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**Integrating Positive and Clinical Psychology: Viewing Human Functioning as Continua
from Positive to Negative Can Benefit Clinical Assessment, Interventions and
Understandings of Resilience**

Judith Johnson and Alex M. Wood

Abstract

In this review we argue in favour of further integration between the disciplines of positive and clinical psychology. We argue that most of the constructs studied by both positive and clinical psychology exist on continua ranging from positive to negative (e.g., gratitude to ingratitude, anxiety to calmness) and so it is meaningless to speak of one or other field studying the “positive” or the “negative”. However, we highlight historical and cultural factors which have led positive and clinical psychologies to focus on *different* constructs; thus the difference between the fields is more due to the constructs of study rather than their being inherently “positive” or “negative”. We argue that there is much benefit to clinical psychology of considering positive psychology constructs because; (a) constructs studied by positive psychology researchers can independently predict wellbeing when accounting for traditional clinical factors, both cross-sectionally and prospectively, (2) the constructs studied by positive psychologists can interact with risk factors to predict outcomes, thereby conferring resilience, (3) interventions that aim to increase movement towards the positive pole of well-being can be used encourage movement away from the negative pole, either in isolation or alongside traditional clinical interventions, and (4) research from positive psychology can support clinical psychology as it seeks to adapt therapies developed in Western nations to other cultures.

Integrating Positive and Clinical Psychology: Viewing Human Functioning as Continua from Positive to Negative Can Benefit Clinical Assessment, Interventions and Understandings of Resilience

There has been an artificial separation in the research literature between positive psychological research and clinical psychology. Both disciplines aim to enhance wellbeing, with positive psychology researchers aiming to investigate those factors which support flourishing and clinical psychology researchers aiming to focus on the reduction of distress. However, despite a clear alliance in these aims, there has been minimal work focused on integrating findings from these two literatures. In the present article, we argue that the large body of research conducted by positive psychological researchers represents an untapped resource for clinical psychologists, which could support clinical assessment and interventions with individuals with diagnosable disorders in practice.

A fundamental argument in favour of integrating these two literatures has been the simple observation that all positive or negative factors have an inverse (Johnson, Wood, Gooding, Taylor, & Tarrier, 2011b; Joseph & Wood, 2010; Wood & Tarrier, 2010). For example, traits that are highlighted as core to positive psychology (in the VIA classification of Peterson & Seligman, 2004) include humility, fairness, integrity, kindness, open-mindedness, and (one assumes high) social intelligence. However, these traits represent continuums with their opposites being respectively arrogance, unfairness, mendacity, unkindness, closed mindedness, and low social intelligence. Indeed, the scales that measure these traits commonly include an equal balance of items that represent one pole and reversed coded items that represent the other (e.g., fairness and unfairness). The labelling of these traits as positive is completely arbitrary, and one could just as easily code the scales in the other directions and legitimately call them by their “negative” opposite names. Indeed, was the zeitgeist such that publication motivations were still to exclusively look at “negative

topics”, presumably this is what would be happening. Similarly, many constructs studied within clinical psychology equally exist on continuums from positive to negative. That is, the process of diagnosis involves ascertaining whether perceived problematic constructs such as depression, anxiety, or insomnia are present or absent, and if they are deemed present, whether they can be regarded as mild, moderate or severe. However, these constructs have counterparts; for example, depression lies on a continuum with happiness, anxiety lies on a continuum with calmness, and insomnia lies on a sleep continuum, with the other end represented by easy, regular sleep patterns.

As such, the great majority of human functioning factors can be regarded as constituting a spectrum from negative to positive, and any research into either the ‘positive’ or the ‘negative’ will have implications for the opposite pole (Johnson et al., 2011b). The failure of researchers to recognise this bipolarity of psychological factors can be viewed as a conceptual ‘blind spot’ which has underpinned the divide between these two literatures. This simple observation that positive and clinical psychologists are both studying constructs that are on continua from positive to negative (and, thus, by definition cannot speak only to one or the other) has largely gone unnoticed by people within both communities. This has led to strange claims as, for example, by Westerhof and Keyes’s (2010) who propose a “two continua model” (p. 110) of mental health and mental distress. To show this, they factor analysed two sets of questions: First, those on such topics as self-acceptance, purpose in life, autonomy and other measures associated with positive psychology (Ryff & Keyes, 1995). Second, traditional clinical psychology measures such as depression and anxiety. In keeping with earlier work (Linley et al., 2009) they find that the two constitute separate factors; this, as with their earlier work, is a highly valuable contribution as it suggests that the two aspects of living are separable and thus worth looking at jointly (one is not subsumed into the other). However, they erred by labelling the “positive psychology measures” as positive, the

“clinical psychology measures” as negative, and concluding from their results that positive and negative functioning are on different continua. Clearly, the “positive psychology measures” have both positive and negative poles (e.g., self-rejection to self-acceptance; purposeless in life to purposefulness in life; subjugation to autonomy etc.). Equally, depression is continuous with happiness and anxiety with calmness (Joseph and Wood, 2010). They fall for treating the direction in which the scales are labelled as arbitrary indications as to whether they are positive or negative, and the tradition from which they have emerged to also indicate such, and thus arbitrarily label them as positive or negative *in nature*, and then incorrectly conclude from the factor analytical evidence that the positive and negative are separate continua. What the results actually show is that there are two (highly correlated) types of well-being, both of which ranges from positive to negative.

We (Johnson et al., 2011b; Johnson, in press; Joseph and Wood, 2010; Wood and Tarrier, 2010; Wood, Taylor, and Joseph, 2010) have previously argued that this is a key reason why positive and clinical psychology needs to be integrated, and indeed why it is not logical not to do so. In this paper we develop this argument much further, clearing up conceptual inconsistencies, and considering the implications for clinical psychology.

