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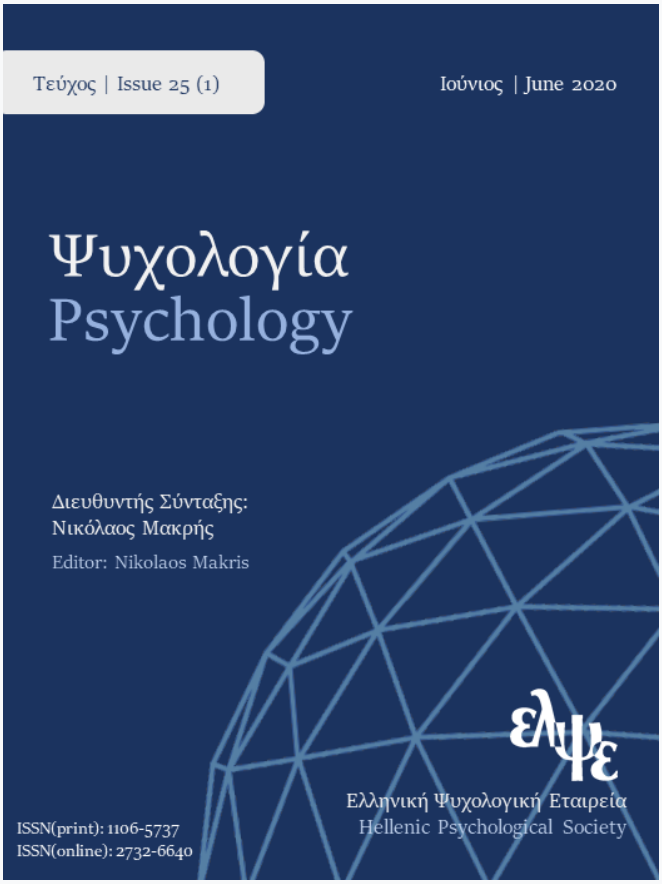

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Vasiliki Yotsidi

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The Integration of Positive Psychology in the Clinical Milieu: Conceptual, Empirical and Practical Implications in the Mental Health Care

Vasiliki YOTSIDI[1]

[1] Department of Psychology, Panteion University of Social and Political Sciences, Athens, Greece

KEYWORDS

clinical psychology, positive psychology, Positive psychology interventions (PPIs), psychotherapy integration, well-being

CORRESPONDENCE

Vasiliki Yotsidi
Department of Psychology, Panteion University of Social and Political Sciences
136, Syggrou ave.
176 71 Athens, Greece
email v.yiotsidi@panteion.gr

ABSTRACT

As clinical psychology becomes a more integrative discipline, the introduction of positive psychology in the clinical realm has been a new promising trend. Several positive interventions to treat mental health difficulties have been recently developed, aiming to promote therapeutic change by facilitating increased well-being. The aim of this paper is to review the conceptual trajectories of positive psychology in the clinical domain throughout the last twenty years and to provide a comprehensive perspective toward a positive psychology-oriented psychotherapy. Current positive psychology theoretical, empirical, and practical insights are provided to illustrate how the integration of positive psychology in the clinical environment is theoretically and practically useful as well as scientifically valid. Clinical research evidence of the contemporary theories of well-being and self-determination is presented along with the most recent empirical findings on the efficacy of positive psychology interventions in the mental health system. Examples of evidence-based positive psychology interventions further exemplify the ways of integrating positive psychology treatments into clinical practice. Such a synthesis of the evidence regarding the outcomes of positive clinical interventions can expand the research and practice of clinical psychology and may contribute to broadening the role of clinical psychologists in promoting well-being along with treating distress.

After twenty years of positive psychology research, the need to shed light on the conceptual trajectories of positive psychology in the clinical realm as well as to present the most recent empirical evidence of clinical positive psychology applications is warranted. Clinical psychology has several conceptual, scientific, and practical benefits to gain from the incorporation of positive psychology research findings and interventions. The overarching outcome of this synergy appears to be the development of a more comprehensive approach with regard to human functioning. Under this scope, the positive and the negative are studied together in promoting optimal well-being as well as treating distress, since they usually exist on the same continua (Wood & Tarrier, 2010). Nevertheless, positive psychology and its contribution to the clinical practice went through several phases along the way in its process of growth.

