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Positive Clinical Psychology: A new vision and strategy for integrated research and practice

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ABSTRACT

This review argues for the development of a Positive Clinical Psychology, which has an integrated and equally weighted focus on both positive and negative functioning in all areas of research and practice. Positive characteristics (such as gratitude, flexibility, and positive emotions) can uniquely predict disorder beyond the predictive power of the presence of negative characteristics, and buffer the impact of negative life events, potentially preventing the development of disorder. Increased study of these characteristics can rapidly expand the knowledge base of clinical psychology and utilize the promising new interventions to treat disorder through promoting the positive. Further, positive and negative characteristics cannot logically be studied or changed in isolation as (a) they interact to predict clinical outcomes, (b) characteristics are neither "positive" or "negative", with outcomes depending on specific situation and concomitant goals and motivations, and (c) positive and negative well-being often exist on the same continuum. Responding to criticisms of the Positive Psychology movement, we do not suggest the study of positive functioning as a separate field of clinical psychology, but rather that clinical psychology itself changes to become a more integrative discipline. An agenda for research and practice is proposed including reconceptualizing well-being, forming stronger collaborations with allied disciplines, rigorously evaluating the new positive interventions, and considering a role for clinical psychologists in promoting well-being as well as treating distress.

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1. Introduction

We suggest the development of a Positive Clinical Psychology in which the understanding and treatment of clinical levels of distress is based on a balanced and equally weighted focus on the positive and negative aspect of life. We argue that a focus on the positive must equally compliment a focus on the negative in clinical psychology because positive characteristics (a) can predict disorder above and beyond the predictive power of the presence of negative characteristics, (b) buffer the impact of negative life events on distress, potentially preventing the development of disorder, (c) can be promoted in non-clinical populations to promote resilience, (d) can be fostered to treat clinical disorder, (e) offer opportunity for clinical psychologists to use their unique skills in new domains of life, and (f) have the potential to rapidly expand the knowledge base of clinical psychology.

We draw a distinction between previous positive psychology *research* (which has huge implications for understanding distress) and the now decade old positive psychology *movement* (Seligman & Csikszentmihalyi, 2000) (which has separatist implications and has attracted criticism). We suggest that positive psychology research can best impact on the scientific knowledge base of psychology, and be utilized to improve people's lives, if it avoids becoming embroiled in a movement and rather becomes fully integrated with the daily research and practice of mainstream disciplines (so that positive functioning is included alongside negative functioning in research designs, and increasing the positive is as important a focus of therapy as decreasing the negative). Clinical psychology is uniquely positioned to both take advantage of this integration (thorough improved understanding of disorder and the use novel treatments), and to become a vehicle through which positive psychology research can contribute to psychological science and practice. Clinical psychology contains the infrastructure that the positive psychology movement lacked, and can achieve an integrated focus on both the positive and the negative in a way that the positive psychology movement could not, due to an exclusive focus on the positive. The positive psychology movement has made a great contribution to psychology through increasing the focus on the positive (see Linley, Joseph, Harrington, & Wood, 2006). However, if the impact is to last, a second wave of research and practice is needed which addresses the criticisms leveled at the movement. Clinical Psychology is ideally placed to implement this second wave and we suggest a distinct agenda through which this can happen. To clarify what is meant by Positive Clinical Psychology; we do not in any way suggest that positive characteristics are emphasized over negative ones, or that a focus on the negative is removed. Quite the converse, we suggest that the field fully integrates the study and fostering of positive and negative characteristics equally; the positivity comes from developing a better and more integrated field rather than narrowly focusing on only one domain of life. This mirrors clinical practice in which new positive behavioral repertoires are created to displace behavior and affect associated with psychopathology.

In making this call we draw on the excellent contributions to this special issue, which have highlighted the relevance to clinical psychology of positive emotions (Garland et al., 2010-this issue), positive affect (Watson & Naragon-Gainey, 2010-this issue), psychological flexibility (Kashdan & Rottenberg, 2010-this issue), optimism (Carver, Scheier, & Segerstrom, 2010-this issue), and gratitude (Joseph & Wood, 2010-this issue), as well as how positive functioning can be conceptualized, measured, and assessed (Joseph & Wood, 2010-this issue). Such research is at the forefront of the study of positive functioning and clinical distress and offers a sound bedrock from on which Positive Clinical Psychology can stand.

2. Benefits of a Positive Clinical Psychology

We argue there are five key benefits of a Positive Clinical Psychology. First, this would involve a more balanced research field, with a more thorough understanding of clinical disorder and distress. Second, the field would be better able to predict, explain, and conceptualize disorder. The absence of positive characteristics has been shown to be a robust risk factor for distress (Wood & Joseph, 2010a), with longitudinal evidence suggesting this relationship may be causal (Brissette, Scheier, & Carver, 2002; Wood, Maltby, Gillett, Linley, & Joseph, 2008). Further, the absence of positive characteristics forms an *independent* risk factor for understanding well-being and distress, after controlling for the presence of negative characteristics (Wood, Joseph, & Maltby, 2008, 2009). Third, a Positive Clinical Psychology would be better able to better understand the concept of resilience to disorder; people high on positive characteristics are be buffered from the impact of negative life event and characteristics on clinical distress (Johnson, Gooding, Wood, & Tarrier, 2010; Johnson et al., 2010). As positive and negative characteristics interact in this way, not studying both together would provide a misleading picture of the etiology of distress and a miss-guided "one size fits all" approach. Forth, several techniques have been developed to foster positive characteristics and these have been shown to be useful in alleviating many forms of distress (Sin & Lyubomirsky, 2009). These techniques have the potential to add much to a clinical psychologist's repertoire of techniques, and may be uniquely beneficial in some situations (Seligman, Rashid, & Parks, 2006; Seligman, Steen, Park, & Peterson, 2005). Fifth, the largely uncharted territory of positive characteristics and clinical distress offers unique opportunities to rapidly expand the knowledge base of psychology without initially expending many resources (cf., Gable & Haidt, 2005).

