further research is therefore needed to clarify the definition, components and measurement of wellbeing and researchers are urged to explicitly describe the theoretical framework that inform interventions. Despite these challenges, we found that participants reported satisfaction with the interventions and that many completed the programmes. This is particularly promising considering the fact that traditional trauma interventions have been judged for being time-consuming and having high drop-out rates (Cusack et al., 2016; Paintain & Cassidy, 2018).

To our knowledge, this scoping review is the first to provide an overview of studies conducted on the application of PPIs in the context of trauma. Our findings indicate that various PPIs have been implemented in different trauma contexts and formats. Although these interventions appear to be useful in decreasing trauma-related psychopathology and promoting wellbeing in the aftermath of trauma, further research is needed to clarify what works for whom and in which contexts. This is particularly relevant given that individuals exposed to different forms and severities of trauma may present with varied clinical profiles and respond markedly differently to treatment (Hogg et al., 2023; Volgenau et al., 2023). It could be fruitful to conduct meta-analyses of PPIs in the context of trauma, and specifically examine trauma type and severity as potential moderators. This may ultimately inform the development and implementation of effective and contextually relevant interventions. Despite the contribution of this study, we acknowledge some limitations. First, limited studies have been conducted on the application of PPIs in the context of trauma and those available show substantial heterogeneity with regard to samples studied, interventions used, and the type and severity of trauma that was addressed which may have influenced the conclusions drawn from this review. Second, our review only included studies that were published in English and were available in full-text, indicating both

publication and language bias. Relevant interventions may thus have been omitted from this review. Third, due to the varied definitions of positive psychology interventions, some studies which used PPIs, but did not frame it as such, may have been excluded. Likewise, studies conducted in the context of trauma but not explicitly described as focusing on psychological trauma or PTSD may have been overlooked. Fourth, wellbeing was considered according to the terminology used in the studies reviewed. However, taking into account the inconsistency regarding the conceptualisation and measurement of wellbeing, descriptions should be interpreted with discretion. Finally, assessment of research quality was not included in this review, and poorly conducted research may have influenced the results. Nevertheless, we employed a rigorous and scientific methodology which supports the validity of the findings.

5. Conclusion

This scoping review indicated that various PPIs have been implemented with people exposed to different forms of trauma and experiencing trauma-related distress. Most interventions focused on enhancing positive emotions, thoughts, experiences, relationships and resources, developing character strengths, or fostering mindfulness and incorporated various positive psychological activities and techniques. Interventions were mostly conducted in group format, by a mental health practitioner at out-patient centres or clinics, over the course of four to eight sessions. Studies included in this review suggested that PPIs may be useful in decreasing trauma-related psychopathology and promoting wellbeing in the aftermath of trauma. However, further research is needed to investigate the effectiveness, acceptability and feasibility of positive psychological trauma interventions in order to optimise the application thereof in diverse populations. Future studies may also strive towards finding consistency regarding the conceptualisation and measurement of wellbeing.

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Author contribution statement

JJvA was responsible for the conceptualisation, study design, and data collection. TG assisted JJvA with data analysis and both authors contributed towards writing and reviewing the manuscript.

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This study is a scoping review of published literature. All data analysed during this study are included in the published articles cited in the reference list.

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