Positive Clinical Psychology (PCP) is not new. As shown in chapters throughout this book, clinical psychology has a long history of incorporating the positive into clinical practice. From Maslow (1954) onward there have been calls to change clinical psychology to focus more on the positive in life, and even the term “positive clinical psychology” has been used in the past (see, e.g., Duckworth, Steen, & Seligman, 2005; Maddux, Chapter 2, this volume). What is new is the movement from wise but isolated calls, often from outside clinical psychology, to a real impetus for change from within. PCP is built around a clearly defined shared set of aims that are increasingly considered mainstream within the field. We set out our mission statement in a special issue of *Clinical Psychology Review* (Wood & Tarrier, 2010, as clarified in Johnson & Wood, in press). This has proved seminal to the acceptance in mainstream clinical psychology of calls to increase a focus on the “positive” alongside the “negative.” PCP, as we envision it, aims to change the discipline of clinical psychology into one “which has an integrated and equally weighted focus on both positive and negative functioning in all areas of research and practice” (Wood & Tarrier, 2010, p. 819). The distinctive feature of PCP is the emphasis on integration; PCP points out the illogicality and impossibility of studying only the “positive” or the “negative” in clinical psychology (or for that matter, in any discipline), and it seeks to better integrate research and practice toward a joint focus on both. We are staggered by how much this message has resonated amongst clinical psychologists in the last six years, including the expert contributors for this book, to whom we are very grateful for enthusiastically contributing outstanding chapters. This *Handbook*, the first of its kind, represents the culmination of six years of increasing acceptance of PCP. It is built on decades of scholarship from the contributors to this book and others, without whom the development of PCP would not be possible.

The purpose of this chapter is to provide an overview of the development of PCP and to overview the empirical and theoretical evidence as to why the movement is needed. This burgeoning area seeks to draw together the two fields of Positive Psychology and Clinical Psychology, which have generally developed independently of each other despite many convergences in research foci and aims. We suggest that further integration between positive and clinical psychologies could serve to advance the research, knowledge, goals, and practice of both. Our hope is that this book can contribute to this endeavor. We have been overawed by the responses we received from authors we approached to write on this topic for the book, each leaders in their field. As such, the book represents a bringing together of expert clinical psychologists, keen to consider how a recognition of the positive relates to their work, and the expert positive psychologists, keen to integrate their research with the wider clinical research base and move towards a PCP.
The Historical Development of Positive Clinical Psychology

Prior to the Second World War, psychology had the key aim of curing distress and fostering optimal functioning (see Linley, Joseph, Harrington, & Wood, 2006). In the immediate aftermath of the war, there was an urgent need within war-torn countries to explain and address the psychological distress and trauma that the war had created. Within clinical psychology, there was a renewed focus on curing distress, particularly that related to trauma (later known as post-traumatic stress disorder). Within social psychology, there was a focus on such topics as conformity that aimed to explain why the atrocities associated with the war had occurred. This was all valuable, and much needed, but it had two undesired side effects. First, it led to an over-focusing of psychology on distress and dysfunction. Second, and potentially more seriously, it led to distress and dysfunction becoming viewed as a discrete subject of enquiry, rather than as part of a broader enquiry into the full continuum of human functioning. In the United States, this process was accelerated by the development of the National Institute of Mental Health in 1947 (which exclusively focused on ill health) and the Veterans’ Administration in 1949. Both organizations funded excellent research and treatment, but by providing financial incentives (e.g., research grants) to study the dysfunctional side of the mental ill-health continuum, there was perhaps too much encouragement for researchers to focus on these topics. Furthermore, the tendency of academics to teach in their areas of research is likely to have led this focus upon poor mental health and distress to be transferred to their students. As such, it can be seen how well-meaning and valuable funding into distress led to new generations of psychologists viewing the discipline of psychology as one focused upon maladaptive, rather than adaptive, functioning. As Abraham Maslow warned over half a century ago:

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. (Maslow, 1954, p. 354)

This situation largely persisted throughout the latter half of twentieth century. A concerted attempt to reintroduce the “positive” into psychology arose from the positive psychology movement initiated by the American Psychological Association (APA) President Martin Seligman, with his joint special issue and the accompanying influential editorial (Seligman & Csikszentmihalyi, 2000). This, and the ensuing movement, had a huge impact on psychology in a very short space of time, with millions of dollars in funding, the development of new psychotherapeutic techniques, specialist masters courses across the world, and several special issues of journals and handbooks (see Linley et al., 2006). A quantitative bibliometric analysis (Rusk & Waters, 2013) charted the growth of positive psychology, showing that 18,000 papers linked to positive psychology topics have been published, and that there has been a steady year-on-year increase in the number of publications. In their 2011 census year, there were 2,300 papers published, representing 4% of those indexed by the representative PsychInfo® database. If these papers were classed together as a field, they would be at the median of disciplines indexed in the Journal Citation Reports®, and the 2011 impact factor would be 2.64, showing that the number of citations to the papers would respectably rank amongst other academic fields. The increase in number of papers was seen in each field in which the papers were published, including psychology (and all sub-areas), psychiatry, sports science, business, and management. This quantitative analysis showed that positive psychology can no longer be considered a minority or fringe endeavor.