The Foci of Study of Positive and Clinical Psychologists

Two misperceptions may arise from the observation that all factors fall on a continuum from positive to negative. First, one may assume that we do not need to study positive factors (or positive psychology) as these are simply the inverse of the more widely studied negative factors (conversely, one may argue we do not need to study the negative, nor have clinical psychology). If this argument means that ultimately we should aim to have a truly integrative psychology, which focuses equally on the positive and the negative, then we would be completely in agreement – indeed, this definition is the hallmark of what we term ‘Positive Clinical Psychology’ (Wood and Tarrier, 2010). However, if this argument means

to say that we can ignore either positive or clinical psychology research *right now*, then it misses the point: Whilst both fields may study constructs which are on continua from positive to negative; the *fields have tended to study different constructs*. Our (Linley et al., 2009) and Westerhof and Key's (2010) show this with some variables. While Clinical psychology research has tended to focus on disorder and the most prevalent and consistent predictors of this (e.g., demographic, mood and cognitive variables), positive psychology researchers have focused more on discovering new forms of individual differences, in order to understand better how to support human flourishing. For example, work in positive psychology has focused on personality variables such as gratitude (Wood, Froh, & Geraghty, 2010), forgiveness (McCullough, 2000), courage (Woodard & Pury, 2007), generosity (Dunn, Aknin, & Norton, 2008), and optimism (Scheier & Carver, 1985), which are qualitatively distinct from the often demographic, cognitive and affect- related variables studied by clinical psychologists.

This observation addresses the second misperception that arises, namely that if constructs are on continua from positive to negative, then one cannot then make the common claim within positive psychology that the absence of “positive” constructs protects the onset of “negative” constructs. For example, can one say that the “positive” construct of gratitude protects from the “negative” construct of depression? Strictly one cannot, as gratitude is continuous with ingratitude and depression is continuous with positive functioning (Wood, Taylor, and Joseph, 2010) so neither can be termed as positive or negative. However, as positive and clinical psychologists have studied qualitatively *different* constructs, one can argue that *the constructs* that positive psychologists have studied can have substantial incremental validity in predicting clinical outcomes, not because either is “positive or negative” but rather because they are understudied. Gratitude, for example, has much to contribute to clinical psychology (Wood et al., 2010), not because it is “positive” (being on a

continuum with ingratitude), but rather because it is distinct from the variables generally studied in clinical psychology, and it is a major and previously ignored longitudinal predictor of clinical functioning.

The reason for the divergence in the foci of clinical and positive psychology may lie in the differing motivations of these clinical and positive researchers. Clinical psychology is first and foremost an applied psychological discipline, the roots of which lie in assessing and addressing negative deviations from 'normality' (McReynolds, 1987; Taylor, 2000). In the present day, the work of most clinical psychologists involves making meaning and sense of psychological problems; looking for patterns in cognition, emotion and behaviour, and carefully identifying recurring themes from a range of concerns, difficulties, and experiences that have been reported. Often, clients feel overwhelmed by the various difficulties they are facing, and the role of clinical psychologist is to help them make sense of this, to draw out a 'story' from their experiences. Researching clinical psychologists search for those treatment interventions that can be used in different individuals reporting similar symptoms with the same reliable hope of a positive outcome. This work has led to the development of disorder-specific models which clinicians can refer to, to guide their work with individual clients (Tarrrier & Johnson, 2015). In short, the task of the clinical psychologist is to see simplicity in complexity; to find the heart of a problem, and to work with the client to solve it. Instead, Researchers focusing on positive psychology, on the other hand, are often not involved in clinical practice. Their task is to better identify those individual differences that can predict the ways in which people will behave and respond over time, and to varying different stressors. Where interventions are designed and tested, they are more often focused on the general population; and rather than correcting deviations from normality, their goal is to enhance the likelihood of positive outcomes (or conversely, to reduce the likelihood of negative outcomes).

These differing motivations also point to an underlying divergence in the assumptions and perspectives of these two disciplines. The perspective of clinical psychology is that most individuals are healthy, which leads the focus to be on helping those people who are considered to be ‘unhealthy’ to improve so that they are within a ‘normal range’. Positive psychology, on the other hand, takes a spectrum focus, and assumes that large groups of individuals who may be considered to be within a ‘normal range’ could achieve better wellbeing than they are currently experiencing. As these assumptions are simply differing perspectives on the same situation, it is not possible to state that either of these are correct or incorrect (Maddux, 2008). However, in support of the positive psychology view point, is an overwhelming body of evidence suggesting that those individuals who might be considered within the normal range – that is, not in services, on medication or in therapy for mental health problems, and in employment – report symptoms of psychological disorder. For example, over 30% of consultant doctors demonstrate evidence of psychiatric morbidity (Taylor, Graham, Potts, Richards, & Ramirez, 2005), and 26% of both veterinarians (Bartram, Yadegarfar, & Baldwin, 2009) and teachers (Travers & Cooper, 1993) report diagnosable rates of anxiety, depression or both. Even – as is the case for most people – when people are score highly on measures of well-being such as life satisfaction (Myers, 2000), positive psychologists argue that these people can be helped more to live life to the full and “flourish”.

In the present article, we aim to outline the ways in positive psychological research can enhance knowledge, understanding, and practice in clinical psychology, leading to an integration of these two literatures, or a ‘Positive Clinical Psychology’ (Wood and Tarrier, 2010). Building on the work on previous researchers in this area (Maddux, 2008; Vázquez, 2013; Wood & Tarrier, 2010), we will suggest that (1) factors studied by positive psychology researchers can independently predict wellbeing when accounting for traditional negative

factors, and do this prospectively, (2) the factors studied by positive psychologists can interact with risk factors to predict outcomes, thereby conferring resilience, (3) interventions that aim to increase movement towards the positive pole of well-being can be used encourage movement away from the negative pole, either in isolation or alongside traditional clinical interventions to enhance the outcomes of treatment as usual, and (4) research from positive psychology can support clinical psychology as it seeks to adapt therapies developed in Western nations to other cultures. Finally, we will consider areas where there is increasing integration between clinical psychology and positive psychology, and what the outcomes of this work have been.

