Chapter 26
Integrating Positive Psychology, Religion/Spirituality, and a Virtue Focus Within Culturally Responsive Mental Healthcare

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In his groundbreaking book *Authentic Happiness*, Martin Seligman (2002) bemoaned: "Rely[ing] on shortcuts to happiness, joy, rapture, comfort, and ecstasy, rather than [achieving] these feelings by the exercise of personal strengths and virtues, leads to legions of people who in the middle of great wealth are starving spiritually" (p. 8). Recognizing this possibility, positive psychologists and psychologists of religion/spirituality have explored what constitutes and contributes to the good life—which often is referred to as human flourishing (VanderWeele et al., 2019). But what makes life *good*, and who decides what is good? What if one person's pursuit of flourishing brings harm to another? And how do these concerns intersect with the realities of suffering and inequity? Such questions have important implications for mental healthcare in a diverse world (Sue et al., 2019). Drawing on systemic and intercultural sensibilities, this chapter explores some of the complexities and dilemmas inherent in integrating the contributions of positive psychology,

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religion/spirituality, and virtue. To begin, we give an overview of key definitions and orient readers to our dialectical, developmental framework. Next, we synthesize the evidence for psychological interventions that integrate these domains. Third, we offer recommendations for an integrated line of research and practice, emphasizing the need for emic approaches that promote culturally responsive care. Finally, we discuss innovative clinical and community applications, suggesting that helping people and systems grow in the virtues salient within their cultural and spiritual context can promote flourishing.

Getting Oriented: Definitions and Conceptual Framework

We understand *mental health* to exist on a continuum, ranging from *illness* (e.g., high symptoms, low well-being) to *languishing* (e.g., low symptoms, low well-being) to *health/flourishing* (e.g., low symptoms, high well-being; Keyes, 2002). Flourishing involves not only the amelioration of symptoms but also the presence of well-being—an umbrella term broadly including "all different forms of evaluating one's life or emotional experience, such as satisfaction, positive affect, and low negative affect" (Diener et al., 2017, p. 87). Although there are many subclassifications of well-being, here we highlight two broad categories: (a) *hedonic well-being* focuses on personal pleasure and enjoyment (e.g., feeling good), whereas (b) *eudaimonic well-being* more broadly emphasizes relational maturity, meaningful life purpose, and communal concerns (e.g., pursuing good). Taken together, holistic flourishing is a multidimensional, developmental process that integrates hedonic and eudaimonic well-being with personal beliefs, values, and cultural contexts (Jankowski et al., 2020; Lambert et al., 2015).

Shifting from a deficit-based, symptom-alleviating medical model to a more holistic, capacity-building framework respects the complexity of human experience and is resonant with core tenets of many religious/spiritual (R/S) traditions. We utilize a pluralistic definition of R/S that includes *Spiritual, Existential, Religious*, and *Theological* dimensions of human experience (SERT; Sandage et al., 2020), partly in response to the growing number of people who identify as multireligious (i.e., interweaving aspects of multiple traditions), spiritual but not religious, or as neither spiritual nor religious. Even among this latter group, existential themes (e.g., death, loss, meaning) are often relevant. Thus, we consider whatever a person views as ultimately most important, whether that be a divine being and/or other spiritual entities, cherished principles and values, or other ultimate concerns. This framework opens broad conceptual space to consider both the salutary and harmful ways people relate to whatever they consider sacred or ultimate.

Our engagement with positive psychology draws significantly on critical and intercultural lenses, often termed *positive psychology 2.0* (Chang et al., 2016; Wong, 2011). Positive psychology 2.0 calls for attention to eudaimonic well-being (e.g., cultivating virtue and meaning) as well as contextual (e.g., culture, religious) and systemic (e.g., oppression, empowerment) factors. Although positive psychology's

historically etic approach has brought scientific rigor to researching human strengths, it is risky to decontextualize these constructs from their sociocultural situatedness. The resulting expectation can be that positive psychology constructs are universally positive and promote well-being irrespective of race, ethnicity, gender, social location, and other factors. However, a one-size-fits-all approach can be problematic. For example, R/S people often understand strengths in light of their R/S worldview and utilize embedded R/S practices that are not always acculturated to psychological language. In addition, for people with less privilege, strengths often intersect with minority stress and structural oppression, such that there are some cases where a particular virtue could appear counter to flourishing (e.g., gratitude and humility may seem like colluding with oppression). Positive psychology 2.0 attends to these nuances.