The uncontroversial message from positive psychology was that psychology (and other fields) must consider the positive as well as the negative. The movement can be credited with raising the profile of topics that are considered “positive,” and making them as likely to receive funding
and to be published as those considered “negative.” However, in the intervening years since the initial rush of enthusiasm, and despite the ever-growing impact of the field, the wider field of psychology has arguably become somewhat ambivalent about positive psychology (see Wood, et al., in press), and many critical pieces have been written against the movement (e.g., Bohart, 2002; Lazarus, 2003; Tennen & Affleck, 2003; Held, 2004; Coyne & Tennen, 2010; Coyne, Tennen, & Ranchor, 2010).

Perhaps one reason for this ambivalence within wider psychology relates to the movement’s lack of clear aims. The most distinguishable goal of the movement was that psychology should focus more upon the positive, a message which most psychologists endorsed. However, this perhaps led to a growing tension between those who wanted to integrate the study of the positive and the negative, and those who wanted to create a separatist field of positive psychology. Notably, Rusk’s and Water’s (2013) bibliometric analysis focused on papers on positive psychology topics, but many of these would not have been self-identified as “positive psychology”; they were just seen by the authors as “psychology.” The growth of the study of positive psychology topics is undeniable. The nature of the “movement,” whether there is even still a movement, the aims of this movement, and its consequences are more controversial. A separation (not often made by critics) needs to be clearly made between the research on topics associated with positive psychology (which, other than isolated examples, attract no more criticism than other areas of psychology) and a possible straw man of a positive psychology movement. It is on the latter most criticisms have been leveled.

The critical narrative around the positive psychology movement often seems to be dominated by concerns of separatism, with “positive” research and interventions sometimes seen to be developing in isolation from the wider literature. It could be argued that this branding of positive approaches within “positive psychology” helped to raise their profile and served to highlight the importance of their study. However, we would suggest that any separation between positive psychology and other fields – particularly from clinical psychology – comes at the cost of the advancement of each. Both positive and clinical psychology research psychological treatments, often in similar groups (e.g., those with depression), but sometimes independently and without either fully recognizing or utilizing the findings of the other. In failing to acknowledge the full influence from clinical psychology research, the positive psychology movement has failed to fulfill its full potential to influence clinical psychology in return. PCP aims to address these concerns through transforming the discipline of clinical psychology into one that equally studies and intervenes in topics branded as “positive” or “negative.” It is designed to utilize the great scholarship within positive psychology to the full effect within clinical psychology by making it inseparably a part of the fabric of the field.

The development of PCP is also aimed to help positive psychology research more broadly by making it accessible to new audiences and addressing some of the previous criticisms. Perhaps if there had been a greater focus on the message of those within positive psychology movement seeking to integrate positive with the negative (e.g., Joseph & Linley, 2006a,b), then greater advances would already have been made toward building a more holistic psychology. The danger that the positive psychology movement faces is that it will be dominated by a different separatist message, the content of which seems to be leading to a growing consternation in wider psychology, including clinical psychology, where it is in some quarters seen as being a research-lite “happiology.” Whether or not this characterization is appropriate is moot; the perception itself is hampering attempts to focus clinical psychology more on the positive.

Through promoting a fundamentally integrative message between positive and clinical psychologies, between the focus on maladaptive and adaptive functioning, this Handbook aims to help positive psychology regain its true vision of a holistic and balanced psychology, through showing common ground between different approaches and fundamentally challenging any separatist message with conceptual, evidential, and pragmatic arguments. We also seek to address the (often unfair) criticisms of positive psychology that have been raised.
Criticisms of Positive Psychology

Several concerns were raised about positive psychology, in addition to the increasingly perceived separatist message. First, the original paper (Seligman & Csikszentmihalyi, 2000) included factually untrue statements about humanistic psychology lacking an evidence base. This was particularly unfortunate considering the similarities in the goals of both fields (see the Maslow quote above). This avoided the opportunity to engage with the very community that may have been most supportive to the integrative aim of positive psychology (see Sanders and Joseph, Chapter 28, this volume, for the fit between positive and humanistic approaches). With PCP we aim to rebuild bridges between communities, and some of the chapters in this book are dedicated to showing how many areas are already incorporating what may be classed otherwise as positive psychology.

Second, the quality of the research in the field was questioned from inception (e.g., Lazarus, 2003). This was probably an unfair criticism as: (a) the complaints often overgeneralized from isolated examples of research in the field; (b) many of the criticisms (e.g., a reliance on self-report) apply to psychology as a whole; and (c) the critiques did not recognize that the research methods that were being criticized were often commensurate with the developmental stage of research into new topics (e.g., showing correlation before causation). Nevertheless, PCP needs to hold itself to the highest level of methodological account, building on the increasing refinement within positive psychology and the best clinical psychology practice.

Third, there are concerns that there has perhaps been an overwillingness to put positive psychology research into practice before interventions are tested to the same level as clinical interventions. In our opinion, the flaws highlighted in the second and third criticisms may have been due to the foundations of the movement in personality psychology. Indeed, most positive psychologists had begun as personality psychologists, and the studies that they designed to test interventions were based on common designs for proof of concept studies published in top rated personality journals. Here, the interest is in showing a potentially causal impact of a characteristic rather than providing a full interventional trial. Whilst this was often appropriate for the research questions in the original publications, this strategy became problematic and potentially dangerous when this evidence base (and not a clinical trial) was used to make recommendations for interventions. In part, this reflected a poor tendency amongst psychology researchers in general, reinforced by journal reviewers, to make “practical recommendations” as part of the discussion in a research study. From a proof of concept study, such recommendations should not go beyond suggesting that a clinical trial be conducted. However, the claim is that the tendency has instead been to overspeculate about the implications of the findings. In some cases this has involved claiming that a study with undergraduate participants, and no follow-up, was a basis for recommending a therapeutic approach. There has also been more general concern about how the media reporting of scientific studies make claims that go beyond the evidence base, which seems to originate from the press release of the institution (Sumner et al., 2014). The early proof of concept studies within positive psychology have been seminal in suggesting what might work (analogous to the early stages of a drug trial), and there now needs to be more full clinical trials that completely test interventions using the clinical psychology methods that have emerged from the best practice within medicine. The increased linkage that this Handbook seeks to provide between positive and clinical psychologists is hoped to help build the multidisciplinary teams that this kind of work will require.