Positive Psychology in the Clinical Milieu: The Glass as Half-Empty or Half-Full

Broadly speaking, the perception of bipolarities, such as truth and false, good and evil, objective and subjective, nature and nurture stand as the fabric of human societies (Gergen & Ness, 2016; Rosling, 2019). Dating from the origination of psychotherapy, dualism has been manifested since the era of Freud's psychoanalysis with the introduction of the binary concepts of life *vs*. death drives (Freud, 1915/1957). Subsequently, a dichotomous conflictual thinking prevailed in the clinical realm through the conceptual division between "pathological/abnormal" *vs.* "normal", and "mental illness/disorder" *vs.* "mental health". From the 1930s to date, however, various psychotherapeutic models have been developed in an attempt to overcome this bipolarity (Goldfried et al., 2005). Along these lines, within the complex and diverse framework of clinical psychology, several approaches (e.g., humanistic, person-centered, systemic, relational psychodynamic, cognitive-behavioral, solution-focused, narrative) adopted a strength-focused perspective and they aimed at fostering resources as well as resolving difficulties.

Notwithstanding these integrative theoretical contributions, the medical model dominated in mental health research, while clinical psychology has been rather defined as a healing discipline (Maddux et al., 2005), mainly concerned with identifying the innate and environmental etiological factors of mental health problems, remediating deficits and negative functioning, ameliorating symptoms, and alleviating suffering. As Duckworth et al. (2005, p. 631) pointed out: "Although good therapists likely both remediate deficits and build competencies in their clients, historically there has been more empirical attention and explicit training given to the former than to the latter". The emergence of positive psychology in 1998, cast light upon the positive spectrum of human experience, that of optimal functioning and flourishing. Based on common theoretical grounds with earlier contributors that sought to define positive functioning in clinical work, the growth of positive psychology promoted scientifically-rigorous research on positive dimensions that have been neglected in clinical practice. With a new head-on approach, positive psychology suggested a shift towards character strengths, positive individual traits, positive experiences, and well-being, as well as the contextual circumstances that facilitate their development (Seligman & Peterson, 2003). Along these lines, the positives were considered to buffer against suffering by replacing negative experiences with positive ones (Parks & Biswas-Diener, 2013).

However, the orientation of positive psychology towards the increase of positive functioning and well-being was deemed to be narrowed and fragmentary itself (Snyder & Lopez, 2007), while it was also considered to involve the risk of misleading treatment towards a "one size fits all" approach that is far from the needs of the individual client (Bohart, 2002). Consequently, the predominant positive-only focus of positive psychology interventions (Ehrenreich, 2010; Held, 2004; Seligman & Peterson, 2003; Snyder & Lopez, 2007; Wong, 2011) turned positive psychology science to be accounted as a positive psychology ideology (Wood & Tarrier, 2010). That is, a positive psychology movement, juxtaposed to a rather rose-tinted model with unidimensional happiness-enhancing activities. This "tyranny of the positive attitude" (Held, 2002) dominated the positive psychology agenda for a substantial time, thus limiting the opportunity to develop an interactive balanced approach that would embrace positive and negative dimensions of human functioning.

Clinical Psychology and Positive Psychology: Towards an Integration

Would there be any difference in suggesting an intervention that could make clients less unhappy and another one that could make them happier? Besides, wouldn't it be rather reductionist to define the goal

of treatment only in terms of happiness, or instead, further nuanced objectives may be equally valid? It has been less than a decade that the term Positive Clinical Psychology (Wood & Tarrier, 2010) was introduced to overcome such an "either-or" thinking. Peterson and Seligman (2003) had previously applied the same term to define strength-enhancing interventions on clinical populations. By then, Positive Psychology Interventions (PPIs) were described as "another arrow in the quiver of the therapist" (Duckworth et al., 2005, p. 12) and Positive Psychotherapy was the treatment of choice for people to build their strengths rather than deal with their troubles and weaknesses (Seligman et al., 2006). Aside from such unidimensional views that may result in clients asking for the "happy therapy", Positive Clinical Psychology is a promising new avenue of integrative research and practice.

Targeting Mental Distress and Mental Health

Positive Clinical Psychology acknowledges that human issues and life vicissitudes are complex enough to necessitate a more inclusive approach. Additionally, whether specific elements are either "positive" or "negative" usually depends on broader contextual and motivational factors (Hayes, 2013), thus rendering bipolarity scientifically and clinically invalid. Along these lines, Positive Clinical Psychology suggests an equally weighted focus of therapy on increasing the positive as well as on decreasing the negative. Similarly, it adopts a balanced scope of research based on current evidence that both positive and negative characteristics interact to predict clinical outcomes, taking into account that the absence of positive characteristics often predicts emotional distress more than the presence of negative characteristics (Wood & Tarrier, 2010).

Hence, a second wave of clinical research and practice that included human assets alongside deficits was then considered to play an important role in improving understanding of emotional and behavioral difficulties (Compton & Hoffman, 2019). In other words, a joint emphasis on both protective and risk factors of mental health was thought to better embrace recent evidence in treating distress as well as promoting well-being. Along these lines, a recent review (Cooke et al., 2016) has shown that therapeutic changes should be assessed by using clinical measures together with well-being measures to avoid providing a misleading picture of the etiology of distress and treatment outcomes.