Throughout this chapter, we integrate *virtue ethics*—a framework rooted in Aristotelian philosophy and expanded upon by Confucius, Maimonides, Aquinas, Al-Ijī, and other diverse traditions (MacIntyre, 2007)—to contextualize positive psychology within each person's culture, worldview, and presenting concerns. A core premise of virtue ethics is that flourishing cannot be achieved solely through symptom reduction but rather is inextricably connected with virtue development. *Virtues* refer to "qualities of human character and excellence which enhance the capacity to live well" (Sandage & Hill, 2001, p. 243); put differently, virtues are "morally based [thoughts, feelings, and] actions that enable an individual and his or her social world to thrive" (Lerner, 2019, p. 79). The developmental language of virtue orients people to reflect on who they *are* and *are becoming* in relation to others (McMinn et al., 2016). Virtues are often motivated by personal beliefs, values, and goals, so understanding a person's SERT context is vital. Virtue ethics prioritizes practical wisdom as a meta-virtue to navigate (a) particularities of *when* to draw on which virtue and (b) the complexity of considering multiple virtues *in tandem*. For example, navigating conflicts may require self-control, honesty, and forgiveness, and doing antiracist work often necessitates justice, courage, and creativity. Dose and behavioral manifestation of each virtue may vary based on identity characteristics, R/S worldview, and the present moment.

What We Know: Synthesizing the Empirical Evidence

We searched seven major electronic databases to identify meta-analyses comparing (a) interventions integrating religion/spirituality, positive psychology, and/or virtues with (b) either an alternative active treatment condition or a no-treatment control. For the purposes of this review, *intervention* includes psychotherapy and other mental health supports (e.g., self-help programs). To maintain a reasonable scope, we did not include meta-analyses of spiritual direction or ministry, which tend to be more loosely defined. Our use of the term *integrated* specifies drawing substantively on the contributions of religion/spirituality, positive psychology, or virtue, which have been defined in detail above. Reviewing results available in English as of May

1, 2021, we identified 36 meta-analyses. Below we summarize our findings in three domains: (a) spiritually integrated interventions, (b) positive psychology interventions, and (c) virtue-based interventions. See Appendix 26.S1 (Tables 26.S1, 26.S2, and 26.S3) for more detail.

Spiritually Integrated Interventions

Integrating clients' spirituality is an important aspect of evidence-based practice, described as a three-legged stool synthesizing (a) research evidence with (b) clinical expertise and (c) clients' values, preferences, and contexts (Shafranske, 2013). Spiritually integrated interventions (SIIs) can be conducted in "virtually any psychotherapeutic tradition—psychodynamic, cognitive behavioral, family systems, humanistic, and existential" (Pargament et al., 2005, p. 161). Currently, the largest efficacy base is in cognitive behavioral approaches adapted by religion, including Christian, Muslim, Jewish, Hindu, and Buddhist contexts (Abu Raiya & Pargament, 2010; Koenig et al., 2015; Milevsky & Eisenberg, 2012); however, there also are more pluralistic approaches that incorporate whatever a person considers sacred (Koszycki et al., 2014; Rosmarin et al., 2019). Furthermore, models have been developed to address comorbid distress, such as body–mind–spirit interventions for physical and mental illness (McGrady & Moss, 2018) and meaning-centered therapy for end of life (Thomas et al., 2014).