Possibly these three criticisms of positive psychology culminated in the attraction to the field of untrained, unaccredited, and unregulated “positive psychology coaches.” This development has been particularly harmful to the field of psychology, as whilst such a title is unprotected, and essentially meaningless, it seems to infer that psychology has leant its credibility and regulatory procedures to this “profession.” Claimants of this approach have been keen to stress the “scientific basis” of their studies (which have usually been the proof of concept studies within personality psychology journals, at best). As might have been predicted, there has been a backlash
against this approach, and this backlash has not been confined simply to positive psychology. To the wider population not familiar with the distinction between “positive psychology” and “clinical psychology,” both psychologies have been at risk of being discredited. Unsurprisingly, it seems that this has led to some resentment amongst clinical psychologists of their positive psychology colleagues. PCP aims to utilize the existing regulatory frameworks within clinical psychology to provide public assurance of safety of interventions and thus increase their acceptability and usability amongst many communities, including amongst those who are most vulnerable.

We stress that many of these criticisms are concerns for psychology at large, and that they are perhaps unfair characterizations of positive psychology. However, irrespective of whether one accepts them with regard to positive psychology, it seems apt to raise them here as PCP must avoid these pitfalls and characterizations. We stress that we are positive psychologists, in the sense of promoting an integrative message between studying both the positive and the negative, and that we both work and publish within both positive and clinical psychology. Our emphasis here on criticisms of positive psychology is simply based on our desire to be aware of the (real or imagined) pitfalls of the movement and to ensure that these do not reoccur with PCP.

The PCP Solution

PCP aims to address the separatist criticism of positive psychology and redress any imbalanced focus on either the “positive” or “negative” in both positive and clinical psychologies in order to promote a more fully integrative field of psychology. Incorporating the strengths of positive psychology, and responding to the criticisms, PCP aims to develop a field where adaptive and maladaptive functioning are considered holistically, as inseparable, and as deserving of an equal amount of attention in both research and practice. It aims, at least within a clinical setting, to reset the positive psychology movement, having it originate from within clinical psychology. PCPs aim is that positive psychology will not be (or be seen to be) a separatist endeavor, but would instead both influence and work with the existing field of clinical psychology. The potential benefits of this approach are considerable and bidirectional between positive and clinical psychology. These benefits include:

1. The attraction of a new population of researchers and practitioners to work on the integration of maladaptive and adaptive functioning.
2. The likely attraction of those with a healthy degree of skepticism about the value of studying adaptive functioning. Having such critics on board will help maintain credibility and the focus on trying to disprove the importance of the “positive,” in line with how positivistic science should be conducted. Where such attempts to disprove the hypotheses fail, we can have more confidence in the research base.
3. The influence on positive psychology of clinical psychology standards of what is deemed optimum interventional research. As clinical psychology standards have arisen in part from medicine, they tend to be of a higher standard than the proof of concept studies within personality psychology. For example, clinical journals are moving towards requiring that trials involve: (a) pre-trial registration; (b) a sample from the population to which the authors generalize; (c) use of best practice CONSORT guidelines for the conduct of clinical trials; (d) adequately powered designs; (e) proper and active control groups; (f) avoidance of demand characteristics with steps in place to prevent selection effects (e.g., where those interested in positive psychology are most likely to take part); (g) replication; and (h) conclusions that do not go beyond the data. Positive psychology has much to offer such trials, including highly novel ways of viewing mental health, its correlates, antecedents, and consequences. As such, an integration of both these fields is likely to lead to a raising of research standards in both, and more generally we do strongly encourage researchers in all fields to adopt these best practice approaches.
The well-established accreditation and regulation procedures to safeguard client well-being within clinical psychology, which can be used to ensure that positive psychology interventions are given to the most vulnerable people by the most appropriately trained and accountable practitioners.

Overall, the key aim of PCP is to engender a change within clinical psychology, so that the field examines functioning holistically, at both the adaptive and maladaptive end, and makes use of a full range of treatment techniques – including those from traditional and positive psychology – in a balanced manner to individual client need.

Why Do We Need a Positive Clinical Psychology?

In many ways, all chapters within this Handbook are focused on stating the need for PCP. Each author was asked – interpreting the question and issues as they chose – to consider whether the “positive” and “negative” should be considered together by clinical psychologists with respect to their expert topic area. Although a selected and self-selecting group, it notable that not a single author concluded that they should not. The book is organized into five parts, which largely correspond to the topics forming the argument for PCP: “Developing a Positive Clinical Psychology,” “Personality and Individual Differences,” “Disorders,” “Positive Psychology Interventions in Clinical Practice,” and “Reinterpreting Existing Therapies.” We highlight and integrate the core arguments for PCP from across the book here.