Targeting through Specific and Universal Interventions

With the aim to reduce the prevalence of common mental health problems, the integration of positive topics within the remit of clinical psychology also set forward the need to intervene at a general population level, along with applying specific interventions to individuals and groups at high risk or with specific mental health needs (Huppert, 2005). As Wood and Tarrier (2010) underpinned, clinical psychology should re-conceptualize its preventive and treatment scope to engage with public demand for interventions that improve the well-being of people without any diagnosed mental disorder. Such a broadened strategy of mental health practice reflects an additional common ground between positive psychology and clinical psychology.

According to evidence from epidemiology (Huppert, 2009), a small change in the average level of symptoms in the population can produce a large decrease in the prevalence of psychiatric morbidity. Hence, although a targeted approach may alleviate from suffering in the short term, universal approaches reduce the number of people with common mental health problems in the long run. A new avenue of research, then, is to examine the potential impact of positive psychology applications on the well-being levels of

general population, since this may also result in a decrease in the number of people with mental health difficulties. However, such research is still lacking, while the emphasis has been on the evaluation of the efficacy of specific and universal PPIs to clinical and non-clinical groups, respectively.

Targeting Happiness and Meaning

Based on traditional definitions, the PPIs include any kind of psychological intervention (i.e., training, exercise, therapy) that has been developed in line with the theoretical premises of positive psychology and aimed at raising positive feelings, cognitions, or behaviors (Sin & Lyubomirsky, 2009). A more nuanced definition (Parks & Biswas-Diener, 2013) describes PPIs to be: (a) focused on positive topics, (b) designed to promote wellness, (c) operated by a positive mechanism, and (d) targeted a positive outcome variable (e.g., subjective and psychological well-being). In accordance with Seligman's (2002) three domains of life (i.e., pleasant, engaged, and meaningful), the PPIs present a great diversity of components principally targeting positive emotions, engagement and meaning. For example, PPIs may concern life satisfaction, gratitude, savoring, hope and optimism, character strengths, flow, positive relationships, goal-setting, purpose, and meaning in life, just to mention some.

Despite their broad range, PPIs have attracted much criticism due to the fact that the direct pursuit of happiness was defined exclusively on the basis of individualistic cultural and scientific standards (Norem & Chang, 2002; Wong & Roy, 2017), while less attention has been paid to the benefits people can gain in dealing with life constraints and traumatic experiences (Joseph & Linley, 2006). As a result, meaning-oriented interventions of a dialectic interaction between positives and negatives were largely underdeveloped in positive psychology (Wong, 2016). Given that both happiness and suffering, pleasure and pain, satisfaction, and frustration are inevitable and necessary constituents of human life, the role of meaning-making, self-growth, and self-transcendence is crucial in the framework of a holistic approach. To this end, Wong (2011) has introduced a second wave of positive psychology, named PP 2.0, that provides researchers and practitioners with the opportunity to promote a complete understanding of well-being by taking into account multicultural insights and empirical findings (Flora, 2019; Ivtzan et al., 2016), a necessity that has been acknowledged in the third edition of *Positive Psychology: The Science of Happiness and Flourishing* (Compton & Hoffman, 2019).

Traditionally, the meaning-making of painful experiences has several underpinnings in conventional treatment models. For example, in psychoanalytic psychotherapy, the increased meaning-making of painful experiences, through the increase of insight, contributes to clients' integrity and individuation (Mahler et al., 1975), while it minimizes their resistances to change (Yotsidi, 2013). Similarly, existential meaning-centered therapies, aiming at the increase of authenticity, reduce clients' depressive and anxiety symptoms, and improve well-being and quality of life (Vos, 2016). Meaning-making is also an intrinsic constituent of spiritual (Monod et al., 2011) and mindfulness (Bishop et al., 2004) interventions, developed in recent years. Despite the conceptual and technical differences in meaning-making in all of these cases, it is clear that the cultivation of meaning in life plays a vital role in human flourishing since it is considered to be in line with the agentic, directional, future-oriented and teleological qualities of human behavior (Cooper, 2019).

At a theoretical level, the contribution of positive psychology to the existing meaning-oriented interventions lies in the fact that positive psychology stresses the role of positive affect in shaping and supporting human directions as well as in blending happiness with meaningful self-fulfilling strivings. At a practical level, through a psycho-educational approach in PPIs that deploy positive psychology exercises

(e.g., positive emotions, positive relationships) as well as meaning-making techniques (e.g., goal achievement, flow, virtues, and strengths) (Stalikas & Boutri, 2018), positive psychology appears to contribute to our understanding of human potentials and constrains both emotionally, cognitively and spiritually, and at the same time, at both individual and wider interpersonal and contextual levels. Such a holistic approach is recognized to be a hallmark of integrative clinical practice (Cooper, 2019). Below, current conceptual, empirical, and practical insights from the field of positive psychology better illustrate how a dialectic attitude between positive psychology and clinical psychology holds substantial value within the contemporary scientific milieu.