2.1. A more balanced research field

Clinical psychology has traditionally attempted to understand and cure disorder through a focus on the negative aspects of life and how these can be reduced. For example, by reducing inappropriate behavior, eradicating elevated anxiety or reducing depressive cognition. This focus on the negative has led an unbalanced research field, with research studying the negative aspects of life without considering the role of the positive aspects (c.f., Duckworth, Steen, & Seligman, 2005; Maddux, Snyder, & Lopez, 2004). Whilst substantial attention had focused on how relationships help a person deal with occasional adversity (social support: Hogan, Linden, & Najarian, 2002), almost no attention has focused on how relationships help people capitalize on their successes (Gable, Reis, Impett, & Asher, 2004). Whilst a vast literature has focused on the clinical significance of loneliness (Heinrich & Gullone, 2006), much less research has focused on positive relationships or love (Levin, 2000). A large clinical focus continues into ridged cognitive processes such as worry and rumination (Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008), but there has yet to be an integrated focus on psychological flexibility (Kashdan & Rottenberg, 2010-this issue). Research into post-traumatic stress had attracted immense considerable clinical attention (e.g., Panagioti, Gooding, & Tarrier, 2009; Rosen & Lilienfeld, 2008), although less much attention has been paid to the positive meaning and benefit people can gain in overcoming their trauma (Joseph & Linley, 2006a). Considerable clinical attention has focused on anger (Howells & Day, 2003), but much less on forgiveness (Maltby et al., 2008). Huge literatures exist on depressive cognitions (Wisco, 2009), such as feeling defeated and trapped (Taylor et al., 2010; Taylor, Wood, Gooding, Johnson, & Tarrier, 2009), although almost no research had focused on appreciative and grateful outlooks (Wood, Froh, & Geraghty, 2010-this issue; Wood, Maltby, Stewart, & Joseph, 2008). Such examples illustrate the field of clinical psychology has focused disproportionately on the negative aspects of life when trying to predict and treat distress.

Previously it may have been argued that such positive topics are not within the remit of clinical psychology. However, as considered in detail below, given that such positive characteristics are causally

implicated in the development of disorder, and buffer the impact of life events on distress, the understanding of these topics now appears to be highly relevant to the clinical psychology mission. Further, no topic can be deemed as fundamentally "positive" or "negative" (cf., Joseph & Wood, 2010-this issue). Whilst high forgiveness, flexible thought processes, and positive relationships may seem positive, their opposite polls of inability to forgive, inflexible processes, and negative relationships appear to involve what is clearly dysfunctional. Positive and negative topics must be studied together as they are intimately linked and cannot be logically separated. Clinical psychologists also have unique knowledge and skills sets, placing the profession in an ideal position to contribute to these research lines and therapeutically increase positive well-being in addition to alleviating distress. Given these benefits the development of a more balanced research field in clinical psychology should be a high priority for the discipline.

2.2. Improved prediction of disorder

Studying positive functioning can substantially increase prediction and understanding of clinical disorder. Much of the reason why clinical psychologists have focused on negative characteristics, life events, and social interactions is because the aim of the field has fundamentally been about understanding distress. It is therefore ironic that some of the biggest predictors of distress do not involve the presence of negative characteristics, but rather involve the absence of positive characteristics—the absence of the aspects that make life worth living. For example, in a longitudinal study of 5500 people (Wood & Joseph, 2010a), people low on such characteristics as self-acceptance, autonomy, purpose in life, positive relationships with others, environmental mastery, and personal growth were up to seven times more likely to meet the cut-off for clinical depression 10 years later. Similarly, both optimism (Carver et al., 2010-this issue) and gratitude (Wood et al., 2010-this issue) lead to lower levels of stress and depression over time (Brissette et al., 2002; Wood, Maltby, Gillett et al., 2008). Note that in each of these cases positive characteristics have prospectively predicted psychological dysfunction; thus these characteristics are not simply correlated with distress, rather they appear to be causally implicated in the disorder's etiology.

Positive characteristics also appear to form an *independent* prospective risk factor for disorder. For example, Wood and Joseph (2010a) also tested whether the absence of positive characteristics could predict the onset of depression above the presence of various negative aspects of life including; (a) current and previous depression; (b) neuroticism; and (c) physical ill-health. After controlling for these negative characteristics, the people low on the positive characteristics were still at a doubled risk of developing depression. Controlling for neuroticism doesn't affect the prospective relationship between gratitude and depression (Wood, Maltby, Gillett et al., 2008). In schizophrenia it is the absence of a positive relationship with a case worker that predict later negative clinical outcome (Tattan & Tarrier, 2000) and it is high negative self-evaluation that mediates the effects of relative's expressed emotion on positive psychotic symptoms, whereas low positive self-evaluation is independently associated with negative psychotic symptoms (Barrowclough et al., 2003).

Not studying positive functioning in clinical psychology not only potentially misses a major risk factor for disorder, but also misses the opportunity to improve the prediction of disorder above and beyond what can be predicted with more commonly studied negative variables. Consider trying to predict depression from stress and loneliness (as in a regression). These two variables would predict depression quite highly. However, adding a third negative characteristic (e.g., anxiety) wouldn't improve prediction greatly, as this characteristic would share considerable variance with the predictors already in the model. In contrast, adding a positive characteristic (e.g., gratitude) would be lead to a much better prediction of depression as this variable would share much less in common with the negative characteristics. For example, the 30 Big Five personality traits (including anxiety, hostility, depression, self-consciousness, impulsivity, and vulnerability to stress) can predict 25% of the variance in satisfaction with life. These variables *plus* gratitude (Wood et al., 2010-this issue) can improve prediction to 31%, with gratitude uniquely predicting 9% of satisfaction with life ($r = .30$) above what can be predicted from negative characteristics alone (Wood, Joseph et al., 2008; see also Wood et al., 2009). These effects may occur as a positive characteristic is likely to be more distinct from a negative characteristic than two negative characteristics are from each other (cf., Watson & Naragon-Gainey, 2010-this issue). Routinely considering the absence of positive characteristics would lead to much improved prediction of clinical distress.

2.3. Buffering negative life events

Positive characteristics can also act as a buffer between negative events and distress and clinical disorder. For example, positive beliefs about relationship support and personal coping ability ("resilience appraisals") moderate the effect of life events on suicidiality (Johnson et al., 2010). For people with low positive beliefs, more negative life events lead to greater suicidiality. However, this effect is removed for people with high positive beliefs, where the data trended towards suggesting that that more negative life events lead to less suicidiality (an example of the "tough getting going", or increased resource mobilization in times of need). Similar results have been observed in people with psychosis, where hopelessness only leads to greater suicidiality in the absence of positive beliefs; people who had high hopelessness but also high positive beliefs were at much lower risk (Johnson et al., 2010). Similarly, in a study predicting PTSD after a road traffic accident it was found that seeking social support used as a coping strategy 4 weeks after the accident was associated with a good outcome at 6 months post-accident. However, those who relied on seeking social support but perceived their significant others as negative were eight times more likely to suffer from PTSD than those who did not use seeking support as a strategy or those who rated their supporters positively (Holeva, Tarrier, & Wells, 2001).