Factors Studied in Positive Psychology Research Prospectively, Independently Predict Symptoms of Psychological Disorder

In much clinical research into psychological disorder, the predictors studied have been restricted to cognitive, emotional and demographic factors such as intellectual ability, mood-related variables, income and marital status. Although it is usually the negative end of these constructs which are focused upon (e.g., deficits in intellectual ability, or elevated depression), these are not inherently negative constructs (e.g., the opposite end of these continua are proficient intellectual ability, and happiness, respectively). If one sees the constructs in such ways, then one may ask why clinical psychologists have focused on these particular domains of positive to negative functioning and not the many other continuous individual differences that characterise people. The answer is that these are the kind of continua on which if one is low one is most likely to end up seeking services. Perhaps there is something inherent in these particular continua that makes being low on them especially intolerable; evolutionary evidence, for example, suggests that we might be hardwired to experience the symptoms of psychological disorder in situations which would have been threatening in the evolutionary past (Taylor, Gooding, Wood, & Tarrier, 2011). An example

of this is the withdrawal, hypervigilance, depressed affect, etc. that results from perceiving that one is of low social rank (Griffiths, Wood, Maltby, Taylor, & Tai, 2014; Taylor et al., 2010; Taylor, Gooding, Wood, Johnson, & Tarrier, 2011); necessary, perhaps, when the pack may set against one if different actions were taken, but wholly perverse when triggered by being of low income in today's society (Daly, Boyce & Wood, in press; Wood, Boyce, Moore, & Brown, 2012). However, whilst we may have some evolutionary propensity to react more to being low on some constructs than others, the extent to which this reaction occurs and is seen as intolerable (by the individual concerned, or by those providing or resourcing the treatment) depends in part on what society itself sees as intolerable and indeed treatable. In classical Greece and Rome, for example, influenced by Aristotle (2011), and later Stoic developments (Epictetus, 2008), the key concern of many was not emotional, but rather virtuous functioning. Moreover, this was seen as "treatable", in that many of the classical philosophy schools (e.g., Cynicism, Epicureanism, Stoicism) tried to teach overcoming practical problems with life, often with writing exercises and a form of group therapy (Robertson, 2013). More recent work within positive psychology has similarly aimed at using therapeutic techniques to move people up the various continuums associated with virtue (Parks & Schueller, 2014). The point is that if one sees the constructs with which clinical psychologists concern themselves as not inherently positive or negative, but rather continua of functioning, one has to question why these and not other continua were selected; and further, whether some of the other continua not normally studied should be a focus of clinical psychology.

Empirically, many of the continua (we stress, again, from positive to negative) that positive psychologists study have incremental validity in predicting disorder above and beyond what is commonly studied with clinical psychology. For example, in a cohort of 5,666 adults aged 51-56, Kelly, Wood and Mansell (2013) found that tenacity and flexibility

at baseline predicted depression symptoms measured 10 years later, such that individuals low in tenacity or flexibility had a higher risk of increases in depression symptoms, and people low in both these traits had a particularly high risk. In a study of the same cohort, Wood and Joseph (2010) found that individuals low on existential measures of well-being (self acceptance, autonomy, purpose in life, positive relationships with others, environmental mastery, and personal growth) were over seven times more likely to meet the cut-off for clinical depression at ten year follow-up. Similarly, other longitudinal studies have found evidence for the protective effects of optimism (Brissette, Scheier, & Carver, 2002; Giltay, Zitman, & Kromhout, 2006) and gratitude has emerged in recent years as one of the most clinically relevant traits (Wood, Froh, & Geraghty, 2010). For example, our work shows that gratitude – the habitual noticing and appreciating of the positive in the world (Wood, Maltby, Stewart, & Joseph, 2008) - is related to well-being above and beyond the 30 facets of the Big Five model (Wood, Joseph, & Maltby, 2008), which include anxiety, depression, impulsivity, emotional vulnerability, and stress (the neuroticism traits, a common focus within abnormal psychology). Gratitude relates to more positive coping strategies (broadly characterisable as more approach and less avoidance coping, combined with greater use of social support (Wood, Joseph, & Maltby, 2009), which partially mediate the relationship between gratitude and (lower) stress. During a life transition, gratitude is related to the development of less depression (Wood, Maltby, Gillett, Linley, & Joseph, 2008), and gratitude relates to less clinically impaired sleep (in both cases beyond neuroticism) (Wood, Joseph, Lloyd, & Atkins, 2009). Finally, whilst gratitude in part arises from prior distributions of rewards (Wood, Brown, & Maltby, 2011), low levels of gratitude are associated with negative schematic processing of social events (seeing aid as less valuable, less costly to the benefactor, and intended with ulterior motives; Wood, Maltby, Stewart, Linley, & Joseph, 2008). Thus this trait, which emerged initially under the rubric of positive psychology, has

emerged as a key incremental predictor of clinically relevant outcomes. The point is not, as commonly considered, that these constructs are somehow positive (other than in the minds of positive psychologists), as loosely, tenacity is bipolar with giving-up tendencies, flexibility with rigidity, self-acceptance with self-rejection, autonomy with subjugation, purpose in life with meaninglessness, environmental mastery with defeat, personal growth with psychological stagnation, optimism with pessimism, and gratitude with ingratitude. Rather these represent different types of constructs than those commonly studied within clinical psychology and these constructs are shown to provide strong incremental validity for the very outcomes that are of most interest to people in the field.

Importantly, the prospective nature of these studies indicates a causal role for these variables in the aetiology of disorder. However, of equal importance is evidence that these factors appear to constitute an independent risk factor for clinical functioning; they are not simply a repetition of commonly recognised risk factors. In their cohort study, Wood and Joseph (2010) found that even when they controlled for negative functioning, previous depression, economic, demographic, and physical health variables, individuals scoring low on the six factors of positive wellbeing were still more than twice as likely to reach criteria for depression at follow-up. Consistent with this, in their study of dispositional optimism amongst older men, Giltay et al. (2006) found that the association between higher optimism and lower subsequent depression remained, even controlling for the recognised predictors of age, cardiovascular disease, self-rated health, level of education, and level of physical activity. Research into depression amongst non-depressed, recovered-depressed and currently depressed individuals found that a tendency to ‘dampen’, or reduce the impact of positive emotion are uniquely associated with symptoms of anhedonic depression, even after controlling for anxious arousal and general distress (Werner-Seidler, Banks, Dunn, & Moulds, 2013). The evidence from these studies may be particularly relevant for clinicians,

who are often working within time constraints and unwilling to burden clients with unnecessary assessment questions. This research suggests, however, that these factors, which have been typically studied by positive psychologists, provide information that could predict subsequent changes in a client's symptomatology, in a way that could not be predicted by traditional factors alone.