Our review identified seven meta-analyses examining the efficacy of SIIs (see Table 26.S1). Broadly speaking, the existing evidence suggests SIIs are effective in ameliorating mental health symptoms to a modest or moderate degree, especially when people "learn to apply their own religious/spiritual beliefs to their mental health" (Smith et al., 2007, p. 653). SIIs are particularly effective in improving R/S well-being, such as increasing R/S believers' sense of meaning and the quality of their relationship with whatever they view as sacred. However, much remains unclear about the conditions and mechanisms that make SIIs effective (or ineffective) in routine clinical practice. Although most research has focused on explicit integration, including helping clients draw on personally salient practices (e.g., prayer, meditation, sacred scriptures, time in nature), implicit integration may also occur, as a client internalizes their therapist's attuned, responsive presence, resulting in positive changes in the person's relational schemas of the divine (e.g., experiencing a higher power as present and responsive, rather than distant and harsh). Research is needed to explicate how clients' SERT concerns may intersect with other aspects of their identity and culture, as well as how SERT concerns may lead to vulnerabilities or harm when R/S beliefs or practices are used defensively. For instance, *spiritual bypass* (i.e., "the use of spiritual practices and beliefs as a way of avoiding dealing with unresolved psychological issues" (Picciotto & Fox, 2018, p. 65) could be a barrier to virtue development. Thus, it is vital for clinicians to consider how religion/spirituality can both facilitate *and* hinder flourishing.

Positive Psychology Interventions

Positive psychology interventions (PPIs) have emerged in response to growing evidence that the medical model, which focuses on symptom reduction, often falls short of promoting flourishing. PPIs focus broadly on enhancing well-being and attend particularly to the experience of languishing ("emptiness and stagnation, constituting a life of quiet despair," Keyes, 2002, p. 210), through fostering positive states (e.g., emotions, cognitions, behaviors) using evidence-based pathways (e.g., savoring, meaning, strengths). PPIs can be used as stand-alone (e.g., self-help) interventions in nonclinical settings, as adjuncts to mental health treatment (e.g., assigned for use between sessions) or as components integrated in individual or group therapies. Distinct therapeutic approaches have been developed using a PPI lens, such as well-being (Fava et al., 2005) and positive (Seligman et al., 2006) psychotherapies. Contemporary non-PPI treatments have also begun to prioritize a well-being focus, including acceptance and commitment therapy (Trompetter et al., 2017) and mindfulness-based interventions (Weiss et al., 2016).

Our review identified 12 meta-analyses examining the efficacy of PPIs (see Table 26.S2). High-quality studies consistently support the use of PPIs to foster hedonic and eudaimonic well-being to a modest or moderate degree, but the evidence is less clear when it comes to reducing symptoms (e.g., anxiety, depression). Divergent findings between symptoms and well-being substantiate the need to conceptualize mental health as a continuum (i.e., not a category) that has related but distinct dimensions. Overall, PPIs appear more efficacious over longer periods of time (rather than as brief interventions) and in the context of psychotherapy (compared with self-help programs). PPIs may have differing relevance to people, based on clients' presenting concerns and level of distress. In mental healthcare, there is evidence for multiple change trajectories (Stulz & Lutz, 2007). For some clients, attention to strengths early in treatment supports agency and instills hope. For other clients, especially when their distress is overwhelming, focusing on symptom management and reduction may be most helpful before trying to enhance well-being. Future research can help clarify which PPI ingredients carry the weight of change in symptoms and well-being, for which populations, at which points in time.

Virtue-Based Interventions

Although PPIs focus on increasing well-being, virtue-based interventions (VBIs) are guided by a specific developmental telos, which may or may not be explicitly framed using a SERT lens. VBIs explicitly target the development of virtues, based on emerging evidence that growth in virtues promotes positive mental health and flourishing. Virtue development is thought to interact with other mechanisms of change (e.g., positive affect, intrinsic motivation, prosocial behavior), fostering self-reinforcing upward spirals of engagement, agency, and meaning that catalyze

well-being (Rusk et al., 2018). As Jankowski et al. (2020) have elaborated, "Virtues as change mechanisms consist of repeated *acts* of virtuousness *and* growing levels of *dispositional virtuousness* over time" (p. 296). This perspective resonates with the ancient wisdom of all five major R/S traditions, each of which emphasize personal growth and transformation as central to flourishing. To date, VBIs fostering forgiveness, gratitude, and self-compassion have been studied most frequently, with growing research on hope, kindness, and empathy. VBIs can be implemented as stand-alone (self-help) interventions in nonclinical settings, as a virtue focus integrated into psychotherapy, or as a virtue-specific therapeutic model. For example, loving-kindness meditation can be used as a personal practice or can be integrated in treatment (Galante et al., 2014), and the REACH Forgiveness model has similarly been utilized both for self-help and in therapy, with greater gains found when SERT context was integrated (Wade et al., 2014). Distinct virtue-based therapeutic approaches have also been developed, including compassion-focused psychotherapy (Gilbert, 2014) and hope-focused couples therapy (Worthington, 2013).