In studying the impact of negative life events on distress (and likely other areas of clinical psychology), ignoring positive characteristics would not only reduce the prediction of disorder, but would actually lead to a misleading picture. For example, it would not be accurate to simply say that worse life events or greater hopelessness lead to more suicidiality, as this effect only occurs when positive beliefs are low. Any research that does not specifically examine the moderating effect of positive characteristics could misestimate the size and possibly even the direction of the effect (statistically: main effects cannot be interpreted on their own in the presence of an interaction).

Why positive characteristics should act as a buffer is suggested by Broaden-and-Build theory (Garland et al., 2010-this issue). Positive emotions appear to reduce the consequences of negative emotions. For example, experiencing positive emotions speeds the return of heart rate to baseline following a stressor (Fredrickson, Mancuso, Branigan, & Tugade, 2000). Additionally, experiencing positive emotions appear to broaden attentional scope (Johnson & Fredrickson, 2005) and may serve an evolutionarily purpose. Specifically, each positive emotion appears to occur in pleasant times and to motivate thought-action tendencies which serve to increase resources for future more difficult life periods (Fredrickson, 1998, 2001). Thus creativity motives exploration, potentially leading to the identification of new resources, and gratitude motives the repayment of aid (Tsang, 2006), potentially leading to better social relationships. Thus the experience of positive emotions may be expected to buffer the impact of life events on clinical disorders, and to the extent that people with disorders can still experience positive emotions, their suffering appears to be diminished (e.g., Davis, Nolen-Hoeksema, & Larson, 1998; Kashdan, Uswatte, & Julian, 2006).

2.4. Developing positive clinical interventions

Given the mentally beneficial effects of positive emotions and characteristics, the question emerges of whether they can be fostered through clinical techniques. As reviewed elsewhere in this issue (Wood et al., 2010-this issue) interventions have been developed to increase gratitude, and these interventions are as effective in reducing body dissatisfaction and worry as commonly used cognitive behavioral techniques (Geraghty, Wood, & Hyland, 2010a; Geraghty, Wood, & Hyland, 2010b). Interventions to increase the positive characteristics that Wood and Joseph (2010a) identified as prospectively predicting depression (above) have been developed to reduce the residual effects of affective disorders (Fava, Rafanelli, Cazzaro, Conti, & Grandi, 1998; Fava et al., 2005). The concept of reciprocity has been used to encourage PTSD sufferers to build up 'social currency' by aiding and helping others which serves both as a way of encouraging positive social interactions, elevating feelings of self-worth and self-efficacy but which can also be 'traded in' to receive social support (Tarrier & Humphreys, 2003). The newly developed Broad Minded Affective Coping (BMAC) technique (Tarrier, 2010a) is designed to promote positive emotions through the recall of positive autobiographical memories, and has achieved promising early results. Various other interventions have also been developed (e.g., Seligman et al., 2006, 2005) and early results are highly encouraging (Sin & Lyubomirsky, 2009).

2.5. Rapid research progress

Given the relatively low body of knowledge into how positive functioning relates to clinical distress, even quite small research projects can make a considerable contribution to the field (c.f., Gable & Haidt, 2005). In such uncharted territory, even with limited resources it is possible to rapidly advance knowledge. For example, with over a 100,000 articles making reference to stress, providing an advance in stress research would either need a new paradigm or very abundant resources. In contrast, with only a handful of studies on such emotions as gratitude, very rapid advances can be made with limited resources; thus research into positive functioning and distress represents an improved cost/benefit ratio over many other areas of clinical psychology. This should be a particularly relevant consideration for funding bodies, where cost effectiveness must be a large consideration, and in the supervision of doctorial students, who both have only limited resources and a need for early high level publications to begin on their career track.

3. Integration with and separation from the Positive Psychology Movement

In developing a Positive Clinical Psychology, much can be learnt from the positive psychology movement (see Gable & Haidt, 2005; Linley et al., 2006; Seligman & Csikszentmihalyi, 2000; Sheldon & King, 2001). Many of the messages of this now decade old movement are as relevant to clinical psychology today as they were to psychology in 2000. Whilst the movement aimed to take its message equally to all areas of psychology, the impact appears to have been concentrated on personality/social psychology, despite attempts to widen the impact to other fields, and the impact on the day to day work of clinical psychologists appears to have been minimal. Additionally, considering the criticisms of the movement provide new insights into the interdependency of positive and negative characteristics, and can avoid such mistakes being repeated by clinical psychology. We emphasize the dissociation between positive psychology research (a unambiguously beneficial endeavor) and the sometimes political way in which it has been conducted (the positive psychology movement, a more controversial issue). As will be seen, the criticisms focus on the movement, and it is possible to conduct the research in ways which avoid the concerns that have been raised.

3.1. Positive psychology research

Positive psychological research probably developed as a result of a vacuum of research into positive functioning in psychology in general, which had occurred partially due to changes that occurred in the aftermath of World War II (Seligman & Csikszentmihalyi, 2000). Prior to the war, psychology had the dual aims of curing mental illness and promoting excellence and positive communities. Faced with the immense suffering caused by the war, many psychologists saw the most urgent need as repairing damage. Governmental priorities promoted this focus, earmarking funding for research into repairing the psychological impact of the war. With the founding of the Veterans Administration in 1949 and the National Institute of Mental Health (which focused exclusively on disorder) in 1947, psychologists found unparalleled funding opportunities if they were prepared to study disorder (Seligman & Csikszentmihalyi, 2000).

This deliberate focus on disorder created a substantial and valuable body of research into distress, although some have argued that this focus had the side effect of transforming psychology into a healing discipline, based upon a medical model of disorder (Maddux, 2002; Maddux, Gosselin, & Winstead, 2005; Maddux et al., 2004). In many fields, they argue, psychology essentially became a sub-field of psychiatry, with psychologists working exclusively to treat distress and saddled with a conceptual basis that was not their own (Tarrier, 1979). Psychology's orientation towards the negative persisted long after the war, with successive generations of psychologists being socialized into the perception of psychology as disproportionately involving the study of disorder. Psychology became a profession effective at "learning how to bring people up from negative eight to zero, but not as good at understanding how people rise from zero to positive eight" (Gable & Haidt, 2005, p. 103). As Maslow pointed out back in 1970:

> The science of psychology has been far more successful on the negative than on the positive side. It has revealed to us much about man's shortcomings, his illness, his sins, but little about his potentialities, his virtues, his achievable aspirations, or his full psychological height. It is as if psychology has voluntarily restricted itself to only half its rightful jurisdiction, and that, the darker, meaner half (p. 354).

