Wiki

Positive Psychology:

The clinical solution or tyranny of positivity?

"Psychology is not just the study of disease, weakness, and damage; it also is the study of strength and virtue. Treatment is not just fixing what is wrong; it also is building what is right."

- Seligman

Introduction

Mental health practitioners who treat clinical populations can struggle with the relevance of positive psychology. It can sometimes be seen as a "don't worry, be happy" approach that ignores significant problems of

living and the psychodynamics of dysfunction. But how does it really work? This page will give you more information about the clinical benefits of positive psychology.

With its roots in the philosophy of phenomenology and existentialism, positive psychology aims to focus the field of psychology away from the illness centered approach and toward the strengths and positive aspects of the individual. Positive psychology supports the universal pursuit of happiness and encourages individuals to lead more meaningful and fulfiling lives by nurturing the talents and strengths they posess.

Positive Clinical Psychology has taken these humanistic ideas and applied them within a clinical setting, presenting an alternative to traditional psychotherapy. Developed by Seligman and his colleagues at the University of Pennsylvania, Positive Psychotherapy is a way to treat depression by building positive emotions, character strengths, and sense of meaning, not just by reducing negative symptoms such as sadness.

Apparent from the key paper, evidence shows that the absence of positive well-being in one's life can be a predictive risk factor in the development of depression in the future. This evidence provides support for the clinical positive psychology movement. Understanding the influence of positive well-being is essential for understanding what makes people vulnerable to depression (and possibly other illnesses). This evidence also supports interventions which are being put in place to help increase PWB as a means of preventing and treating depression.

The negative approach of positive psychology is that positive psychology will harm itself if it submits to the tyranny of positivity (Held, 2002) , that is apparent in parts of the self-help literature and for some of its prominent members. Negative emotions serve a critical function in our lives, and will enable us to stay focused on the parts of reality that are necessary for optimal functioning

The Evolution of Positive Psychology

Cultural Connections

Martin E. P. Seligman defines positive psychology as “the study of how human beings prosper in the face of adversity. Its goals are to identify and enhance the human strengths and virtues that make life worth living, and allow individuals and communities to thrive.” In short, the goal is to shift psychology from a negative connotation to a positive one.

These ideas cannot be described as being radical because the push for seeking happiness and love above all else has been present throughout our history. Religions and philosophies alike have pondered over questions of what it is that makes us happy and what we need to feel a sense of complete wellbeing. Both western and eastern anthropological philosophy have emphasised ideas of: living in moderation, having a comprehensive world view, getting to know oneself, controlling anger, searching for spiritual harmony and peace and favouring internal potential (Fernandez-Rios & Cornes, 2009). Similalrly, a vast number of religions encourage their followers to create a relationship with God because this will help them find meaning and prosperity within their lives.

Thus, there seems to be a historically rooted focus on maximising the positive aspects of one’s life. Positive Clinical Psychology has taken these ideas and created a science out of them by testing how ideas of happiness and individual growth can be applied to the treatment of mental suffering.

Modern Developments

In his Presidential Address to the American Psychological Association in 1998, Seligman first announced his theory of Positive Psychology and its implications and after his speech, the idea of positive psychology spurred into action. The Positive Psychology Steering Committee was first formed, then the Positive Psychology Network, and finally the Positive Psychology Center at the University of Pennsylvania.

This movement has progressed so diligently in such short time that it is difficult to believe that it all happened at once. In fact, positive psychology has actually been around for much longer, it just had never been formally addressed.

o Seligman, positive psychology has some connections with humanistic psychology of the 20th century, as well as sections of highly valued beliefs of several religions and philosophical approaches. Positive psychology shares interests with humanistic psychology, such as the emphasis on the fully functional person, self-actualization and the study of healthy individuals. William James, humanistic psychologist and author of “Healthy Mindedness” (1902) has several references to positive psychology. His belief was that optimal human functioning was only accessible through including the study of subjective experiences.