Resilience: Factors Studied by Positive Psychology Researchers Buffer the Impact of Risk

A compelling argument in favour of incorporating positive psychology research into traditional clinical psychology is the consistent observation that factors studied by positive psychologists can confer resilience against known risk factors for disorders. Resilience has long been a popular topic, but the concept of resilience, and how it should be understood, has often been poorly defined. A wide variety of terms have been used interchangeably when referring to resilience or resilience factors, such as hardiness, mental toughness and 'protective factors'. Furthermore, a wide range of methods have been used to investigate resilience. Whilst resilience has been commonly viewed as factors that enable continued strength in the face of stressors, it has often been investigated as a direct associate of the outcome variable of interest. That is, researchers have examined whether a proposed 'positive' resilience variable occurs with a reduced likelihood of a poor outcome. This fails to acknowledge a key part of the definition of resilience: Stress. Without incorporating the presence of stress into the analysis, it is not possible to know whether the proposed resilience variable is protecting individuals from stress, or whether it simply occurs with lower levels of stress. Further, as all positive variables are negative when inversed, it could be argued that these individuals are merely at lower risk.

In order to overcome these limitations, Johnson and colleagues (2010a, 2011a, in press) have introduced the Bi-dimensional Framework for the investigation of resilience. This

framework is not focused upon offering a definition of what leads a person to be resilient, as such, but instead outlines criteria by which to test proposed resilience variables. Three criteria are proposed. The first of these states that resilience must be viewed as a representing a separate dimension to risk, which moderates or buffers the likelihood that risk will lead to negative outcomes. The second criterion suggests that both risk and resilience should be viewed as bipolar dimensions – continua running between positive and negative poles- with risk factors having an inverse which is positive and protective, and resilience factors having an inverse which is negative, amplifying the impact of risk. For this reason, concepts of resilience should not simplify it to constituting only positive factors, but should recognise that resilience is a spectrum with both positive and negative poles. Third, the framework suggests that where the research is focused at the level of the individual (as is most positive and clinical psychological research), then resilience should be understood as psychological constructs. Whilst external or social factors may contribute towards, or damage an individual's resilience, ultimately concepts of psychological resilience are most often referring to a quality of the individual or unit, and the framework seeks to enable research findings which reflect this.

These criteria are designed to support researchers who want to test whether particular variables confer resilience, and using it ensures that the research will establish whether the variable is a construct which buffers the risk of undesirable outcomes in the face of stress. According to the framework, resilience is a factor which can be established by the presence of fewer negative/more positive outcomes in response to stressors and risk factors. The framework itself does not seek to identify any particular resilience variables, but instead offers a route by which to find them. In addition to offering a way to design new studies of resilience, it also provides a common framework for interpreting existing research. By defining resilience by methodology rather than the interchangeable terms used by researchers

(e.g., 'resilience', 'hardiness'), the use of the framework enables a wide variety of studies to be interpreted, including those which may not have considered themselves as resilience research. This allows for the collation and systematic review of resilience factors against particular negative outcomes. That is, a researcher can simply search for all studies of interactions between (a) a risk factor and (b) a psychological construct in relation to the outcome of interest, which may be a clinical disorder or problematic behaviour. As clinical psychologists often work in specialised clinics focused on specific disorders or sets of disorders (e.g., for clients with personality disorders and self-harm, depression and anxiety, eating disorders or PTSD), reviews of this nature may have strong clinical utility.

The Bi-dimensional Framework was developed in the context of suicide research. It has since been used to guide research demonstrating a buffering effect of more positive self-appraisals on the relationship between stressful life events and suicidality in clinical and non clinical groups (Johnson, Gooding, Wood, & Tarrrier, 2010a; Johnson et al., 2010b). It has also guided research demonstrating a buffering effect of low levels of reappraisal (a cognitive coping strategy) on negative emotional response to failure (Johnson et al., 2011a) and a moderating impact of low levels of shame on the association between life stress and paranoia in higher-risk young adults (Johnson et al., 2014). In addition to guiding the design of original research, it has been used to guide a review of all suicide resilience factors (Johnson et al., 2011a). At the time this was conducted, a search for 'resilience' and 'suicide' or 'suicidality' drew around four hits, none of which had examined the proposed resilience factors as a buffer of risk. However, when resilience was instead defined by the criteria outlined by the framework, 77 studies were identified, which suggested a consistent buffering role for positive attributional style, higher levels of agency and lower levels of perfectionism and hopelessness. The majority of studies had not self-identified as investigating 'resilience',

demonstrating the importance of identifying resilience studies based on methodology rather than terminology.

Although it was developed in the context of suicide research, the Bi-dimensional Framework can be applied to resilience research in relation to any outcome of interest, and may be a particularly useful tool for understanding how factors studied by positive psychological researchers can enhance understanding in clinical psychology. Positive psychology factors have been studied in relation to a wide range of clinical outcomes, and recent years have seen a growing interest in interactions between factors studied by positive psychologists and stressors in predicting outcomes. Research into gratitude has found that it can mitigate the risk of financial strain leading to depressive symptoms amongst older adults (Krause, 2009), and for those who are depressed, it can buffer the association between increasing depressive symptoms and suicidal ideation (Kleiman, Adams, Kashdan, & Riskind, 2013). Similarly, optimism has been found to confer resilience against the development of anxiety in the face of illness burden amongst older adults (Hirsch, Walker, Chang, & Lyness, 2012), and to buffer the likelihood that both chronic and acute life stressors will increase depressive symptoms amongst disadvantaged women (Grote, Bledsoe, Larkin, Lemay, & Brown, 2007). Trait hope has been found to buffer against the association between stressful life events and depression when measured cross-sectionally (Visser, Loess, Jeglic, & Hirsch, 2013) and daily stressors and negative affect in a diary study (Ong, Edwards, & Bergeman, 2006). Authenticity (Wood et al., 2008) has also been studied as a resilience factor, and has been found to buffer the association between low social support and depressive symptoms in adolescent females (Theran, 2010).

Resilience in clinical practice. The concept of resilience is popular in clinical psychology practice, but as with research, it has been poorly defined. Generally it has been viewed as simply ‘positive’ factors (e.g., strong social support, a good job) which are added

to a formulation otherwise focused on negative contributors to the problem. The Bi-dimensional Framework brings clarity in this area, suggesting that resilience factors are those internal characteristics which have a disproportionately significant impact on mental health outcomes. In statistical terms, resilience factors are those which ‘moderate’ the likelihood of risk leading to outcome; in other words, they are variables which have the power to muffle or dampen the negative impact of risk. Because of this, focusing on the development of risk factors may be important for clinical interventions, particularly when the stressors or risk factors at hand are difficult to change (such as those related to demographic variables, e.g., age or socio-economic status). The framework also highlights the number of positive psychology studies which (though not labelling themselves as studies of ‘psychological resilience’) could be important for clinicians seeking to help their clients develop resilience. For example, evidence that gratitude both buffers individuals from developing depression (Krause, 2009) and buffers depressed individuals from suicidal ideation (Kleiman et al., 2013) suggests that gratitude diaries may be a useful part of interventions amongst depressed individuals.