This situation does not seem to have markedly changed in the intervening four decades. Representative population surveys have repeatedly found that 90% of people report themselves as either "happy" or "very happy" (Myers, 2000), although psychology could say most about the 10% of people for whom this statement was not true. Psychology could also explain little about traits that had been considered important historically and continue to be a major part of people's lives. For example, Peterson and Seligman (2004) identified 24 character traits which have been considered strengths throughout history in a number of cultures (for overview Linley et al., 2007). These strengths include gratitude, authenticity, love, fairness, bravery, and vitality. As they review, there is very little research on these topics, although these are probably topics that are more important to many people than many areas of psychology. From this vacuum of research into the positive developed the positive psychology movement.

3.2. The positive psychology movement

The positive psychology movement developed in the late 1990s and was self-consciously concerned at redressing the balance of focus within psychology, so that positive aspects of life were once again part of the mainstream research agenda in psychology (Seligman

& Csikszentmihalyi, 2000). A precise definition of the mission of the movement was never provided, although indication can be taken from influential sources written at the beginning of the movement.

The following quotations are indicative of definitions from authoritative contemporary sources within the positive psychology movement:

> The field of positive psychology at the subjective level is about valued subjective experiences: well-being, contentment, and satisfaction (in the past); hope and optimism (for the future); and flow and happiness (in the present). At the individual level, it is about positive individual traits: the capacity for love and vocation, courage, interpersonal skill, aesthetic sensibility, perseverance, forgiveness, originality, future mindedness, spirituality, high talent, and wisdom. At the group level, it is about the civic virtues and the institutions that move individuals toward better citizenship: responsibility, nurturance, altruism, civility, moderation, tolerance, and work ethic (Seligman & Csikszentmihalyi, 2000, p. 5).
>
> What is positive psychology? It is nothing more than the scientific study of ordinary human strengths and virtues. Positive psychology revisits 'the average person,' with an interest in finding out what works, what is right, and what is improving…positive psychology is simply psychology (Sheldon & King, 2001, p. 216).
>
> Positive psychology is about scientifically informed perspectives on what makes life worth living. It focuses on aspects of the human condition that lead to happiness, fulfilment, and flourishing." *The Journal of Positive Psychology* (2005).

As an ideological movement, positive psychology is often attributed to the work of Martin E. P. Seligman, who served as president of the American Psychological Association (APA) from 1998 to 1999 (see Linley et al., 2006). Seligman made the promotion of positive psychology his key presidential initiative of his term in office (Seligman, 1999). Seligman himself attributes the movement to two key events in his own life (Seligman, 2002; Seligman & Csikszentmihalyi, 2000). The first was a moment with his daughter Nikki. After he had unfairly berated his 5-year old daughter for interrupting him whilst gardening, she allegedly responded "From the time I was three to the time I was five, I was a whiner. I whined every day. When I turned five, I decided not to whine any-more. That was the hardest thing I've ever done. And if I can stop whining, you can stop being such a grouch" (Seligman, 2002, p. 4). Seligman (Seligman, 2002; Seligman & Csikszentmihalyi, 2000) reports that at this moment he realized that psychology should not be aimed at reducing weakness (which his daughter could do by herself), but rather at promoting strength. Seligman reports the second event as being a serendipitous meeting with Michael Csikszentmihalyi at a holiday resort whilst considering his key presidential initiatives.

Linley et al. (2006) consider Seligman's role within the wider lens of the "great person" verses zeitgeist debate within historical research; whether movements and scientific advances occur due to the impact of given individuals, or whether such individuals naturally emerge and capitalize on historical events, such as a vacuum of research into positive functioning and clear benefits of changing this situation. The zeitgeist perspective on the positive psychology movement appears more likely, as there was already a surge in research into these areas (such as the $363,000 grant into perspectives and dimensions of gratitude in 1999, predating the positive psychology movement (Emmons, 2007). Seligman was also in reality only one of many major figures who were involved in the conception of the movement (see Linley et al., 2006). Thus Seligman's contribution, although doubtless considerable, cannot account for how the movement actually came into being.

Regardless of the precise cause of the positive psychology movement, between 1999 and 2006 the movement had become influential within psychology, with 16 special journal issues, a new dedicated journal, tens of millions of pounds of funding, at least eight international conferences, the development of Masters level courses across the world, and hundreds of articles in the popular press (Linley et al., 2006; Seligman, 2005).

3.3. Criticisms of positive psychology

The positive psychology movement has had considerable success in fostering and drawing attention to research into positive topic areas, which we consider essential to the understanding of clinical distress. However, the movement has also attracted considerable criticism. Again, we emphasize the dissociation between positive psychology *research* and the positive psychology *movement*. The criticisms below pertain largely to the movement rather than the importance or viability of research into positive functioning. We focus on these criticisms with productive aims. First, many of these criticism, such as how to conceptualize well-being, relate to how research and clinical practice is conducted and, for a reflective discipline, these are important issues on which to reflect. Second, in promoting a new Positive Clinical Psychology, it is important to avoid mistakes of the past. Third, criticisms contain at least some implicit suggestions for improvement, and through focusing on these criticisms we lead on to distinct new agenda for positive clinical research. However, although many of these criticisms have substantial validity, they should not overshadow the contributions of the positive psychology movement in fostering and promoting positive research. We simply now suggest the focus now moves solely onto the research and avoids the following pitfalls.

3.3.1. Not a new idea

Positive Psychology has been criticized for overstating its claims to novelty. Seligman did not "invent" the concept of studying the positive, nor in many ways was the message new. As Tennen and Affleck (2003) point out, various other people had called for an increased focus on positive topics, including Gordon Allport in the mid-50s, Carl Rogers in the 60s, Rollo May and Eric Fromm 70s and 80s. If Horney (1951) was added to this list, then calls to study the positive can be seen to emerge from the major counseling psychology approaches (humanistic, existential, and psychodynamic) as well as social/personality psychology. Similarly the 'constructional approach' of Goldiamond was the behavioral forerunner of the 'positive approach' (Schwartz & Goldiamond, 1975). Indeed, even the term "positive psychology" had been coined some decades earlier by Maslow (1970), as indicated by the quote above. Such criticisms can be avoided in the future by not attempting to set up a new field, but rather by self-consciously regaining some of the pre-World War II focus of clinical psychology. Such would be a revolution in the most technical definition; a revolving back to a previous state.