Our review identified 17 meta-analyses examining the efficacy of VBIs (see Table 26.S3). Despite emerging support both for increased well-being and for symptom reduction, the evidence is less well-established for VBIs than for SIIs or PPIs. VBIs have most often been (a) compared to a no-treatment controls, (b) tested in nonclinical (e.g., college student) samples, and (c) limited by short duration. However, the available evidence suggests that context and dosage are important. VBIs may be more readily integrated with students and community members (compared to clinical/psychiatric populations), and longer interventions appear to facilitate greater gains. One limitation to date has been interventional focus on a single virtue, when, in daily life, virtues likely interact with one other to promote well-being. For example, highly R/S people often embrace numerous interlocking virtues, so separating the effects of a single virtue is fraught. Exploration of underlying change mechanisms is needed in real-world clinical settings, where chronic distress is often intertwined with "significant struggles in… unforgiveness, hopelessness, envy, and/or self-criticalness" (Jankowski et al., 2020, p. 301). Ongoing empirical work can help explicate the nuances of *how* and *in what ways* a focus on virtue may promote flourishing.

What's Next?: Advancing Integrative, Culturally Responsive Research

Readers will notice some overlap in these three intervention areas. However, scant attention has been given to the development and implementation of positive psychology and virtue-based interventions that are *tailored to* and *situated within* specific SERT and cultural contexts. One exception is some Christian-focused interventions. To date, research has primarily (a) captured the experiences of majority populations who hold substantial societal privilege, relative to racial, ethnic,

R/S, sexual, and gender minorities; (b) focused on individual well-being, with less attention to couple, family, and systemic functioning; and (c) examined each virtue in isolation, without accounting for potential synergistic effects of multiple virtues acting and developing concurrently. Next, we discuss priorities for elucidating the interplay of positive psychology, religion/spirituality, and virtue in daily life, particularly among nonmajority groups.

Test Virtue–Flourishing Links, Considering Intervention Setting and Format

To advance the framework of virtue ethics, intervention studies need to continue testing the hypothesis that virtue development promotes flourishing. We also know very little about potential mediating and moderating factors, even though scholars theorize that relational and emotion regulation capacities may play influential roles (Jankowski et al., 2020). To date, most interventions have been developed and tested as short-term, psychoeducational protocols with college students. Moving the science forward will require testing virtue–flourishing links in a variety of settings, including individual, couple and family, and group therapies (within mental health treatment), as well as in systems-wide interventions, such as within schools, workplaces, and R/S communities. If scientists really want to understand how to help people, systems, and communities flourish, they must investigate a number of areas: What interventions are most effective, relevant, *and* feasible for promoting virtue development? How does this vary based on personal, cultural, and contextual factors? Which people benefit from which interventions? Some individuals and groups may be more interested in a broad well-being-focused intervention rather than one aimed at virtue development, whereas people for whom R/S is very important may prefer approaches that translate psychological science into theologically relevant terms.

Furthermore, based on these differences, what delivery format(s) might work best? For example, in some more collectivistic contexts, family and group interventions may be more salient and effective. Technologically delivered interventions may be more engaging and effective among teens and young adults. In populations not acculturated to Western models of mental health, interventions delivered within a culturally trusted institution (e.g., an educational setting, faith community, or other network with a history of trust and reliability) may increase accessibility and effectiveness. Research is also needed to explore the impact of the *person* or *people* facilitating the interventions, whether that be a psychotherapist, R/S leader, teacher, or someone else in the community. There could be potential differences in effectiveness depending on the intervention's orientation toward collaboration and interaction (ranging from very structured/didactic to experiential/cocreated). Relatedly, it is likely that people who seek out an intervention may more invested—and thus

experience greater gains in flourishing—compared to people for whom intervention participation is expected (e.g., to meet educational requirements).