The implications of the benefits of positive psychology in the clinical setting have varied. One theory is that it may be “prescribed”, but the client, situation, culture and time must be considered before doing so. Applying the theory of positive psychology to clinical psychology is mainly seen as using a strengths-based approach, where the goal is to focus on the positive and negative functioning to treat patients. The saying “too much of a good thing” may be applicable, considering there is much speculation that an overload of an optimistic approach may actually do more harm than good in the clinical setting. In comparison, positive psychology is seen as equally effective as cognitive behavioral therapy, considering the focus on strengths and positive emotions.

The future implications of research and study of positive psychology are vast. The main drive? The field of psychology wishes “to be able to take more informed and reflective decisions on what positive psychology should do; why it should do it; how it relates to psychology more broadly, and to other disciplines, such as economics, sociology, and anthropology; and perhaps most importantly, how positive psychology might be harnessed most effectively in the service of promoting integral human flourishing and fulfillment.” (Positive Psychology, 2006)

Positive Psychology- Clinical Benefits

Clinical applications

The basis of both positive and clinical psychology are concerned with the promotion of well-being and the reduction of psychologically-based

dysfunction. The overlap between the two areas caused Wood & Tarrier (2010) to propose a new branch of psychology, Positive Clinical Psychology. They believe that the incorporation of Positive characteristics (such as gratitude, flexibility and positive emotions) into the field of Clinical Psychology would promote new alternatives to treat disorders and change Clinical Psychology into a more integrative discipline. Duckworth et al. (2005) summarises this effectively, they state that: “Positive Psychology aims to broaden the focus of Clinical Psychology beyond suffering and its direct alleviation”.

Empirical Evidence to Support Clinical Applications

Positive Psychology can be used as tool to combat aspects of depression. Wood & Joseph (2010) proposed that low positive well-being is directly related to depression. They hypothesised that if positive well-being can be increased, then the symptoms of depression can be alleviated. After controlling for other risk factors such as personality, prior depression, negative functioning and demographic and health variables, the authors still found negative well-being to be the crucial factor in determining whether an individual is at serious risk of developing depression.

Positive Psychotherapy (PPT) is a method of psychotherapy developed by Peseschkian and co-workers in 1968 that uses a mixture of psychodynamic and behaviour therapy. PPT aims to reduce psychological distress and establish self-confidence within the patient by foccussing on the positive aspect of conflict and suffering through the use of three main principles: The Principle of Hope, The Principle of Balance and the Principle of Consultation.

Using the Principle of Hope, Positive Psychotherapists aim to get their patients to view their disturbance in a new light, in a clear and meaningful way. For example, a patient with Depression would be encouraged to see their depression as a capacity to experience deep emotions and an Anorexic patient would be able to view their disorder as an ability to identify with starvation around the world. The Principle of Balance is used by psychotherapists to attempt to modify patients’

coping mechanisms to enable them to view the stimuli they receive as a composition of different areas that interact with each other to generate their world as a whole. Finally, the Principle of Consultation involves five stages of self-help that the patient can use to achieve an informed solution to their disorder. If all these principles are adhered to, patients should be able to yield pleasure, engagement and meaning from their newly enriched lives.

Interventions using Positive Clinical Psychology

The research on the effects of Positive Psychology in clinical practice is still a project in progress, however there are a number of studies that have been conducted which show the potential of these interventions for clinical treatment:

- **Grant, Salcedo, Hynan, Frisch and Puster. (1995)**

One of the first positive psychology interventions, this study was a small and uncontrolled biblio-therapy study. The participants were 16 individuals who had been classified as being depressed on the Beck Depression Index. As part of the 15-week intervention, they read about strategies for increasing their satisfaction in various domains of life (e.g., health, self-esteem, goals, values, money, work, play, learning, creativity, love, helping, friends, children, relatives, home, neighbourhood, and community) and met weekly to discuss these topics.