3.3.2. Alienation of counseling psychologists

Perhaps influenced by this history, counseling and community psychologists were already rejecting the deficit orientation and focusing on strengths (Bohart & Greening, 2001; Linley, 2006). Elaborating on this point, Cowen and Kilmer (2002) identify 24 highly influential citations from this field (dating from 1958 to the birth of the positive psychology movement in 1999). Writing in the APA's *Journal of Counseling Psychology*, Fordyce (1977, 1983) reported seven studies (with follow-up between 2 weeks and 18-months), involving 14 activities to increase happiness, all compared to control conditions; such work is remarkably similar to the contemporary interventions that have been considered a key success of positive psychology. Counseling psychologists have a wealth of experience of considering positive functioning. Further, some counseling approaches, such as (Rogerian) Person Centered Therapy (Rogers, 1951; for empirical evaluation see Ward et al., 2000) have always fully integrated improving positive functioning into their practice (Joseph

& Linley, 2006c). Partially this is due to a conception of well-being as a continuum from extreme distress to optimum performance, and through a willingness to help anyone improve their well-being irrespective of their current level of functioning (Joseph & Linley, 2006b; Joseph & Worsley, 2005). Humanistic counseling also differ in core assumptions from many other approaches, seeing people as orientated towards growth, and dysfunction as arising as a thwarting of this growth process by adverse environmental conditions (Wood & Joseph, 2007). Such meta-assumptions naturally place the focus on fostering growth rather than simply curing distress (and have recently received empirical support, see Patterson & Joseph, 2007; Sheldon, Arndt, & Houser-Marko, 2003; Wood, Linley, Maltby, Baliousis, & Joseph, 2008).

3.3.3. Failure to integrate the positive and the negative

The positive psychology movement attracted much criticism for focusing on the positive and neglecting the negative (e.g., Bohart, 2002; Held, 2002, 2004; Kowalski, 2002; Lazarus, 2003; Norem & Chang, 2002; Woolfolk, 2002). At the worst, this could have the consequence of moving against integration and creating two fields; one that only studies the positive and one that only studies the negative. Such an outcome would be both practically damaging and scientifically incorrect. Practically, it would neglect how both positive and negative characteristics are needed to predict outcomes and understanding the buffering of life events. Scientifically, it would be based on the faulty assumption that any emotion or aspect of life can be designated as always "positive or negative" and separated from its polar opposite aspects.

Kashdan and Rottenberg (2010-this issue) discuss how the "positivity" or appropriateness and adaptiveness of an emotion is situation dependant. Anger, for example, is often considered a negative emotion, and it indeed arises from aversive situations, increases the risk of violence, and prevents forgiveness (Maltby et al., 2008); at the extreme anger can become the clinical disorder commonly treated by clinical psychologists (Howells & Day, 2003). However, anger can also be adaptive, motivating people to redress genuine personal or societal wrongs. Experimentally, people choose to regulate their moods to become *more* angry (for example through listening to anger inducing music) before going into a situation where they have confrontational goals (Tamir, Mitchell, & Gross, 2008). People who see themselves as being low in bargaining power do better in negotiations if they are angry than if they are in a positive mood (Van Kleef & Cote, 2007). Thus anger only appears to be maladaptive when it is in an inappropriate setting or occurs excessively.

Such findings are not confined to anger, with most "negative" emotions or characteristics having adaptive value (indeed, it would be hard to imagine how they would have evolved if they conferred no advantage, at least at some point in history). Much as positive emotions widen attentional span, encouraging creativity, negative emotions focus in on the source of the problem (Fredrickson, 2001). Individual "negative acts" can bring productive benefits. Even complaining, which although related to rumination and interpersonal problems, is also cathartic, helping people avoid the health and clinical problems associated with emotional repression, and creating solidarity amongst people who have been wronged (Kowalski, 2002). Unhappiness can become very maladaptive, as in depression, but can also encourage people to locate and change sub-optimal aspects of their lives (cf., Held, 2004). Similar logic and research findings can be applied to pretty much any "negative" characteristic, and thus whether it is genuinely "positive" or "negative" depends on the concomitant context, goals, and motivations, as well as the extent to which it is experienced.

"Positive" emotions and characteristics are not always beneficial (as classily portrayed by laughing at a funeral). For example, conscientiousness is related to greater well-being (DeNeve & Cooper, 1998), goal setting, and occupational performance (Barrick, Stewart, Neubert, & Mount, 1998). Based on these findings, conscientiousness has traditionally been considered been considered an overwhelmingly "positive" characteristic; as such, it which would seem to be well within the positive psychology remit. However, it has recently been shown that conscientious people suffer more from defeat; in a prospective 4-year longitudinal study of 10,000 working adults, people initially high in unemployment suffered a 120% greater decrease in well-being if they became unemployed (Boyce, Wood, & Brown, 2010). Similarly, as discussed by Carver et al. (2010-this issue) whilst optimism is related to a very broad range of beneficial clinical and health outcomes, optimists are also less likely to disengage from an unwinnable task (and reduce betting after a poor outcome) and more likely to over-spread their resources leading to personal goal conflict (see also Norem & Chang, 2002).

Emotions and characteristics can neither be seen to be "positive" or "negative" as their harmful or beneficial impact is context specific and motivation dependant. The benefits of a characteristic are also not linear, with most characteristics becoming maladaptive at higher levels; thus righteous anger can become anger management problems, happiness becomes mania. Given such empirical and conceptual reasons to believe that emotions or characteristics are not positive or negative, it makes no sense to study them separately, and provides a strong argument for a unified field of research and practice which considers characteristics equally, irrespective of whether they are conventionally seen as positive or negative. Kashdan and Rottenberg (2010-this issue) suggest that psychological flexibility may be a key to well-being, with people able to maximize the benefits of any characteristic through recognizing situational demands and adapting to them through a wiliness and ability to change mindsets and behavioral repertoires. This perspective has much potential to unify the research on the situational specific benefits of "positive" and "negative" characteristics, and can only arise from an approach which considers the two together.