Attend to the Complexities of Real-World Clinical Practice

One limitation of efficacy research is the gap between well-controlled trials and real-world practice, where (a) people often present with comorbid diagnoses (and hence are excluded from efficacy studies) and (b) therapists frequently integrate multiple treatment approaches and modalities to address clients' needs. Despite the evidence reviewed above, there has been a significant lag in dissemination to mainstream mental healthcare. This dearth is vital to address. Both etic and emic studies are needed to investigate generalizable patterns (*and* exceptions to those patterns) unique to particular persons and contexts. For example, although we know that attending to spirituality, well-being, and virtues in treatment is generally helpful, much remains unclear about the conditions and mechanisms of change that make these interventions effective (or ineffective) in day-to-day practice. What are the choice points between implicit and explicit integration of these domains in treatment? For which people? At what points in therapy? And what role might the therapist's embodiment of virtue play (i.e., are virtues *taught* or *caught*)?

Although few clients present to therapy with a primary goal of increasing virtue, many describe wanting to better manage emotions and navigate relationships, and evidence suggests that virtues such as humility, gratitude, and forgiveness are associated with affect regulation and secure attachment (Dwiwardani et al., 2014). Interweaving a virtue and well-being focus—contextualized to a client's SERT context—within clinical formulation and treatment has significant potential, but it is much more difficult to study and thus is less empirically developed. As one example, a recent practice-based study found that clients in psychodynamic therapy evidenced growth in humility, which predicted changes both in symptoms and well-being (Jankowski et al., 2021). For some clients, virtues may be a relevant explicit focus (e.g., integrating the REACH Forgiveness model into therapy); for others, virtues may emerge within the treatment process (e.g., the therapist embodies humility amidst an alliance rupture). In the former situation, cognitive and behavioral foci may facilitate virtue development, whereas in the latter, virtues may be internalized via emotional and relational processes of therapeutic action (Schore, 2014). In real-world practice, treatment responsiveness may matter more than fidelity to a particular intervention (Norcross & Wampold, 2018). To the extent that is true, research is needed that (a) tracks facilitators and hindrances of dissemination and effectiveness, (b) incorporates longitudinal and mixed-method practice-based research designs, (c) uses person-centered analyses to identify subgroups that respond well (vs. poorly) to treatment, and (d) explicates conditions for and mechanisms of change in symptoms and well-being.

Critically Consider Diversity, Equity, and Justice

Expanding positive psychology beyond a Eurocentric perspective requires grappling with how virtue and well-being constructs intersect with structural inequality, minority stress, and intersectionality. Most existing models and self-report measures (e.g., of optimism, gratitude, hope) center the experiences of White individuals from a higher socioeconomic status and education level (Paquin et al., 2019). However, these constructs "are necessarily embedded in a cultural context" (Sandage et al., 2003, p. 571). The diverse ways that virtues are understood, valued, and embodied can vary significantly, often based on the intersections of a person's culture, R/S beliefs, and social location, to name just a few areas. Therefore, flourishing needs to be investigated with increased (a) attention to diverse cultural and SERT understandings and (b) consideration of systemic and sociocultural factors that impact disparities in flourishing. Holistic and communal forms of well-being more closely align with the cultural worldviews and values of many clients, rather than the medical model's focus on symptom alleviation (which dominates healthcare in Europe and the United States). Research is needed that (a) examines pathways to flourishing for all people, not just dominant group members, and (b) interrogates organizational dynamics that perpetuate prejudice and inequities in mental healthcare (Paquin et al., 2019).

The interplay between eudaimonic and hedonic well-being holds important implications in the face of injustice, as Seligman (2002) has noted: "People who are impoverished, depressed, or suicidal care about much more than just the relief of their suffering. These people care—sometimes desperately—about virtue, about purpose, about integrity, and about meaning" (p. xi). It is vital to explore how chronic oppression may tax people's resilience and compromise their expression of virtues. As one example, scholars have begun to explicate the concept of *burdened virtues*, capturing how inequitable societal conditions often necessitate oppressed groups developing "a set of virtues that carry a moral cost to those who practice them" (i.e., they support survival but not flourishing; Tessman, 2005, p. 1). We invite researchers to consider ways to (a) privilege the narratives of individuals who have been historically oppressed and systemically affected by poverty, racism, and sexism; (b) use community action research designs to engage these populations in every stage of scholarly work, from theory building and measurement to intervention design and implementation; and (c) integrate clients' culturally embedded strengths and SERT perspectives about human suffering and well-being into psychotherapy approaches.