After 15 weeks, none of the 13 participants who completed the intervention met the criteria for clinical depression as assessed by the Hamilton Rating Scale of Depression or the Beck Depression Inventory.

- **Parks and Seligman (2004)**

They developed a 6-week positive intervention program, made up of 6 exercises. These exercises were designed to treat depressive symptoms in mild to moderate depressed young adults by increasing pleasure, engagement and meaning.

Participants in the intervention condition attained a score 6 points lower on the Beck Depression Inventory after 6 weeks than did the no intervention control group. In addition, participants in the positive intervention condition also experienced notable, but not statistically significant increases in happiness measures and decreases in anxiety symptoms

symptoms.

- **Seligman, Rashid and Park (2006)**

This study tested the effects of PPT in 2 face-to-face studies with mild to moderately depressed young adults as well as severely depressed young adults. They included the following positive exercises in their intervention: using signature strengths, thinking of 3 blessings, writing a positive obituary, going on a gratitude visit, active-constructive responding and savouring.

The results showed that these tasks resulted in the reduction of depressive symptoms over the 6 month period. The intervention was most effective for participants with severe depression.

There were however a number of limitations with this study: there was a small sample size of 11-13 participants in each condition which affected the external validity of the study (these results may not be applicable to all patients of depression); there was also a possible placebo effect (some participants showed reduced symptoms after just one week), hence these issues need to be addressed in the future.

Current situation within the UK Health Services

Currently, the NHS recognises the field of Positive Psychology and it's linkage with Clinical Psychology to combat psychologically-based dysfunction . However, very little practice takes place within the NHS and Positive Psychology practices are not available nationwide.

It is important for patients to be aware of all their options when it comes to their own healthcare. This is why more information about Positive Psychology should be made readily available so that patients are able to make an informed decision before embarking on any treatment.

Our Key Paper

Joseph, S. & Wood, A.. (2010). Assessment of positive functioning in clinical psychology: Theoretical and practical issues. Clinical Psychology Review. 30 (1), 830–838.

Introduction and Aims

Previous research has consistently focused on the *presence* of negative personality traits and how these, along with impaired well-being, create vulnerability towards the development of depression. The positive aspects of life seem to have been neglected by both psychology and psychiatry and this paper aimed to explore how the *absence* of these positive traits creates an additional risk factor for depression.

First of all it must be noted that in order to examine well-being fully, it must be split into two separate categories: subjective (“hedonic”) and psychological (“eudemonic”) well-being (SWB and PWB respectively).

1. SWB “ encompasses emotional functioning and an individual's subjective evaluation of their life (Diener,1984).

2. PWB “focuses on more existential concerns, and the way in which an individual interacts with the world”

In this article PWB will be discussed. The authors wished to examine whether people who have a low PWB (at time one – T1) are at risk of clinically elevated levels of depression ten years later (T2).

Issues Addressed

This paper aims to address the main challenges faced by clinical psychologists including;

1. By including positive functioning assessment in the practise of clinical psychology, more theory must be developed that informs this practise of the relationship between psychopathology and positive functioning and

2. How including positive functioning can lead to implications in the development of clinical psychology and to determine if it will continue to be influenced by the medical model.

Participants and Methods

A total of 5566 individuals took part in this study (54.7% female) ages between 51 and 56 at T1 and 63 and 67 at T2. Homeownership, vehicle ownership, annual income/assets, education, marital and employment status were all taken into consideration too. Alongside these demographic and economic factors, personality and current illness were taken into account. Current illness included 16 conditions ranging from asthma to multiple sclerosis. Additionally, participants also completed the CES-D measure which assesses current levels of depression. Finally, at T1, subjects completed the 18-item version of the Scales of Psychological Well-Being (Ryff and Keyes, 1995) which provided an overall PWB score for each participant as well as six sub-scales including autonomy and personal growth.

Results

The analysis was designed to explore whether people with a low PWB at T1 (age 51-56) were at a higher risk of being depressed at T2 (age 63-67).