3.3.4. Inadequate evaluation of interventions

Despite the potential of positive interventions, as discussed more extensively elsewhere in this issue, the existing positive intervention literature has suffered from a number of weaknesses, especially in the use of inappropriate control groups (for a detailed evaluations, see Wood et al., 2010-this issue). For example, within the gratitude literature, control conditions have included listing daily hassles (versus things for which to be grateful) and listing things over the summer you were unable to do (versus things over the summer for which you are grateful). Such control groups make interpretation of the effect of positive interventions difficult and claims for the efficacy of such interventions premature. (For example, in some the examples above, the gratitude condition could be viewed as the neutral control, and the research viewed as simply showing that negative interventions such as writing about hassles increase distress.) Such issues necessarily impact on integrative research reviews, with the recent meta-analysis by Sin and Lyubomirsky (2009) categorizing "neutral controls" according to how they were defined in the original papers (so that thinking about things you could not do over the summer was considered to have a neutral impact on mood, expectancies of mood change, etc., p. 474). Even with these issues, this meta-analysis showed that the interventions were less effective against these "control conditions" than when they were compared to no-treatment controls, showing that the effectiveness of positive interventions is at least partially due to demand effects or the general therapeutic effects of participating in any intervention (c.f., Wampold, 2007).

We do not mean to be critical of the pioneering work into positive interventions, which we believe to hold considerable potential for clinical psychology. Rather we aim to urge caution against the over enthusiastic promotion and utilization of such interventions. Particularly with the high public interest and effective dissemination of positive psychology findings and approaches, there is a risk of a public

backlash occurring if such approaches are over promoted and ultimately emerge as ineffectual. Such is the public profile of positive psychology that such a backlash may not remain confined to this particular approach but may generalize to clinical psychology and well validated treatments. The huge potential of positive interventions combined with the current use of these interventions in practice indicates a urgent need for thorough evaluation.

4. A research, practice, and political agenda for Positive Clinical Psychology

We suggest that Positive Clinical Psychology builds on many of the messages and successes of the positive psychology movement, but remains a separate entity, existing as part of clinical psychology. Specifically, we are not suggesting the development of a new fragment of clinical psychology, but rather a change or reorientation of clinical psychology itself, so that positive and negative functioning are considered equally when predicting, understanding, and treating distress. Thus we avoid many of the criticisms leveled at the positive psychology movement, through advocating more integration within a current discipline. Such a change would make logical sense, given that the positive and negative functioning can never be separated. Whist this was presented as criticism of the positive psychology movement, equally it could be a criticism of clinical psychology's traditional over focus on the negative.

We envision a Positive Clinical Psychology where the study of the positive and negative are fully integrated. Indeed, such a change is likely inevitable for the same zeitgeist reasons that the positive psychology movement arose; simply, a huge vacuum of research into the positive and clear untapped potential. Specifically, such an integrative approach would be more successful at understanding and treating disorder. For this to occur, and to learn lessons from the positive psychology movement, we suggest (a) that clinical psychologists re-conceptualize the relationship between positive and negative well-being, (b) that a collaborative attitude is taken towards other fields that are experienced in studying and fostering positive functioning, (c) that positive interventions are subjected to the same level of rigor as mainstream clinical interventions (cf., Tarrier & Wykes, 2004), (d) that clinical psychologists, as individuals and as a profession, consider how much they want to engage with public demand for interventions to improve the well-being of people without marked psychopathology.

4.1. Re-conceptualizing the relationship between "positive and negative well-being"

First, Positive Clinical Psychology needs to re-conceptualize well-being. As considered extensively above, there are strong conceptual and empirical arguments that no emotion or characteristic can be uniformly positive or negative. However, Joseph and Wood (2010-this issue) show this to be only part of a more fundamental and less considered issue; a lack of appreciation that most characteristics have both positive and negative polls. For many characteristics, presumably due to historical or zeitgeist reasons, focus is predominantly on only one poll, with the other becoming forgotten or ignored, and a lack of appreciation of the bipolarity of the construct.

Consider depression and happiness. Conventionally, they are considered two separate constructs, however there is good reason to believe they both exist on the same continuum (Wood, Taylor, & Joseph, 2010). First, scales that purport to measure happiness include the measurement of depression, and depression measures include items on happiness. Thus many scale development programs, which underpin the science of the field, have implicitly considered depression and happiness to be a single continuum. That these scales were developed, published, and widely used suggests that a happiness-to-depression continuum has face validity for both researchers and practitioners. For example, the dominant measure of happiness, the Oxford Happiness Inventory (Argyle, Martin, & Crossland, 1989), was developed by producing positively worded versions of items from the Beck Depression Inventory. Conversely, the Center for Epidemiologic Studies Depression (CES-D) Scale (Radloff, 1977) is one of the five most widely used depression scale in both basic science and treatment outcome research (Santor, Gregus, & Welch, 2006), and yet contains the (reverse coded) items "I felt happy", "I enjoyed life", "I felt that I was just as good as other people", and "I felt hopeful about the future"; these items clearly indicate the presence of happiness. Given that the CES-D is normally given a single overall score, the scale appears to measure a continuum from happiness to depression (Joseph, 2006, 2007).

Second, examination of the distribution of responses to items assessing happiness and depression provides indirect evidence that they exist on the same continuum. For example, Fig. 1 shows the distributions of average responses to the CES-D questions asking how frequently people experience (a) happiness "symptoms" (left panel) and (b) depression "symptoms" (right panel) (data from Wood et al., 2010, N = 6048). Happy experiences are very *negatively* skewed, with most people's responses clustering near to 7 days a week (with the highest possible response also being the modal response). Depressive experiences, in contract, are very *positively* skewed, with most people's responses clustering near to 0 days a week (with the lowest possible response again being the modal response). Statistically, high skew combined with the mode taking the most extreme value commonly represents methodological floor (or ceiling) effects where participants want to give more extreme values but are presented from doing so by the question's wording or response options (e.g., if when people answered the depression questions they didn't want to give a response of zero, indicating the absence of depression, but rather wanted to give a positive score indicating the prescience of happiness). In contrast, if the two panels in Fig. 1 were allowed to combine, this would form a normal distribution ranging from extreme depression to a zero point to extreme happiness. (Indeed models of bipolar disorder appear to endorse this view, with people varying between existing on the happiness or depression poll.)

Third, direct evidence is provided by Wood, Taylor, and Joseph (2010), who use the CES-D to present empirical evidence supporting a happiness to depression continuum. Using a recently developed confirmatory factor analysis technique, responses to the happiness and depression questions were shown to form a single continuum, with a single (happiness to depression) factor model (allowing for method effects) fitting better than a model where happiness and depression were separate factors. Thus happiness and depression come out as a single continuum in people's self report responding.