Characteristics Are on a Continuum from Low to High

As we have previously argued (Joseph & Wood, 2010; Johnson, Wood, Gooding, & Tarrier, 2011; Johnson & Wood, in press) and discussed by Joseph and Patterson (Chapter 4, this volume), a simple fact that has been ignored by both the positive and clinical psychology communities is that all characteristics range from low to high. Consider the traits that Peterson and Seligman (2004) highlight in the “Values in Action” (VIA) project, which they consider “virtues.” These included humility, fairness, kindness, integrity, gratitude, optimism, open-mindedness, and (one assumes high) social intelligence. A moment’s reflection shows that each of these is on continua from arrogance to humility, unfairness to fairness, unkindness to kindness, dishonesty to integrity, ingratitude to gratitude, pessimism to optimism, closed- to open-mindedness, low to high social intelligence. Obviously, one cannot say the whole continuum is positive; rather, researchers seem to simply be referring to the “high end.” It then becomes theoretically nonsensical for a field to focus only on the high end of a continuum, and even more so to write papers as if the other half of the continuum did not exist. It is no less a mistake to focus on only the low end of a continuum and write papers as if the high end does not exist.

To claim that positive psychologists are normally studying anything other than the high end of a bipolar continuum would be inconsistent with both the methods and the findings of the field. Normally the characteristics are studied with self-report scales that include items that are reverse coded prior to analysis. Thus, for example, the GQ6 measure of gratitude includes items measuring ingratitude, and the scale has been shown to be a single continuum (McCullough, Emmons, & Tsang, 2002). The same can be said for most of the measures in positive psychology. Indeed, when the “positive psychology” scales were developed, given that there was generally a balance of positively and negatively worded items (or should have been with normal psychometric practice), it was an arbitrary choice which of the items to reverse code. The gratitude scales, for example, could equally be called ingratitude scales if the arbitrary decision to recode the ingratitude items had not been made in favor of the equally arbitrary decision to recode the gratitude items.
In such a case, it would be called the ingratitude scale, although it would be the same scale. At the moment we have the absurd situation where if one codes the scales in one direction it can go to a positive psychology journal, and if one codes it the other it can go to a clinical psychology journal.

Johnson (Chapter 6) considers the implications of not realizing that constructs are on a continuum from high to low with respect to the literature on resilience, where it has been typical to take the same characteristic (such as social support) and call low levels risk and high levels resilience (Johnson, Gooding, Wood, and Tarrier, 2010). With these definitions, the construct of resilience is meaningless as it is just a word for low risk. Instead, this chapter proposes that resilience lies in the particular interaction between two characteristics. Each characteristic (the resilience variable and the risk variable) goes from low to high, but the interaction between the two contributes more than the sum of its parts (e.g., the presence of high levels of one mitigates low levels of another). This model has previously been used to explain resilience to suicide in both non-clinical populations (where coping self-efficacy moderates the impact of negative life events; Johnson et al., 2010) and clinical populations (where coping self-efficacy moderates the effect of hopelessness; Johnson, Gooding, Wood, Taylor, Pratt, and Tarrier, 2010).

It seems, then, that some positive psychologists have failed to recognize that factors fall on a continuum from high to low, and as such, they have failed to recognize where their research studies the “negative.” However, clinical psychologists have also fallen into this trap. For example, assessment of global functioning is often included as part of a diagnostic assessment of clinical disorders, and functioning ranges from highly impaired to superior. As such, clinical psychologists are in fact already measuring the “positive,” often without fully acknowledging this. Furthermore, given concerns about the scientific basis and usefulness of the diagnostic categories in general, there have been calls to replace these with a greater focus on global functioning. James Maddux (Chapter 2) makes a powerful argument as to how the focus on continua of functioning within PCP can help depathologize and destigmatize mental illness, by moving the focus away from “mental illness” and instead toward “wellness,” a continuum upon which we all exist.

Some measures of global functioning might include “subjective well-being” (SWB) and “psychological well-being” (PWB). As discussed by Joseph and Patterson (Chapter 4), SWB is a higher-order factor comprising positive affect, negative affect, and satisfaction with life. Ruini and Ryff provide a chapter on PWB (Chapter 11), which they see as comprising self-acceptance, positive relationships with others, purpose in life, environmental mastery, and autonomy. It is important to realize that the higher-order constructs of both SWB and PWB are continua ranging from low to high. Specifically, SWB ranges from low positive effect, high negative effect, and low life satisfaction to high positive effect, low negative effect, and high life satisfaction. PWB ranges from self-rejection, impaired relationship with others, purposelessness, environmental incompetence, and subjugation to self-acceptance, positive relationships with others, purpose in life, environmental mastery, and autonomy. Clearly, neither SWB nor PWB are inherently positive, but rather two very different ways of conceptualizing continua of functioning (and in the measurement of both, commonly positively and negatively worded items are used to measure both sides of the continuum). As they measure different conceptions of well-being, each as full continua, they will be somewhat factorially distinct not because one is positive and the other negative, but simply because they are assessing different forms of functioning. The factorial distinctiveness is shown in a large body of work (e.g., Linley Maltby, Wood, Osborn, and Hurling, 2009). Interestingly, these two higher-order factors are very highly correlated (at around \( r = .76 \); Linley et al., 2009), which fits in with what Joseph and Patterson (Chapter 4) present as a humanistic meta-theory. This theory suggests that people do not generally feel good (high SWB) whilst behaving in a personally and socially destructive manner (low PWB; as expanded upon by Pete Sanders and Stephen Joseph in Chapter 28), although these factors are still factorially distinct.