Elucidate Problematic Applications such as Virtue Bypass

Positive psychology has historically focused on increasing positively valenced emotions, which can perpetuate the myth that enhancing positive aspects of one's life will resolve—or prevent—distress. This does not translate well into real-world clinical practice, where clients often present with long-standing suffering. Failing to acknowledge and process life's hardships can produce toxic positivity, "the excessive and ineffective overgeneralization of a happy, optimistic state across all situations" that "results in the denial, minimization, and invalidation of the authentic human emotional experience" (Quintero & Long, 2019, para. 4). In contrast, attending to negatively valenced affect—what Lomas (2018, 2019) has called the virtues of anger and sadness—can enhance adaptation and well-being over time. Affective neuroscience research elucidates the adaptive evolutionary functions of rage, fear, and sadness (Panksepp & Biven, 2012), a keen reminder that *all* emotions lend important insight into our desires and needs and thereby can help motivate action. Although the dichotomies of *positive* and *negative* are useful in research, a dialectical perspective is often more salient, valid, and useful in practice. Rather than viewing positive affect and virtue behaviors as universally beneficial, we need to explore the specific *function* in light of each person's intrapersonal dynamics and social location.

We propose the term *virtue bypass* to describe when virtue language or behaviors are used in ways that undermine or are counter to flourishing, such as to (a) oppress and subjugate others or (b) repress and deny one's own emotions and needs. Consider a sexual abuse survivor whose faith community urges them to forgive as an extension of divine grace. This person may rush to verbalize forgiveness as a trauma response that restores equilibrium, bypassing the virtue of justice and related emotions of rage and mourning. Evidence-based practice here must synthesize positive psychology contributions with evidence that "an optimistic bias can put victims in danger" and in some cases "forgiveness [can] increase likelihood of further transgressions" (Sinclair et al., 2020, p. 26). Or consider a teen who courageously shares pent-up hurt with their parents, only to have their parents snap back, "Stop being dramatic and show some gratitude for all we've done for you!" Here, emotional invalidation is being dressed up in the clothing of virtue, and attending to this parent–child relational dynamic is vital for systemic well-being. Helping the family stay with and process difficult emotions together may foster greater understanding, trust, and connection—from which gratitude could emerge bidirectionally. Taken together, a virtue ethics perspective orients us toward practical wisdom and contextual sensitivity, so we can discern whether virtue language is emerging out of authentic struggle with and acceptance of reality, or it is being used to avoid or contort reality. Intervention frameworks are needed that account for this complexity.

In Real Life: Implementation in Clinical and Community Settings

In mental healthcare systems, clinical decision-making is often guided by attention to disorders, dysfunction, and deficits, which can reduce people to their diagnosis. In one woman's words, "When all you ask about is my symptoms, it feels like nothing else about me is real!" Positive psychology offers critical contributions to a holistic view of flourishing by orienting clinicians toward each client's and family's strengths and adaptive capacities. Yet, integration in routine practice has been stymied by a primary focus in positive psychology on the individual, forgetting that "the conditions in the environments where people are born, live, learn, work, play, worship, and age affect a wide range of health, functioning, and quality-of-life outcomes and risks" (U.S. Department of Health & Human Services, 2021, para. 1). Thus, we offer practical recommendations for psychotherapists, spiritual care providers, and others in helping roles.