The happiness and depression continuum is only one example of how one poll of a bipolar construct has been exclusively studied. Joseph and Wood (2010-this issue) consider this issue in detail; other example include the anxiety to calmness continuum, or a higher order subjective well-being continuum (ranging from high negative affect, low positive affect and low satisfaction with life to low negative affect, high positive affect, and high life satisfaction). The problem, however, exists even more widely than even this. Consider the traits considered important to positive psychology. These are helpfully listed in the Values in Action (VIA) taxonomy, developed by Peterson and Seligman (2004), based in part on exhaustive literature searches of psychology, philosophy, historical inventories, and conference. Leaving aside structural problems with the scheme (Brdar & Kashdan, 2010), this provides a useful list of 24 "strengths" considered important by positive psychologists. These include humility, kindness, open-mindedness, integrity, fairness, and (presumably high) social intelligence (for a full list, see Linley et al., 2007). These characteristics are apparently seen as totally positive; but what about their respective polar opposites of arrogance, unkindness, closed-mindedness, dishonesty, unfairness, and low social intelligence? These characteristics each represent full continua of human functioning,

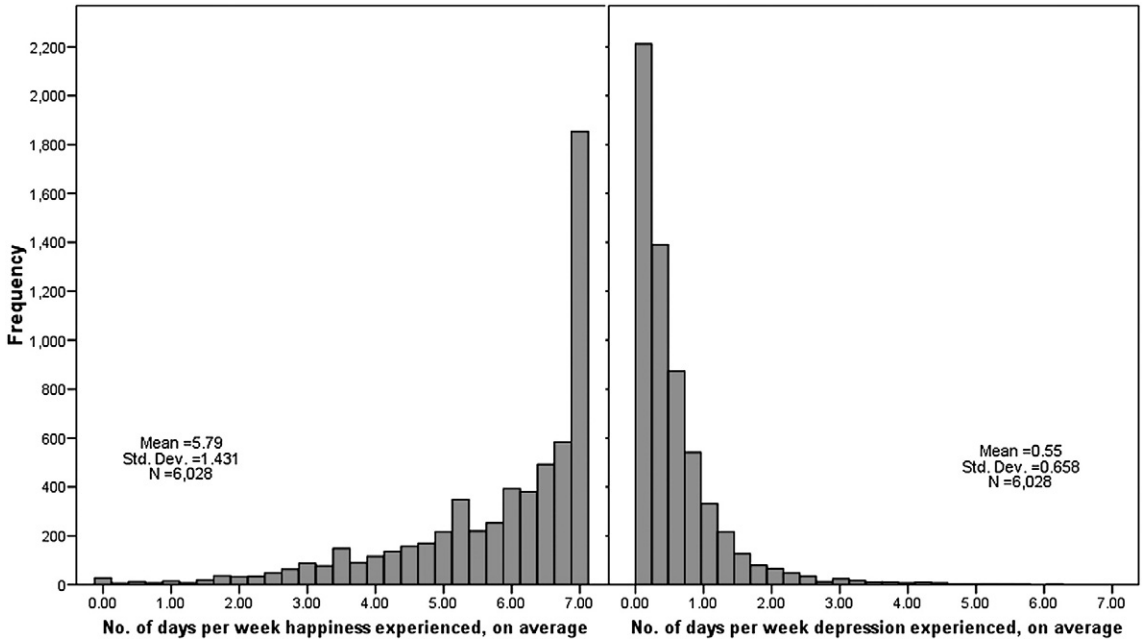

Fig. 1. Distribution of distributions of average responses to the CES-D questions asking how frequently people experience (a) happiness "symptoms" (left panel) and (b) depression "symptoms" (right panel). The figure was produced for this paper from the dataset used by Wood et al. (2010); Participants were 6048 people aged between 65 and 66 who participated in the Wisconsin Longitudinal Survey (similar results were also obtained by a separate sample of 8857 people aged 27–35 from the National Longitudinal Survey of Youth, also reported by Wood et al.).

including both positive and negative aspects, and the designation of the characteristic as either positive or negative is totally arbitrary depending on which poll is focused on (or which way a scale is coded). Indeed, had the authors not been working within positive psychology, then they could have easily have reverse coded their scales, named them after the opposite poll, and conducted mainstream clinical work. The point here is not to be critical of the VIA for identifying these characteristics; indeed, positive, negative, or bipolar, these traits are remarkably understudied in psychology, and it is very useful to highlight this dearth of research. Rather, these issues illustrate yet again how the positive and the negative must be studied together, *as they often exist on the same continua*.

There are several benefits of Positive Clinical Psychology taking this continuum approach. First, to not adopt the continuum approach would be scientifically and logically wrong; research (and reviews summarizing this research) would present a biased view of the construct and its consequences by arbitrarily categorizing it as positive or negative.

Second, adopting a continuum approach would avoid endless "reinventing of the wheel", or the unnecessary duplication of research effort. For example, if happiness and depression are on the same continuum, then the huge research base on depression should largely generalize to happiness; there does not seem much value in taking an existing depression measure, reverse coding the items, and beginning to replicate the whole depression field beginning with the most simple and well established findings. Even with a continuum of happiness to depression, it is possible that happiness would have somewhat different relationship to variables than depression, as in the case of non-linear relationships (where the low part of a construct has much higher impact on an aspect of life than the high end, or vice versa). This would be an important conceptual and empirical issue. However, research addressing this issue would have to begin from recognition that such a continuum exists, and would not have the same design or consequences as research beginning from a position that happiness and depression are separate factors.

Third, the continuum approach widens the possible applicability of interventions, so that interventions known to affect movement away (or towards) one poll (e.g., move away from depression) should have an equal and opposite effect on the other poll (e.g., increase happiness). Thus existing clinical interventions to decrease depression should be of direct relevance to anyone wanting to increase happiness. Equally, the interventions to increase happiness should also operate via decreasing depression. Similar logic can be applied to any bipolar construct (e.g., the anxiety to calmness continuum). Such observations, whilst intuitively obvious, stand in stark contrast to many of the current approaches; the positive psychology movement, for example, often seems to consider separate interventions needed to decrease depression or promote happiness. Such views can only arise from not adopting a continuum approach. Bohart (2002) discusses the negative clinical implications of focusing exclusively on the positive or the negative, such as adopting a "one size fits all" approach, rather than being guided by the needs of the individual client. With a more societal focus, Held (2002) discusses the "tyranny of the positive attitude"; where an over focus on the importance of happiness increases the suffering of people who are not happy, by making their experiences more saliently abnormal. Such problems would not arise with an integrative continuum approach. It is of course possible that interventions would operate differently at different points on the depression to happiness continuum (or any other bipolar dimension), if there were non-linear or moderation effects occurring. However, again this is an important empirical question that would not be addressed without adopting a continuum approach. Such an approach would do much to build a more integrative discipline.