The factorial distinctiveness between SWB and PWB has caused much confusion in the field and has worked against the integration that PCP proposes. For example, Westerhof and Keyes
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(2010) influentially argue for a dual-continuum model of mental health, consisting of ill-being and positive functioning. This is based on SWB and PWB being two (highly correlated but) separate factors. As discussed in Johnson and Wood (in press), their interpretation misses the point that both SWB and PWB are bipolar continua from high to low, and that they are simply measuring different concepts. Thus, one may talk about dual-continua in the sense of our need to assess more than one kind of functioning, but one cannot claim one is positive and the other negative, and to do so directly goes against the integration that we are trying to promote. This obvious although influential error of interpretation has hindered the development of PCP (although we value the author’s contributions to the popularization of the important PWB concept). With Westerhof and Keyes (and Maddux, Chapter 2), we would support a shift away from a sole focus on diagnostic categories toward a larger focus on global assessment, and we agree that SWB and PWB are a good starting point. However, it is critical to have a balanced, holistic, and accurate field that recognizes the fact that each factor ranges from high to low.

Global functioning is one area in which clinical psychologists are already intuitively implementing the core PCP recommendation to focus on full continua from maladaptive to adaptive functioning (even if the implications of this are not normally considered). However, there is a second area in which this is already occurring which is more subtle and even less acknowledged. Almost all clinical disorders, or the processes that underlie them, range from maladaptive to adaptive. Wood, Taylor and Joseph (2010) have shown this directly with respect to depression. This was based on the observation that the Center for Epidemiological Studies Depression (CES-D) scale (one of the five most used) includes both normal depression items as well as reverse coded ones such as “I am happy.” Clearly, then, on the logic above, this can be said to measure a continuum from depression to “happiness.” The factor analyses reported in that paper support the view that these items comprise a single continuum. Similarly, Siddaway, Taylor, and Wood (2016) have investigated the State-Trait Anxiety Inventory (STAI), which again has items measuring both anxiety and reverse coded items measuring calmness, and which also we find form a single continuum. As highlighted by Wood and Joseph (2010), work on depression or anxiety that has used these measures is probably already in line with PCP, as a full continuum of well-being has already been measured. It is simply an error of interpretation that has led to this not being recognized.

Despite our work having shown that the CES-D measures a continuum from depression to happiness, and the STAI from anxiety to calmness, we prefer not to see the constructs in such simplistic terms (and the use of the word “happiness” is particularly problematic, as this is a deep philosophical issue, and what defines happiness is possibly the choice of the individual). Instead, we would suggest that the findings emerge as it is the forms of functioning underlying the diagnostic criteria for mental disorders that range from adaptive to maladaptive. For example, most diagnostic criteria for depression involves high negative affect, low positive affect (anhedonia), lack of engagement, poor sleep, impaired appetite, and poor social relationships. Each of these is clearly on continua from maladaptive to adaptive; respectively, low negative affect, high positive affect, engagement, good sleep, appropriate eating, and good social relationships. Thus, irrespective of our results of studies analyzing depression questionnaires, the criteria on which the construct of depression is based can be said to logically range from maladaptive to adaptive. The same can be said of nearly all mental disorders.

The approach of focusing on the full continuum of the process underlying mental disorders allows for even the most categorical appearing disorders to be seen as existing on a maladaptive to adaptive continuum, consistent with PCP. Thomas Widger (Chapter 18) makes this argument with respect to personality disorders. These disorders are amongst those most frequently viewed as dichotomously “present” or “absent” in the mental health literature (indeed, they are often referred to as “categorical disorders”). In contrast, Widger shows that they arise from particular extreme “normal” personality continua, each of which range from high to low. His model of personality is the Five Factor model, which focuses on the observable psychological differences
between people. It arose from factor analyzing responses to sets of person adjectives sourced from representative dictionaries (excluding skills or not-psychological differences), and thus represents the basic differences in behavioral propensities between people. Treatment, from a PCP perspective, should not then focus on removing the categorical disorder (which turns out to be epiphenomena of the personality process), but rather helping the individual change their levels of behavioral propensities toward what is most adaptive in their lives. Quite how this may be done is shown by Christopher Taylor and Arnoud Arntz (Chapter 30) who make the same argument, but focus on another definition of personality; the particular schematic beliefs about the world which lead to these behavioral propensities. Referring to the work of Lockwood and Perris (2012), they argue that parenting and early life conditions (ranging from traumatic to optimum) lead to needs being met to varying degrees, which in turn leads to eighteen schematic ways of viewing the world (each of which ranges from maladaptive to adaptive). With these additions to Schema Therapy there is an approach with the potential to be an ideal PCP therapy, with the aim of helping all clients move toward the adaptive end of each of the core schemas. The theory would predict that in such a case not only would personality disorders be removed (which arise from certain constellation of schemas), but rather all other psychopathology, and indeed this would foster full psychological development.

Central to our argument for the need for a PCP are the observations that (a) most of the concepts studied by positive psychologists range from low to high, and (b) most of the topics of study for clinical psychologists are equally on continua from maladaptive to adaptive. It is not logical, and perhaps not even possible, to study only half of a continuum. If we have seemed critical here, it is only in order to promote a joining of clinical and positive psychologies into one holistic discipline to better understand and help people.

**No Characteristic is “Positive” or “Negative”**

In her inimitable style, Barbara Held (Chapter 3) has chosen as her focus a critique of one of our own papers, the editorial paper of the special issue on PCP (Wood & Tarrier, 2010). A prominent “positive psychology critic,” she shows her trademark authenticity, and her critique is much needed and welcome. Whilst endorsing the rationale above that all characteristics range from low to high, Held thinks that we should go further in our criticism of a sole focus on the “positive” or “negative.”