The framework also highlights the importance of incorporating resilience factors into risk assessments. Risk assessments are well known for being difficult in clinical practice, especially in relation to rarer outcomes such as suicide (Gangwisch, 2011). Understandably, they usually focus on the most reliable risk factors for relapse, however, these factors, such as past history of relapse and symptom severity, are often broad and generic, and fail to distinguish between clients who have already found themselves in the risk assessment process due to presenting with these types of difficulties. The examination of factors that have been found to buffer the association between risk and outcome offers a more specific, sophisticated method for risk prediction. As with interventions, the framework highlights the number of positive psychology studies which may be useful in this regard. For example, utilising the

studies by Krause (2009) and Johnson et al. (2010a; 2010b), would suggest that for a client leaving inpatient care who is returning to a situation involving financial strain, or who is likely to encounter stressful life events in coming months, those high in gratitude and positive self-appraisals may be at lower-risk of depressive relapse or increasing suicidality, whereas those low in these factors may require a higher level of support.

More widely, the exploration and measurement of positive characteristics in clinical practice can have indirect clinical benefits. The discussion of these more varied, individualised aspects (e.g., the client's consideration of their levels of self appraisals, optimism or gratitude, for example) can bring a sense of positivity into the assessment and therapeutic context; it implicitly communicates to the client that the therapist has not reduced them to the problems that have led them to receiving clinical support, and that they are viewed in a more complex, holistic manner. In a group at risk of low-self-esteem, this can help to build a more positive self-regard, and support the development of the therapeutic relationship, an important feature of successful interventions (Lambert & Barley, 2001).

Positive Psychology Interventions: Effective for Reducing Symptoms of Disorder and Suitable for Clinical Populations

It is important to note here that positive psychology interventions have differed in their focus from traditional clinical psychology treatments. Where traditional clinical treatments have taken a past and problem orientation, seeking to discuss the problem in hand, its context and causes, positive interventions have aimed to cultivate positive qualities and emotions and are usually 'skill building' treatments. As such, positive psychology interventions differ *qualitatively* from traditional interventions, and they are not simply seeking to focus on the other end of the continua (for example, by discussing a client's problem in relation to their strengths or skills). However, some therapies are often delivered as 'hybrid' interventions, where the positive intervention is combined with elements of the

problem-focused approach of traditional therapies (e.g., wellbeing therapy; Fava, Rafanelli, Cazzaro, Conti, & Grandi, 1998).

A wide range of positive psychology interventions have now been developed and tested, from brief, self-help interventions of short duration to more in-depth intervention programmes, involving group work or one-to-one therapeutic input. The self-help interventions have included positive writing interventions, where participants write about intensely positive experiences (Burton & King, 2004), gratitude interventions, where participants recall things in their lives for which they are grateful (Emmons & McCullough, 2003; Geraghty, Wood, & Hyland, 2010a, 2010b; Wood et al., 2010) and kindness interventions, where participants enact or record kind acts towards others (Layous, Nelson, Oberle, Schonert-Reichl, & Lyubomirsky, 2012; Otake, Shimai, Tanaka-Matsumi, Otsui, & Fredrickson, 2006). The more in-depth therapeutic interventions have included hope therapy, an 8-week group intervention (Cheavens, Feldman, Gum, Michael, & Snyder, 2006), life-review therapy, which comprises three one-hour, one-to-one sessions (Davis, 2004) and wellbeing therapy, which consists of 8-12 one-to-one sessions addressing six aspects of positive functioning and eudaimonic well-being (Ruini & Fava, 2012).

To an extent, positive interventions have long been part of clinical psychology treatment approaches. A classic example of this is behavioural activation, which is a core aspect of Cognitive Behavioural Therapy (CBT) for depression, and involves increasing the number and quality of pleasurable and rewarding activities the client undertakes. As Mazzuchelli, Kane and Rees (2010) observe, there is little to distinguish behavioural activation from positive psychology interventions, other than the intention with which it was developed. Behavioural activation has been found to be effective for enhancing wellbeing and reducing symptoms in clinical groups (Dimidjian, Barrera Jr, Martell, Muñoz, & Lewinsohn, 2011;

Mazzucchelli et al., 2010), but despite this success, clinical psychology has been slow to explore further positive interventions.

Understandably, the main outcome of interest for researchers investigating positive interventions has been enhanced wellbeing or positive affect. Consistent with this, there is now a strong body of literature suggesting that positive interventions can enhance positive mood and subjective well-being. In a meta-analysis of positive interventions, Sin and Lyubomirsky (2009) found a significant impact of positive interventions in enhancing wellbeing, reporting a medium effect size. In a more recent meta-analysis, Bolier et al. (2013) utilised alternative criteria for selection of interventions, which resulted in a higher proportion of shorter-term, self-help interventions. However, they still reported a significant impact of positive interventions in enhancing both subjective wellbeing and psychological wellbeing, albeit with a small effect size. As wellbeing can be viewed as a spectrum, with low levels of wellbeing presumably related to presence of depression or other psychological disorder, this information has relevance for the practice of clinical psychology.

Supporting the suggestion that wellbeing is on a continuum with psychological disorder is evidence that as well as increasing wellbeing, positive interventions have the concomitant impact of reducing depression, although this research has been slower to develop. For example, in their meta-analysis, whilst Sin and Lyubomirsky (2009) found 49 studies investigating well-being, there were only 25 investigating depressive symptoms. Despite this, there is now strong evidence that positive interventions are effective for symptoms of disorder. Both the meta-analyses by Sin and Lyubomirsky (2009) and Bolier et al. (2013) reported that positive interventions reduced depressive symptoms with a similar effect size to that found for enhancing wellbeing. Furthermore, there is now some evidence indicating that positive interventions may not only be effective for reducing clinical symptoms in unselected populations, but they may be effective for reducing symptoms in clinical groups. In an

inpatient sample of individuals with substance misuse problems, Lin et al. (2004) found that forgiveness therapy was effective for reducing symptoms of anger, depression and anxiety. Similarly, in a sample with mild-moderate depression, Seligman, Rashid and Parks (2006) found that a group positive intervention based on a combination of positive exercises was effective for reducing depressive symptoms, and in a sample with major depression, they found that a positively-oriented individual intervention was more effective for reducing depression and increasing functioning than treatment as usual. Indeed, positive interventions may be even more effective in clinical groups than the general population (Bolier et al., 2013).