PWB was split into 3 categories; normal functioning, slightly impaired PWB and low PWB.

Results were as follows;

· Overall, 12.89% of the whole sample were depressed at T2

· Of the normally functioning individuals 85 were depressed at T2 compared to 177 and 466 in the impaired and low groups respectively.

· Those with a low and slightly impaired PWB were 7.16 and 2.30 times more likely to be depressed respectively.

· Additionally, when health, demographic and economic variables were included in the analysis, low PWB was still a substantial indicator of depression at the 10 year follow-up

o Those with low PWB were still twice as likely to develop depression compared to non-impaired people.

· When taking into consideration participants current illnesses, several were found to be significant risk factors of depression, including back trouble and circulation problems. However low PWB was found to be a greater risk factor than any of the current health problems.

Discussion

The current study shows how the *absence* of positive well-being is a predicting factor of future depression (at 10 year follow-up in this case), even after controlling for confounding variable such as personality and current health and economic status.

This study was the first of its kind to suggest that PWB is a predictor of future depression, providing support for the positive clinical psychology movement (Duckworth et al., 2005) .

This support suggests an understanding of PWB is essential for further understanding of depression. Furthermore these results also support the interventions which are being put in place to help increase PWB as a means of preventing and treating depression.

Limitations

Overall, there are few limitations to this study. However, limitations that have arisen are of noteworthy quality.

1. The current paper relied solely on elf-report rather than clinical ratings of individual depression. A recent article published by the BBC has suggested that, when confronted by life's difficulties, some people will become depressed and others will not (Watts, 2012). This article suggests there is huge individual differences in depression and self-reports may highlight these.

a. However the authors followed up this criticism by suggesting that the CES-D depression has shown to noticeably link to physician ratings of depression

2. This study only examined one single cohort of people – mid 50's (time 1) and mind 60's (time 2). Future research should consider replication of this study with a different cohort of people and consider a different or multiple follow-up periods.

Three Articles to Read

- **Duckworth, Steen and Seligman (2005)**

Although written in 2005, this review gives a concise introduction to the field of positive psychology and proposes a relationship between the positive and clinical areas. They discuss positive interventions that are put in place, aimed at preventing and treating psychopathology. Furthermore, they offer a 'vision' to the future, discussing how the usefulness of clinically applied positive psychology may be judged. This

‘vision’ of the future however, relates to a decade in the future, which is around about now! Therefore, this paper would be of great use as a tool to examine how the suggestions of positive psychology may be seen in the ‘future’ compare to the reality of today.

- **Wood (2010)**

This paper discusses the importance of clinical psychologists adopting positive interventions and functioning into both their research and practise in order to broaden their therapeutic repertoire. They suggest that, in doing so, clinical psychologists must be aware they are ‘shifting the agenda of clinical psychology’ and therefore must reflect on ‘epistemological foundations’.

- **Sin and Lyubomirsky (2009)**

Sin and Lyubomirsky examine whether positive psychological interventions actually enhance well-being and diminish symptoms of depression using a meta-analysis of 51 of those interventions and 4,266 individuals. Results were promising showing that positive psychology interventions did indeed significantly enhance the well-being of others alongside alleviating the signs of depression. Additionally, several confounding factors were shown to impact the interventions’ effectiveness, all of which are discussed in the analysis.

Negative Approach to Clinical Methods

Positive psychology will harm itself if it submits to the tyranny of positivity (Held, 2002), that is apparent in parts of the self-help literature and for some of its prominent members. Negative emotions serve a critical function in our lives, and will enable us to stay focused on the parts of reality that are necessary for optimal functioning. The positive approach seems to overlook that negative thoughts and feelings can play a constructive role in someone life. Or as Barbara Held (2002, 2004) has expressed it: Positive Psychology is unnecessarily negative about negativity.