Held highlights a core reason of why PCP is needed, namely, that neither the low or high end of any characteristic is inherently “positive” or “negative,” as nothing is good for everyone all of the time. She suggests that we should instead consider where something is adaptive for individual clients in individual situations. Optimism, for example, is considered a “positive psychology” characteristic, and it is generally positively linked to well-being, although it can also lead to overly risky behavior. Conversely, for some individuals “defensive pessimism” is constructive. In previous work, Boyce, Wood, and Brown (2010) focused on how conscientiousness, a trait generally seen as adaptive for everything from well-being to team performance, becomes maladaptive and leads to greater decreases in life satisfaction following unemployment. Wood, Emmons, Algoe, Froh, Lambert, and Watkins, Chapter 10, this volume, argue that “gratitude” can in some situations be mal-adaptive, as when it is inappropriately placed (such as toward an abuser, or when it is being used by a power elite to keep a population subjugated). Warren Mansell explores these issues with respect to bipolar disorder in Chapter 16, arguing that there is nothing inherently negative about any level of the positive or negative moods that characterize the disorder, but rather that problems emerge with how these conflict with each other and the other goals of the individual. Eamonn Ferguson (Chapter 8) shows how high levels of empathy are not indiscriminately desirable, noting that psychopaths have high levels of some kinds of empathy whilst being notably deficient in others. Furthermore, Sedikides and Wildschut (Chapter 9) explore the bittersweet nuances of nostalgia, also a factor, they argue, which is not wholly “positive” at either the high or low end.
Thus, even accepting the point above, that most characteristics range from low to high, we cannot then say that the high (or for that matter, the low), are desirable, as this would be an overgeneralization. Indeed, Aristotle (350 BC/1999) wrote the most conclusive work on virtues, which was based around culturally valued characteristics, and he was very explicit that (a) the behavior associated with the characteristic ranged from low to high, and (b) both too high and too low levels of the characteristics are unvirtuous (lit. vicious). Rather, the virtue (and desirability) lies within situationally appropriate displays of the correct level between these two extremes. Thus, views about the future may be said to range from dysfunctionally strong pessimism, to an appropriate point, to a Pollyanna-like dysfunctional expectation of constant positive outcomes. Deviations from the situationally appropriate point in either direction may lead to inappropriate actions. Where this appropriate point lies will depend on the situation and other characteristics of the person, and where the point lies on the continuum would vary between the two extreme poles between individuals or in different situations. This wisdom is consistent with Held’s account.

To Held’s points, we would like to make a brief response, as we believe that the issues she raises need to be prominently and directly considered by PCP. First, in response to her suggestion that talking about when something is adaptive or maladaptive is of the utmost importance, we agree, but suggest that to make this claim there first needs to be a wider acceptance of the PCP premise that all factors exist on a continuum (from high to low). Only with this in place can it be considered in what situations and for whom different points along the continuum are most adaptive. Second, she correctly chastises errors in our earlier paper (Wood & Tarrier, 2010) in which we, on the one hand, suggested that all factors exist on a continuum from high to low, and, on the other hand, referred to constructs popularized by positive psychology (like gratitude) as “positive,” in direct opposition to the former point. We correct and discuss this extensively in Johnson and Wood (in press). Essentially, the point we raise here is that whilst the constructs studied by positive psychologists cannot be described as “positive” (or those by clinical psychologists described as “negative”), the characteristics studied by positive psychologists are qualitatively different traits than those typically studied by clinical psychologists. That is, where positive psychology research has often investigated personality characteristics such as gratitude, optimism or self-efficacy, traditional clinical psychology has tended to focus more upon cognitive and symptom-related variables. As such, there may be value in considering both sets of characteristics. We hope that these responses address some of Held’s criticisms of PCP, and look forward to future dialogue with critics of PCP. We suggest that it is only through welcoming contributions like Held’s that PCP can be ultimately be successful, useful, and accurate, and avoid the allegations of isolationist and unscientific practice sometimes leveled at certain parts of the positive psychology movement.

If we accept the argument that high (or low) levels of characteristics are not always adaptive for all people, then there are three implications as to why we need PCP. First, it is meaningless for one field to study some characteristics and another field to study others on the basis that some are “positive” and the others “negative,” as whether any variable is “positive” or “negative” will depend upon the individual and the context. The designation of what is positive and negative is also sometimes more of a value judgment of the researchers than being rooted in science, philosophy, or objective reality.

Second, individual case conceptualizations should consider an individual’s life holistically – examining characteristics that are generally seen as “good” or “bad” – whilst keeping an open mind as to the role of these in the particular client’s life, given their biology, early experiences, life history, current environment, and constellations of traits, attitudes, and functioning levels. Only through a PCP approach, where the need for such a holistic approach is emphasized, does this true integration become possible.