Despite increasing interest in the value of positive interventions, the evidence base in clinical populations is still relatively limited; what does exist is mainly restricted to individuals with depressive disorders, and there is a need to investigate the effectiveness of positive interventions for groups with other disorders. Given the time and expense involved in these types of studies, and the existence of other therapies known to be effective, it could be argued that this research is unlikely to be a priority for clinical psychologists. However, in the only two studies to directly compare a technique from positive psychology (gratitude focusing) with one from clinical psychology (automatic thought records), both techniques were found to be equally as effective and the gratitude technique had significantly lower drop-out (Geraghty et al., 2010a, 2010b). Clinical psychology as a discipline is also currently facing several challenges, for which positive interventions may represent a useful resource.

First is the issue of cost: compared to medical interventions delivered by psychiatrists, clinical psychology services usually deliver care at a higher price per client. This is because whilst the salary of clinical psychologists in most countries is less than that of psychiatrists, clinical psychologists usually require much greater periods of time with their clients in order to deliver interventions. In an age of austerity in many countries, this has led to a pressure on

psychology services to demonstrate greater efficiency. In the UK, services have begun to explore more cost-efficient therapy delivery modalities such as online, bibliotherapy, phone consultations, and group interventions. Positive psychology research may be useful in this endeavour, as many positive interventions which have been tested have been self-help (Bolier et al., 2013), and as such offer a cost-efficient way to deliver additional client support by services. Online (e.g., Drozd et al., 2014) and group therapies (e.g., Cheavens et al., 2006; Seligman et al., 2006) have also been developed and tested. An advantage of the self-help approach is that it can be more attractive for clients with certain types of problems, such as those with social anxiety who may find the social interaction with a therapist intimidating. However, research has found that therapies without client contact are at risk of high levels of drop-out (Christensen, Griffiths, Mackinnon, & Brittliffe, 2006; Farvolden, Denisoff, Selby, Bagby, & Rudy, 2005; Rabiun, Pike, Wiatrek & McAlister, 2008). It is to this issue that Geraghty, Wood, and Hyland's (2010a, 2010b) finding that people are less likely to drop out of a gratitude technique than one from classical clinical psychology becomes important.

Second, and related to this, is the issue of waiting lists. Very limited evidence is available regarding the average wait for psychological services, but researchers from a range of countries suggest that delay in access is a problem (Kerr, O'Donovan, & Pepping, In press; Kowalewski, McLennan, & McGrath, 2011; Ní Shiothcháin & Byrne, 2009). Increased delays have been associated with a failure to attend and reduced patient satisfaction (Gallucci, Swartz, & Hackerman, 2005; Grunebaum et al., 1996; Shipley, Hilborn, Hansell, Tyrer, & Tyrer, 2000), and in the UK, wait length is recognised as an ongoing challenge (RCP, 2013). In order to try and address this, the Increasing Access to Psychological Therapies (IAPT) initiative was introduced to treat individuals with depression and anxiety in primary care settings. In these services, average waiting times are now down seven weeks, however, there is a wide variability between services, and a third of service users remained dissatisfied with

their wait (RCP, 2013). Reports for UK secondary care psychological services are not available, but anecdotally these are usually in excess of 6-12 months. The self-help design of many positive interventions may be particularly useful to address this problem, potentially maintaining engagement and providing intervention while clients wait for one-to-one or group therapy. Investigating this possibility, Kerr et al. (In press) assigned clients on the wait-list for psychological therapy to a self-help, 2-week 'pre-treatment' intervention focused either on developing kindness or gratitude, or to a control condition. Results suggest that clients in the kindness and gratitude conditions reported significantly greater increases in satisfaction with life and optimism, and reductions in anxiety than those in the control condition. The attrition rate in the study was high (around 50%) and no comparisons were drawn in terms of subsequent engagement with therapy, but this study demonstrates the feasibility of using positive interventions to tackle the waiting-list problem seen by many clinical psychology services, and the promising findings highlight the need for further research in this area.

Third is the challenge to deliver quality. As outlined above, clinical psychology services are seen as an expensive alternative to medication, and although many services are improving their efficiency in response to this, it is unlikely that they will ever simply cost less than the pharmaceutical alternative. Because of this, there is a need for services to demonstrate better quality outcomes for clients receiving psychological interventions. One positive intervention, well-being therapy, has had a particular focus upon these issues (Fava et al., 1998). Well-being therapy is based upon the six dimensions of positive functioning and wellbeing (autonomy, environmental mastery, purpose in life, personal growth, positive interpersonal relationships, self-acceptance) outlined by Ryff's model of eudaimonic wellbeing (Ryff, 1989), and can be delivered in conjunction with standard cognitive behaviour therapy. It has been found to be effective for tackling difficult-to-treat problems such as residual symptoms

and recurrent depression for which medication is often ineffective (Fava & Offidani, 2011; Fava et al., 1998; Fava et al., 2004). Further, in one small study, it has been directly compared to anti-depressant treatment for relapse, and results indicated it was superior (Fava, Ruini, Rafanelli, & Grandi, 2002). In their study of positive psychotherapy, a positive one-to-one intervention delivered to individuals with a diagnosis of Major Depressive Disorder, Seligman et al. (2006) also directly compared their intervention to individuals receiving pharmaceutical medication. At the end of treatment, they found that a significantly greater number of participants in the positive intervention condition were in remission from their depression than those on medication.