It appears that to be happy(read positive) not automatically associated is with more favorable living conditions. The people who generally say they are extremely happy ,do it for income, education and political participation such worse than people who say they are just happy (Oishi, Diener& Lucas, 2007). Also found people who report that they are extremely happy to live slightly shorter (Diener & Biswas-Diener,

2008). Who is happy for the opportunity probably deprives the course of their own lives now and make adjustments.

The one-sided emphasis on positivity may also adversely affect people who are seriously ill as self-blame when a coping strategy is imposed. If you had been more positive then you would not have become sick and once you are sick it might be your fault that you do not recover (Held, 2004). Give up and let go, in some cases turn out positive, always keep believing in the positive outcome (Carver & Scheier, 2003).

How positive and negative feelings need each other is perhaps most clearly from the work of German psychologist Gabriele Oettingen. She conducted research among women who are obese and joining a weight loss program. Women who assumed that the program would be a success, dropped nearly 13pounds more on average than women who were more pessimistic. But participants in the study who thought that losing weight was easy going, women so with unrealistic positive fantasies, lost nearly 12 pounds less weight than women who thoughtthat it's going to be difficult. In other words, the women with a realistic view were more successful than women who werein blissful ignorance thoughtthe program would be a breeze.

In short optimism about the future, coupled with a healthydose of pessimism about the challenge, led to more positive results (Oettingen & Stephens, 2009).

The Gap between Theory and Empirical Research

Positive clinical psychology draws its roots from a vast array of sources, from the self-actualising ideas of Maslow through to the teachings of Buddhism. Although the ideas associated with positive psychology may not be new, the methods used to test these ideas have only just recently emerged and this presents an obvious problem when comparing the theory and the empirical research within this field.

The theories that have been proposed are quite extensive and researchers need to be careful that the claims they make are modest ones because many are yet to be tested. We have identified some specific gaps between theory and research below:

Failure to incorporate the research that currently exists in psychopathology

Just as positive psychology criticises traditional clinical psychology approaches for focusing on the ‘bad’ and neglecting the ‘good’, so too does positive psychology fail to recognise the importance of traditional methods of therapy within their research. Duckworth, Steen and Seligman (2005) claim that positive psychology is not attempting to replace traditional psychotherapy but rather to supplement it, yet the research that exists involves testing the efficacy of positive psychology interventions only. Little to no research has been conducted on how effective the simultaneous use of *both* traditional and non-traditional positive methods of dealing with depression is and this is one area that needs to be addressed in the future.

It is important to consider this question- if patients of depression underwent traditional cognitive therapy and also carried out positive psychology tasks (e.g. gratitude letter, strengths exercise etc.), how would this compare to using only cognitive therapy or only the positive psychology approach? Another question to be considered is how does using only the traditional psychotherapy approach compare to using only the new positive therapy approach?

Positive psychology as a buffer for future events

The theories of positive clinical psychology also emphasise how these positive interventions can act as a buffer by preventing the onset of future depressive or negative episodes (Wood and Tarrier, 2010). When you look at the research that tests this claim, another problem presents itself as the majority of positive psychology studies that exist only test results over the short term and do not test how these interventions affect depression episodes over a patient's lifetime.

Conclusions

The positive psychology movement has been around for many years, but only recently has it been introduced into the field of clinical psychology. For positive psychology to take root in a clinical setting, it is crucial for clinical psychologists to re-evaluate their views and fully understand its concepts. One suggestion is that although positive interventions may be prescribed in a clinical environment, the individual client’s situation must be carefully considered. This fairly goes against a stereotypical clinical setting where there is often one particular drug/therapy for illnesses such as depression/schizophrenia etc.. Different areas and practical exercises in the positive psychology field ought to be carefully considered when being prescribed to clients

ought to be carefully considered when being prescribed to clients.

However, there does seem to be a growing bank of evidence to suggest that PWB influences an individual's mental health. As shown in the key paper, it seemed as though it was an *absence* of this positive well-being which led to an increased risk of depression amongst an elderly population. Evidence supports positive interventions which are being implemented to help increase the population's PWB in an attempt to not only treat but also prevent depression and many other mental illnesses.