A Positive Clinical Psychology should attempt to be as collaborative as possible with other sub-fields of psychology and allied disciplines to best advance science and practice (cf., Sternberg & Grigorenko, 2001). This should include a realization of the historical context from which the study of positive functioning and distress arose. In particular, the field should consciously aim to make stronger links with counseling psychology. The two approaches have much to offer each other. Many of the deep theoretical perspectives of counseling psychology are highly compatible with clinical psychology models (see, for example, Higginson, Mansell, & Wood, in press), whereas others can inform the field with new and novel perspectives (see, for example, Joseph & Linley, 2006b; Joseph & Wood, 2010-this issue; Wood & Joseph, 2007). Many of these theories have been built on

largely qualitative bases and would greatly benefit from clinical psychology input, through the specialized hypothesis testing techniques the field has honed over the last 50 years (c.f., Joseph & Worsley, 2005). Clinical psychology would certainly want to keep its identity; however much more room is available for productive dialogue and collaboration with counseling psychologists, who have long experience in conceptualizing and studying positive functioning.

4.2. Rigorous evaluation of positive interventions

Positive interventions need a new wave of research which tests them with the same rigor as clinical interventions (cf., Wood et al., 2010-this issue). As indicated above, current research has suffered with various methodological difficulties. A second wave of positive intervention research needs to take several actions (cf., Wood et al., this issue).

First, use appropriate comparison groups. No treatment controls can be highly useful as they provide a direct answer a simple question: How much better is this is intervention than doing nothing? In health service research there are ethical considerations associated with withholding established treatments and thus any new treatment is usually compared pragmatically with standard practice or treatment as usual (Tarrier & Wykes, 2004). If other controls are used, at the very least these need to be designed to ensure both that expectancy is equal between the control condition and the treatment, and that the control condition is having no active effect (see Kirsch, 2005). Authors should clearly state in the papers how this has been achieved to make this expectation transparent and open to scrutiny (listing daily hassles does not provide a genuinely inert condition with which to compare the efficacy of gratitude interventions, see Wood et al., 2010-this issue). The best control conditions are component isolation studies, where participants are given two treatment that are identical in all respects other than the theoretically active component being removed from one of the treatments (see Ahn & Wampold, 2001).

Second, the next wave of positive intervention research needs to show that they can add value (or incremental validity) to what is currently being used in practice. Despite a large number of studies into positive interventions, only three studies (Geraghty et al., 2010a, 2010b; Seligman et al., 2006) have compared the positive intervention with *any* currently used technique. These studies suggested that positive techniques do compare well to other approaches. However, three studies are not sufficient to conclude the efficacy of positive interventions, which suggests that some claims about their value have been overstated. At the moment we do not conclusively know whether positive interventions are superior, equal, or inferior to existing techniques used by clinical psychologists. If they are inferior then with all else equal, they should not be used. If they are equal, then choice between interventions needs to be based on some other criteria (such as cost, other outcomes, or potential side effects of the treatment, Wood & Joseph, 2010b; Tarrier, 2010b).

Third, positive interventions need to be tested within clinical groups. This would be testing whether the interventions are equally as effective at different parts of the various well-being continua (e.g., do gratitude interventions work as well amongst people with severe depression as people with moderate levels of happiness). For positive interventions to be utilized by clinical psychology, it is essential to establish the efficacy of these techniques within the most commonly seen groups which the profession treats.

4.3. Re-consider the role of clinical psychologists as only targeting distress rather than improving well-being

As a Positive Clinical Psychology develops, practitioners will increasingly have a knowledge base that understands positive functioning in addition to negative distress, and a wider variety of interventional techniques, including those that aim to focus to remove distress and those that aim to focus on and foster the positive. At this point a new domain in which clinical skills can be used will have become available. There seems to be high public demand from people who are not severely psychologically unwell but want to increase their well-being, perhaps arising for an increased awareness that possessions and money only contribute trivially to happiness (therapy, for example, is at least 32 times more cost effective at increasing happiness than simply gaining more income, Boyce & Wood, in press). Currently that demand is largely being filled by other practitioners, such as executive or "life-coaches" (Linley & Kauffman, 2007). Indeed, such practitioners have been quick to associate with the positive psychology movement, making much of how they are using "empirically validated techniques". This is worrying as although coaching may emerge as sub-discipline of psychology, in most jurisdictions coaches are currently not state registered, and there are no qualifications or professional body membership required. As such there are no protections in place for the client, and the people carrying out interventions may be far from the clinical psychologist ideal of scientist practitioner. Clinical psychology should seriously consider expanding its remit towards promoting positive functioning, so that the people with the desire (and resources) to seek help to improve their well-being are able to have an expert and accredited practitioner's assistance.

Such a possibility is likely to controversial, with the perception of a danger in focusing away from those with clinical conditions to improving the well-being of the healthy being seen as trivial and a waste of rare resources especially in public health systems in which there is frequently intense competition in accessing psychological treatments. Countering this view, is the conceptual possibility that promoting positive functioning may focus as a preventative measure to reduce the incidence of mental health problems in those vulnerable to develop them. However, there is intrinsic risk in promoting prevention in mental health in that it easily fails to be targeted, effective, efficient or economically viable. Thus the strategy of how this would develop is currently unclear. Nevertheless, where the boundaries of clinical psychology should lie is likely to be become an important debate in the next decade, needing careful economic, political, and philosophical consideration.

5. Conclusion

Studying positive functioning has great potential to improve the prediction, understanding, and conceptualization of psychological distress. It is not logical to study either negative or positive functioning in isolation, as (a) this reduces the prediction of important outcomes (as in the prediction of the development of disorder), (b) positive and negative functioning can interact to predict outcomes (as in the buffering of negative life events and disorder), (c) any designation of a characteristic as positive or negative is simplistic and inaccurate, as any trait or emption can be "positive or negative" depending on the situation and concomitant goals and motivations, (d) positive and negative well-being often exist on the same continuum, (e) this prevents interventions being designed to both decrease the negative and promote the positive, and (f) only understanding positive or negative reduces the potential client groups whom a practitioner can help. In contrast, fully integrating the study and practice of positive and negative functioning in clinical psychology can improve the prediction of disorder, understand resilience, rapidly advance scientific knowledge, and lead to revolutionarily understanding of well-being through reconceptualization of its very nature. Clinical psychology practice would benefit from this stronger scientific basis and more diverse, numerous, and effective interventions, which can be selected based on individual client need. We call for the development of a fully integrative "Positive" Clinical Psychology that avoids problems associated with studying positive or negative well-being in isolation, and gains all the benefits of a genuinely integrative field.

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