Fourth is the challenge clinical psychologists are currently facing in relation to their role as therapists, as therapeutic interventions are increasingly offered by other professions, often at a lower cost. In the UK, this role is being challenged by therapists trained in specific modalities, in the US, this role is challenged by counsellors and social workers. Often, these therapists are trained in specific modalities and use protocol-based treatments. However, research suggests that individualised, formulation-based interventions which respond to the changing needs of the client may produce faster and more effective results (Bickman, Kelley, Breda, de Andrade, & Riemer, 2011; Litt, Kadden, & Kabela - Cormier, 2009; Weisz, Chorpita, Palinkas, & et al., 2012). Positive psychology has developed, and is continuing to develop a wide range of short and long-term interventions, which can be used flexibly in isolation or alongside other interventions. As such, the positive psychology research literature contains a treasure chest of techniques which clinical psychologists can draw on to tailor their treatment approach to the changing needs of individual clients, increasing the likelihood of successful treatment. In this way, clinical psychologists can both ground their position as research-based, flexible and effective therapists, in comparison to

protocol-based therapists, and lead the way in exploring and honing new therapeutic techniques.

Positive Psychology Research can Support Cross-Cultural Clinical Psychology

Recent years have seen an increasing recognition of the need for adequate and effective mental health interventions worldwide, particularly in low and middle income (LMIC) countries, where it is estimated that 80% of individuals who need mental health care do not receive it (WHO, 2008, 2011). In 2008 the Worldwide Health Organisation (WHO) launched its Mental Health Gap Action Programme (mhGAP), referring to the gap between need and provision, in order to address this. Alongside this, a growing interest in global mental health has been evident amongst clinical psychologists. In 2012, the American Psychological Association launched a new journal with a focus on these issues, (*International Perspectives in Psychology: Research, Practice, Consultation*) and since 2010, the British Psychology Society has published two special issues of its 'forum' magazine on the topic. Clinical psychologists working in this area have described a range of challenges that are currently being faced. Here, we will describe these challenges, and outline the ways in which positive psychology research may be able to support this work.

One of the primary challenges that has been highlighted is the underlying approach to identifying and addressing mental health needs in non-Western cultures. In general, this has involved transferring concepts and constructs surrounding mental health which have been developed in Europe and North America to other countries. For example, the WHO mhGAP state that their goal is to focus on 'priority conditions' such as depression, bipolar disorder and psychosis. However, these diagnostic criteria which have been developed in Western countries do not have validity for other cultures, and may not be widely understood or recognised concepts (White, 2013; White & Sashidharan, 2014). Although recent years have seen moves away from this dependence upon diagnostic criteria by some clinical

psychologists (e.g., Bentall, 2006), clinical psychology has developed within this diagnostic framework, and treatments are often bound to these categories. As such, deciding how to apply these diagnostic-specific treatments to groups of individuals who may not 'fit' or understand these diagnostic criteria is likely to represent a significant challenge. Positive psychology, by contrast, has not developed within these diagnostic frameworks, and its interventions, therefore, are inherently 'transdiagnostic' in nature. They have mainly been trialled in large, unselected groups of individuals, demonstrating more general evidence for effectiveness. Furthermore, in addition to evidence suggesting that they are effective for reducing depression (a Western construct), research has found that they can also improve wellbeing (Sin & Lyubomirsky, 2009), which is a broader, and more multi-faceted concept, which could potentially support the likelihood of its cross-cultural transferability.

Related to this is the challenge of transferring theories and concepts underpinning clinical psychology interventions in particular. That is, clinical psychology interventions are usually developed within the context of a theoretical explanatory framework of mental health problems, and often part of interventions (particularly cognitive interventions) is explaining this framework in order to provide a convincing rationale to the client. When used in the culture within which the theory has been developed, this can be an effective and useful part of the intervention (Addis & Jacobson, 2000). However, just like transferring psychiatric diagnostic criteria is invalid, transferring such culturally-bound explanations to other cultures who do not share similar assumptions may be both inappropriate and ineffective. Positive psychology interventions, as they are not couched in explanations of disorder, are not burdened with this same need to provide a theoretical rationale. Because of this, they may be more accessible by individuals from other cultures and therefore less likely to induce feelings of confusion. These aspects could be important when therapists are seeking to build rapport and confidence with clients across a cultural divide.

It is important to add a note of caution here. Although positive psychology does not rely upon culturally bound concepts of ‘mental disorder’, some concepts favoured by positive psychology researchers, such as happiness and wellbeing are also socially constructed, with their meaning varying across cultures (Kitayama, Markus & Kurokawa, 2000; Uchida, Norasakkunkit, & Kitayama, 2004). However, a number of positive psychology interventions do not rely upon the client engaging with these socially constructed concepts. For example, many positive interventions focus on the enacting of positive activities, such as writing down positive events (Chancellor, Layous, & Lyubomirsky, 2014) or things that people are grateful or pleased to have in their lives (Emmons & McCullough, 2003; see Shin & Lyubomirsky, in press, for an overview). As such, this need for shared concepts of health (either positive or negative) are less likely to be a hindrance to the effectiveness of these interventions. Nonetheless, it is important that recognition of the cultural variation in positive concepts of wellbeing is reflected in the translation of interventions across cultural contexts.

A further challenge for cross-cultural clinical psychology is the issue of evidence. That is, although the emphasis in global mental health is on utilising ‘evidence-based’ treatments, the origins of this evidence seem largely confined to European and North-American nations, and so cannot be considered ‘evidence-based’ for use in other cultures, where they have not been tested (White, 2013). Exact figures for clinical psychology research are not available, but a study of psychiatry journals indicated that only 10% of articles published were from non-Western nations (Patel & Sumathipala, 2001). However, by contrast, there is a great focus within positive psychology on cultural differences and the influence of cultural context. This research has found that the whilst some personality factors such as optimism vary in their importance to coping across cultures (Nes & Segerstrom, 2006), others such as generosity appear to have a universally positive impact upon happiness (Aknin et al., 2013). Furthermore, there has been a great interest in testing positive

interventions amongst professionals from non-Western cultures. A full review of this burgeoning literature is beyond the scope of this paper, but research in this area has indicated the efficacy of various positive interventions in a range of countries, including India (Mehrotra, 2013), Japan (Otake et al., 2006), China (Chan, 2010) and Korea (Layous, Lee, Choi, & Lyubomirsky, 2013). It has also highlighted the importance of investigating the interactions between culture and intervention type, for example, Layous et al. (2013) found that while Korean participants responded well to a kindness intervention the effect was less strong for a gratitude intervention. Both the growing evidence base, and the interest amongst researchers from a range of cultures in these interventions, supports their potential usefulness to therapists seeking to develop culture-appropriate interventions.