Although there seems to be a plethora of evidence showing a positive correlation between well-being and the 'prescription' of positive psychology, further research is necessary to confirm its validity. Positive psychology is not trying to replace traditional clinical methods. Instead it attempts to establish a cooperative relationship so as both practices can work together in an effort to increase PWB and decrease an individual's vulnerability to mental illness.

References:

Beekman, A.T.F., Deeg, D.J.H., VanLimbeek, J., Braam, A.W., DeVries, M.Z., VanTilburg, W. (1997) Criterion validity of the Center for Epidemiologic Studies Depression scale (CES-D): results from a community-based sample of older subjects in the Netherlands.Psychological Medicine, 27, 231–235.

Carver, C. S., & Scheier, M. F. (2003). Three human strengths. In L. G.Aspinwall & U.M. Staudinger (Eds.), A psychology of human strengths(pp 87-102).Washington, DC: American Psychological Association.

Diener, E. (1984) Subjective well-being. Psychological Bulletin 95, 542–575.

Duckworth, A. L., Steen, T. A., & Seligman, M. E. P. (2005) Positive psychology in clinical practice. Annual Review of Clinical Psychology , 629–651.

Fernandez-Rios, L., & Cornes, J.M. (2009) A critical review of the history and status of positive psychology. Annuary of Clinical and Health Psychology, 5, 7-13.

Grant G.M., Salcedo V., Hynan, L.S., Frisch, M.B., Puster, K. (1995)Effectiveness of quality of life therapy for depression. Psychology Rep.,76, 1203–1208.

Held, B.S. (2002) The Tyranny of the Positive Attitude in America: Observation and Speculation. Journal of Clinical Psychology, 58, 965–992.

Held, B.S. (2004) The negative side of positive psychology. Journal of Humanistic Psychology, 44, 9-46.

Joseph, S. & Wood, A. (2010) Assessment of positive functioning in clinical psychology: Theoretical and. Clinical Psychology Review. 30, 830–838.

Linley, P., Joseph, S., Wood, A.M., Harrington, S. (2006) Positive psychology: Past, present, and (possible) future. The Journal of Positive Psychology 1.1, 3-16.

Moskowitz & H. Grant (Eds.), The psychology of goals (pp. 153-178). New York: Guilford Press.

Oettingen, G., & Stephens, E. J. (2009) Fantasies and motivationally intelligent goal setting. In G.B.

Oishi, S., Diener, E., & Lucas, R. E. (2007) The optimal level of well-being: Can we be too happy? Perspectives on Psychological Science, 2, 346-360.

Parks A.C., & Seligman, M.E.P. (2004) Treating mild-moderate depressive symptoms with a positive intervention. Presented at International Positive Psychology Summit, 3rd October.

Ryff, C.D., Keyes, C.L.M., 1995. The structure of psychological well-being revisited. Journal of Personality and Social Psychology, 69, 719–727.

Seligman, M.E.P., Rashid, T., & Parks, A.C. (2006) Positive Psychotherapy. American Psychologist, 11, 774-788.

Sin, N.L. & Lyubomirsky, S.. (2009) Enhancing Well-Being and Alleviating Depressive Symptoms With Positive Psychology Interventions: A Practice-Friendly Meta-Analysis. Journal of Clinical Psychology, 65 (5), 467-487.

Watts, G.. (2012) Why do some people never get depressed?. Available: http://www.bbc.co.uk/news/magazine-16749565. Last accessed 1/2/12.

Wood, A.M. & Joseph, S. (2010) The absence of positive psychological (eudemonic) well-being as a risk factor for depression: A ten year cohort study. Journal of Affective Disorders, 122, 213-217.

Wood, A.M. & Tarrier, N. (2010) Positive Clinical Psychology: A new vision and strategy for integrated research and practice. Clinical Psychology Review, 30, 819-829