Third, interventional techniques – from both traditional and positive psychology – that may be helpful to one client may be harmful for another. Again, we draw on our recent work in
personality psychology showing that personality interacts with situation (e.g., Boyce and Wood, 2011a,b), so one cannot just promote any one thing out of context. This shows the need for PCP in that clinicians need to be aware of the full range of techniques, in order to match the best technique with the individual client. Geraghty, Wood, and Hyland (2010a,b), for example, show that in one specific situation (online interventions where drop-out is expected to be high) a technique based on increasing gratitude is as effective on the presenting problem, and results in lower drop-out than automatic thought monitoring and changing. However, as argued by Wood et al., Chapter 10, this volume, on gratitude, there is the potential for carelessly administered gratitude techniques in some situations to be harmful (as where a person is already excessively subjugating their needs to an abusive other, and incorrectly uses the intervention to deepen this problem). The key message is that we have to move away from talking about characteristics as positive or negative, even if this is their impact on average, and rather consider the role of – and advisability of fostering – any characteristic for the specific client. And to do this, we have to stop arbitrarily focusing on one or other, and certainly stop situating the two in separate fields of study, based more on history and value judgments than reality.

Much more work is needed to establish the optimum point on various characteristics. Statistically, Aristotle’s argument implies an inverted “U” relationship between the behaviors underlying virtuous characteristics and their outcomes, where high and low levels are maladaptive and some point in the middle is optimum. Whilst the assumption of linear relationships is tested as a matter of course in fields like economics, this is very rarely seen in psychology. In contrast, it rarely seems to occur to psychological researchers to check that linear regression is appropriate, except in the unusual cases when this is the whole hypothesis under consideration, even though there are very well-known cases of non-linearity effects in the well-being literature (such as adaptation: Boyce and Wood, 2011b). A prominent counterexample to our case here is Park, Peterson, and Seligman (2004), who show that there is a linear relationship between the VIA characteristics and life satisfaction (ruling out inverted “U”s or other nonlinearities appropriately). There are, however, three answers to this.

First, the predictors themselves must actually measure the full continuum of the characteristic. Self-report of highly socially desirable characteristics (that they call virtues) will likely share high method variance with life satisfaction as outcome, so it is perhaps not surprising that people who say they are extremely high on modesty might also say they are very satisfied with their lives.

Second, by accident or by design the predictors may not be intended to ask about a full continuum of behavior, but rather the extent to which those behaviors are displayed in a moderate or situationally appropriate manner. In this case, we would expect a linear relationship between the measure and healthy functioning, as the focus on the moderation and situational appropriateness avoids the high end of the measure picking up dysfunctional immode rate and excessive displays of the underlying behavior. This type of measurement may well be appropriate for many a usage, but precludes an Aristotelian-influenced test of nonlinearities, which would require a measurement of the full continuum of the underlying behaviors. Also, the outcomes must be the appropriate ones. For example, it is quite possible that increasing levels of a characteristic are related to a sense of smugness that is captured by life satisfaction, but that the individual is still not living a good life (under various socially held definitions of the “good life”). Analogically, it has been observed clinically that part of the problem with treating personality disorders is that a sense of entitlement feels good and individuals are not motivated to change until they see how it is destructive to other areas of their lives (i.e., until they change their outcome measure from life satisfaction to something else). Future work in PCP will have to address this directly.

Third, we believe that some characteristics are by their nature always more positive as one moves up the continuum (which is why, after considering Held’s points, we retain the language “maladaptive” and “adaptive” in places within this chapter). If one accepts certain humanistic assumptions about human nature (described by Sanders and Joseph in Chapter 28), then movement
toward core nature may always be seen as positive. To the extent that Taylor and Amtz (Chapter 30) correctly identify these, movement from maladaptive to adaptive ends of schemas will always be positive. Here, however, we show our core assumptions of humanity and with which, whilst unavoidable in clinical practice (Wood & Joseph, 2007), readers are free to disagree.

Positive Psychology Characteristics have Incremental Validity in Predicting Clinical Distress

With the qualification above that the characteristics studied by positive psychologists are not inherently positive, there remains huge evidence that the characteristics that they highlight are novel to psychology, and the topics of study of positive psychologists have incremental validity in predicting clinical outcomes beyond what has previously been studied. Taking gratitude (Wood, Froh, & Geraghty, 2010; Wood et al., Chapter 10, this volume) as an example, it substantially predicts both life satisfaction (Wood, Joseph, & Maltby, 2008) and PWB (Wood, Joseph, & Maltby, 2009) above each of the thirty facets of the NEO-PI R measure of the Big Five, which incorporate the most commonly studied traits in psychology as a whole and are meant to be an exhaustive compilation. Notably, the NEO includes individual trait measurement of trait levels of the clinical characteristics of anxiety, stress, depression, vulnerability, and impulsivity. Gratitude also longitudinally predicts decreases in depression (and concomitant increases in happiness), decreases in stress, and increases in perceptions of social support, again beyond the Big Five (Wood, Maltby, Gillett, Linley, & Joseph, 2008). Finally, gratitude predicts improved quality of sleep, also beyond the Big Five (Wood, Joseph, Lloyd, and Atkins, 2009). Whilst there is nothing inherently positive about a characteristic that ranges from ingratitude to gratitude (but see our language clarifications in Chapter 10), it is clearly a measure originating from the field of positive psychology that is capturing something new to psychology and that has considerable clinical relevance. Much of Parts II and III of this book on individual differences and disorders, respectively, are dedicated to making these arguments, including contributions from David Watson on positive affect (Chapter 5), James Maddux and Evan Kleiman on self-efficacy (Chapter 7), Adam Davidson and George Valliant on understudied characteristics in positive ageing (Chapter 12), and Chiara Ruini and Carol Ryff on PWB (Chapter 11). Philip Watkins and Andrew Pereira discuss the role of positive psychological characteristics in anxiety (Chapter 14), and Peter Taylor in the context of childhood disorders (Chapter 19). The absence of positive mood and expectations are explored by Barney Dunn and Henrietta Roberts in relation to depression (Chapter 13), and in relation to suicide by Andrew MacLeod (Chapter 20). Finally, Elizabeth Addington, Richard Tedeschi, and Lawrence Calhoun (Chapter 15) consider the importance of focusing on growth in response to trauma rather than just suffering. Although we do not see the characteristics studied by positive psychologists as always wholly “positive,” we do see them as highly understudied and of great utility to clinical psychology theory and practice (Johnson & Wood, in press), as each of these chapters highlight.