A final challenge that will be considered here is the issue of resources. In a sense, this challenge is no different to the challenge that many European and North-American clinical psychologists have faced in the recent years of recession and service funding cuts, however, this problem is greatly magnified in a number of countries (WHO, 2008, 2011). In order to try and manage this, some services in LMIC have designed their interventions with a tier-based approach, where there is an emphasis on offering lower-level interventions where possible (e.g., Bosqui, 2014). As described above, positive psychology researchers have developed a wide-range of low-level interventions, which are often self-help in nature and can be undertaken with basic resources such as pencil and paper (Bolier et al., 2013; Sin & Lyubomirsky, 2009). The introduction of these interventions would of course need to be considered for their cultural appropriateness, but there is a wealth of cross-cultural positive psychology research available that would support this process. Further, due to their brief nature, pilot testing of these interventions could also be undertaken both quickly and at relatively low-cost. As such, positive interventions may not only bypass the problem of western psychiatric diagnoses and culturally-bound frameworks of mental health problems,

but could also represent a cost-effective and easily evidenced tool for cross-cultural interventions.

Positive Clinical Psychology: Where Integration is Happening

In this article, we have considered the challenges clinical psychology is facing, and where it stands to benefit from the work undertaken by positive psychology researchers. We have argued that there is a divide, and clinical psychology has much to gain from greater integration. However, there are areas where the divide is unclear, and furthermore, areas where clinical psychologists have begun to incorporate ideas and approaches from positive psychology research into clinical interventions. Here we will briefly discuss some of this work and consider its implications.

A key intervention to consider which appears to blur the divide between positive and clinical interventions is mindfulness. Popularised in the US and Canada by researchers with a medical background such as Jon Kabat Zinn and Zindel Segal, and in the UK by clinical psychology researchers such as Mark Williams and John Teasdale, it has been researched extensively, and has been found to be effective for treating anxiety, depression and chronic depression (Barnhofer et al., 2009; Hofmann, Sawyer, Witt, & Oh, 2010). However, whether mindfulness can be considered a 'positive intervention' as such has been disputed. Although it did not originate in the positive psychology literature, its main aim is skill development and, as such, it is consistent with criteria outlined for positive interventions (Sin & Lyubomirsky, 2009). Because of this, it was included in one meta-analysis of positive interventions (Sin & Lyubomirsky, 2009), but a subsequent meta-analysis rejected including mindfulness studies on the basis that it is not a 'pure' positive intervention (Bolier et al., 2013). If researchers are to move forwards towards developing increasingly effective, appropriately utilised interventions, then efforts to separate literatures based on their origins rather than their content may be backwards-looking and counter-productive. Instead, we

would argue that mindfulness represents one area where clinical psychologists have begun to move forwards from focusing upon problem-focused interventions, incorporating principles outlined by psychology research and focusing on a broader range of factors than has typical of traditional clinical psychology. The success of this intervention to date has been promising, and represents a shared area of interest between positive and clinical psychology that could drive further integration.

A similarly positive-focused intervention which has been developed in the clinical psychology literature has been compassion-focused therapy (Gilbert, 2009). Where this incorporates elements of more traditional interventions, such as a conceptual framework for the development of mental health problems and the direct addressing of negative and critical thinking, it has a strong emphasis on skill development. In particular, it uses relaxation, meditation and imagery exercises, typical of positive interventions, to develop feelings of kindness and compassion (Gilbert, 2009). There is a small but developing literature supporting the effectiveness of compassion focused therapy for treating mental health problems (Braehler et al., 2013; Laithwaite et al., 2009), but what has been perhaps most striking about compassion focused therapy is its popularity amongst clinical psychology therapists, many of whom have begun to incorporate the techniques outlined in it to their practice of other therapies, such as cognitive behaviour therapy (for example, see Tarrier & Johnson, 2015).

The Broaden-and-Build model of positive emotions (Fredrickson & Branigan, 2005; Fredrickson & Levenson, 1998), which developed in the positive psychology literature, has been particularly influential in clinical psychology research. Later claims associated with this model (such as there being a particular ratio of positive to negative emotions needed for good well-being) were later shown to be based on a false analysis of data, leading some to discredit the model (and the researchers; Brown, MacDonald, Samanta, Friedman, & Coyne, 2014;

Brown, Sokal & Friedman, 2013), however the basic earlier observations of the research programme appear to be robust and have clinical utility. This model, and research based upon it, has suggested that positive emotions can ‘un-do’ the effect of negative emotions, broadening the scope of attention and cognition and helping to build resources. For example, this model inspired the Broad-Minded Affective Coping (BMAC) procedure, a stand-alone technique developed by Tarrrier (2010), which involves the recall of personal positive memories. As therapy often evokes negative emotion, the BMAC was proposed as a tool for use by therapists looking to restore emotional equilibrium in sessions, to help their clients recover from the impact of negative emotion and to benefit from the cognitive benefits of positive emotional experience. Research using the BMAC has found it to be effective for boosting positive affect in individuals with a diagnosis of schizophrenia (Johnson, Gooding, Wood, Fair, & Tarrrier, 2013) and post-traumatic stress disorder (Panagioti, Gooding, & Tarrrier, 2012). The Broaden-and-Build literature has also influenced a recent trans-diagnostic model of mood and anxiety disorders proposed by Hoffman , Sawyer, Fang and Asnaani (2012). This model suggests that disorders occur when there is a dysregulation in negative affect which leads to a deficiency in positive affect, and that interventions should aim to simultaneously decrease negative affect and increase positive affect. Subsequent research has supported this model, finding evidence for shared emotion regulation deficits across anxious and depressed groups (D’Avanzato, Joormann, Siemer, & Gotlib, 2013) and suggesting that interventions focused on improving emotion regulation can reduce symptoms of depression (Diedrich, Grant, Hofmann, Hiller, & Berking, 2014).

The brief examples provided here aim to demonstrate that while there remains a divide between clinical and positive psychology, there is a growing acceptance amongst clinical psychologists of the benefits of positive emotion and positive skills training, and an increasing interest in this area. Furthermore, it should be noted that some existing clinical

psychology approaches have been studied to test whether they can boost positive emotions or wellbeing (see Feeney & Hayes, in press, and Taylor & Arntz, in press, for reviews). These issues lead to some 'grey areas', where it is unclear whether an intervention should be categorised as a 'positive intervention'. However, prioritising academic clarity at the cost of shared knowledge is likely to hinder the increased integration of these literatures, which we argue, could significantly denigrate the development of interventions.

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