First, maintain a dialectical, contextual perspective, recognizing that without cultural humility (Hook et al., 2017), we can miss important aspects of people's lived experience and can enact colonizing and oppressive dynamics. Determining which intervention setting and format is most appropriate for a particular person is an iterative, collaborative process. Be mindful of power dynamics and the ethical problems that are embedded in authoritatively communicating—even as part of psychoeducation—that X, Y, and Z virtues *will* promote clients' well-being. A majority of positive psychology research has been conducted with college students, many of whom are White and hold social privilege; thus, findings cannot necessarily be generalized to nonmajority and clinical populations. We can reshift the center beyond Eurocentrism not only in the lab but also in real-world care settings, by using empirical literature as a jumping-off point to spark curiosity and joint exploration about embedded cultural strengths and SERT resources that can promote flourishing *for the person in front of us*. Norcross and Wampold (2018) have captured this complexity in describing the need to cocreate "a new therapy for each patient" (p. 1889). This is different from assuming that virtue growth in a particular area *should* be the interventional focus. Thus, SIIs, PPIs, and VBIs are best understood as clinical resources to guide treatment, rather than scientifically proven parameters to be implemented unquestioningly.

Second, reflect on how your work fits into the continuum of catalyzing flourishing at both individual and communal levels. Virtues have intrapersonal and systemic impacts, and this influence flows both ways. Psychotherapy is only one of multiple potential interventional contexts, and people stand to benefit from a well-being focus within their workplaces, schools, and faith communities. One innovative way to disseminate psychological science is through adapting these interventions to faith and/or learning communities' needs (Wang et al., Chap. 29, this volume). Considering R/S communities as intervention sites, Bufford et al. (2018) collaborated with Christian church leaders to develop and test a grace-focused intervention (e.g., sermon series and small group program), and participants reported growth in

grace and self-forgiveness. Targeting a broader systemic context, Griffin et al. (2019) developed a university-wide forgiveness initiative, including active (e.g., lectures, movie nights) and passive (e.g., social media) components, resulting in student-reported growth in forgiveness. Community-based interventions may have particular salience following mass traumas (e.g., natural disasters, school shootings) and in meaningfully addressing the impacts of intergenerational trauma. For example, African American communities are historically organized around the local church—"the oldest and most resilient social institution in Black America…[and] traditionally the only Black-controlled institution of a historically oppressed people" (Putnam, 2000, p. 68). Religious institutions and community leaders are often looked to for guidance amidst turmoil and uncertainty, so they are uniquely positioned to support positive adaptation (Captari et al., 2019).

Finally, consider pluralistic and intercultural applications relevant to our diverse, global society. People increasingly draw on ideas and practices from multiple traditions, as they differentiate and redefine a new spiritual path across their life (Ammerman, 2020). Hence, approaches adapted to specific religions are inadequate to meet many people's needs. At the same time, it is questionable "whether positive psychology interventions can ever be characterized as purely secular" (Rye et al., 2013, p. 503), as perspectives about a particular virtue are shaped by family and community SERT influences. Without assuming *what's good for me is good for you*, virtue ethics provides a shared language for engaging in meaningful dialogue about the relevance of positive psychology across cultural and worldview differences. For example, recognizing how the COVID-19 pandemic has disproportionately impacted racial and ethnic minorities, expressing anger and grief about the impacts of systemic racism could be more positive (e.g., creative, generative, and healing) than a focus on optimism or gratitude—and it is not up to us to dictate this. By letting clients lead us toward positive psychology resources embedded in their SERT framework, implementation science can advance at a grassroots level.

Conclusions

Positive psychology, religion/spirituality, and virtues each offer a unique lens that can help promote culturally responsive mental healthcare. In this chapter, we have applied virtue ethics to facilitate a rapprochement between these literatures, situating positive psychology within the broader landscape of each person's sociocultural and SERT context. We have synthesized the evidence base for spiritually integrated, positive psychological, and virtue-based interventions to guide readers in utilizing these approaches in their work. These interventions are applicable to clinical practice, R/S and learning communities, and other applied settings (workplaces, humanitarian aid, etc.). Attending to an individual's struggles and strengths in light of (a) personal beliefs, values, and goals as well as (b) systemic and sociocultural processes helps us avoid the pitfalls of both the medical model and a one-size-fits-all approach. Whether you find yourself in a therapy room, classroom, religious

community, or boardroom, consider creative ways to incorporate the strengths and resources of these domains to help people pursue the good life "through meeting suffering head on and transforming it into opportunities for meaning, wisdom, and growth" (Emmons, 2003, p. 156). Together, we can create more compassionate, just, and empowering communities that promote flourishing for all.

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