Positive Psychology Techniques have Potential to be Used in Clinical Practice

Part IV considers specific techniques that have developed from, or are associated with, positive psychology and their application to clinical psychology. Five are deigned to be fully-fledged therapies: positive psychotherapy (Tayyab Rashid, Chapter 22); forgiveness therapy (Everett Worthington et al., Chapter 24); mindfulness (Shauna Shapiro, Sarah de Sousa and Carley Hauck, Chapter 25); well-being therapy (Giovanni Fava, Chapter 26); and quality of life therapy (Michael Frisch, Chapter 27). Each has the potential to be a positive clinical therapy, as although they developed based on the learnings of positive psychology, they remain grounded in traditional therapeutic approaches, keeping a holistic core. As the authors acknowledge, with the exception of mindfulness, the evidence base is still preliminary for these relative to traditional approaches. Nevertheless, each shows promise
and has early supportive evidence. It is hoped that their inclusion here will encourage attention to these highly novel approaches and motivate (and help fund) more multicenter randomized control trials, conducted to the highest standards. In future these therapies may routinely replace more traditional approaches, although further research studies will need to assess which, if any, will amass that evidence base. We hope that they will. For now, they are promising and interesting therapies raising issues that all therapists should consider. Finally, two chapters provide excellent overviews of the specific techniques to have emerged from positive psychology (positive psychological approaches, Acacia Parks and Liudmila Titova, Chapter 21, and positive activities and interventions, Lilian Shin and Sonja Lyubomirsky, Chapter 23). We believe that these positive activities have particular potential to be incorporated into existing clinical psychology therapies. For example, in our previous work we explored the effectiveness of the Broad Minded Affective Coping procedure (BMAC) protocol (Johnson, Gooding, Wood, Fair, & Tarrier, 2013). The BMAC is a positive mood induction technique based on the client’s own memories, and is suitable for use in clinical therapy sessions to boost positively valenced affect. This is consistent with how we generally see the use of positive psychology techniques in clinical psychology. Not as replacements for existing therapies, but rather as specific techniques that can be applied based on individual clinical judgment in collaborative dialogue with the client. These chapters provide a wealth of novel suggestions and discuss the variable evidence base for these. We hope that the next few years will see more rigorous trials in clinical settings testing the relative benefits of adding these positive activities to well-validated therapies.

Many Existing Therapies are Already PCP if Viewed Through this Lens

Finally, PCP is first and foremost intended to be a new way of viewing the fields of positive psychology and clinical psychology. We are delighted that for our Part V, leading experts from major therapeutic approaches have considered how their therapies, as currently practiced, are already working with a full continuum of well-being (or simultaneously working on reducing maladaptive aspects whilst improving adaptive ones). Pete Sanders and Stephen Joseph (Chapter 28) consider person-centered therapy, Timothy Feeney and Steve Hayes (Chapter 29) consider acceptance and commitment therapy, and Christopher Taylor and Arnold Arntz (Chapter 30) consider schema therapy. We hope that the next few years will see wider consideration within other therapies of how they too may already be focusing on the full spectrum of well-being.

Conclusion

Thomas Kuhn (1962), in *The Structure of Scientific Revolutions*, describes the progress of science as distinctly nonlinear and as influenced by the existing zeitgeist. A paradigm develops encapsulating the standard interpretation of the evidence base at the time. This paradigm is strengthened by new evidence, which is generally interpreted as consistent with this paradigm if such an interpretation is possible. Eventually, however, sufficient disconfirming evidence emerges that topples the paradigm, creating a period of healthy crisis. Out of this crisis arises a new paradigm, around which a new critical mass of evidence emerges, until this in turn is toppled; it is such that human knowledge progresses. Until positive psychology came along, the paradigm was based around only understanding and reducing what was seen as the negative within clinical research and practice. Positive psychology successfully provided enough disconfirming evidence to topple this paradigm and create a crisis in the field. Whilst some expected positive psychology to be the next paradigm, arguably this has not happened, possibly due to divisive isolationist factions, lack of acknowledgment of previous approaches, some (isolated) research quality problems, and a lack of openness to criticism. Rather, some might see positive psychology as causing and epitomizing the crisis. This is a massive contribution to psychology, as knowledge
progresses only through the toppling of paradigms and no greater compliment can be made than to have toppled a paradigm. We do not know yet if PCP is the next paradigm for clinical psychology, as history shows that only years after the event can this be judged. PCP may very well be simply a refinement of the criticisms that are contributing to the fall of an untenable paradigm. In that case, it will have provided an invaluable service and we hope to live to see the next paradigm emerge. We are grateful to all our contributors for being a part of this landmark development of PCP, representing a step change in clinical psychology research and practice. The involvement of so many prominent people in the present volume evidences that the PCP approach is now part of the mainstream. We hope that readers will be provoked by the chapters and, even if they disagree with what they read here, that they will leave with more reflections upon assumptions about their work and a new determination to improve the quality of clinical psychology research and practice.

References


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