Contemporary Positive Clinical Theoretical Premises

The Role of Well-being in Mental Health

In overcoming the conventional view of "mental health" and "mental illness" conceived of as two discrete opposite poles, a new dual continua model has been recently developed by Keyes (2002, 2007, 2013). Taking this continuum approach, "mental health" is distinct, yet related, to "mental illness" (Huppert & Whittington, 2003), while mental health relies substantially on well-being (Keyes, 2002). Thus, depression and happiness must be studied together (Wood & Tarrier, 2010). Particularly, drawing from the DSM approach to the diagnosis of major depression, Keyes complete state model of mental health (2005) operationalizes mental health as a syndrome that combines symptoms of emotional well-being (i.e., positive affect, life satisfaction) with a set of symptoms of positive functioning at both personal and social levels (i.e., six symptoms of psychological well-being and five symptoms of social well-being).

Under this definition, well-being has a comprehensive tripartite nature, including positive feelings, individual psychological positive functioning, and personal pursuits, but also an optimal way of living in society, the latter being conceived of as necessary to reflect an individual's complete engagement and adjustment to life (Keyes, 1998). Based on the total number of symptoms exhibited by the individual, three possible diagnostic schemes may emerge, namely flourishing (i.e., high levels of well-being), languishing (i.e., low levels of well-being), and moderate mental health (i.e., neither flourishing nor languishing). The symptoms of emotional vitality and positive functioning are drawn from participants' responses to the Mental Health Continuum-Short Form (MHC-SF; Keyes & Grzywacz, 2005), which is a widely used measure in both non-clinical and clinical populations (see Ferentinos et al., 2019 for a Greek version of MHC-SF).

The key role of well-being has been also underscored in the definition of mental health by the World Health Organization (World Health Organization [WHO], 1948, 2013) Indeed, in recent years, well-being has received increased attention in clinical research. To sum up the main findings, there is abundant evidence that well-being and psychiatric morbidity are two interrelated yet independent constructs of mental health; therefore, the treatment of symptoms alone does not necessarily result in improved well-being (e.g., Lamers et al., 2015; Westerhof & Keyes, 2010). Secondly, well-being protects against psychopathology, including relapse or recurrence symptoms (e.g., Grant et al., 2013; Keyes et al., 2010; Wood & Joseph, 2010) and suicide risk (Keyes et al., 2012). Third, the lack of well-being is associated with an increased probability of all-cause mortality, impaired quality of life, and increased emotional and behavioral problems over time (Keyes et al., 2010). Finally, well-being is related to the pursuit of core life desires and goals, and the concomitant positive affect that comes from actualizing them (Cooper, 2019). Hence, positive psychology interventions that explicitly aim to enhance well-being are deemed necessary

to be further promoted (Chakhssi et al., 2018). Furthermore, as it has been shown from an abundance of research, the role of the newly developed self-determination theory (Ryan & Deci, 2001) is conceived of high importance in attaining well-being goals, especially in the clinical domains.

Self-determination Theory

Self-determination theory (STD) is a positive psychology theory of motivation, which includes three, imperative for the individuals' well-being, psychological needs: autonomy, competence, and relatedness (Deci & Ryan, 2008; Reis et al., 2000; Ryan & Deci, 2000). The main principles of STD are that human behavior is intentional, initiated by our strivings to be self-governed and that directing oneself towards personally meaningful goals is important to well-being (Hefferon & Boniwell, 2011).

Particularly, autonomy refers to the human tendency for personal volition, freedom, and control of ones' own behavior, without being determined or dominated by others or things. It is the need to voluntarily choose and engage in actions consistent with one's integrated sense of self and in accordance with situational affordances, regardless of external restrains and pressures (Deci & Ryan, 2000). The need for competence is related to achievement, self-efficacy, mastery, and self-worth. It is the feeling of being effective in one's interactions with others, having the opportunity to exercise one's capacities and affecting the environment (Ryan & Deci, 2002). The need for relatedness is the human tendency for attachment, belongingness, and connectedness to others. It is the feeling of caring for and being cared for by others, which promotes mutual protection and community cohesion (Ryan & Deci, 2002). Interestingly, SDT provides within a therapeutic context an integrative theoretical framework *per se,* since it combines autonomy with relatedness, as complementary human needs.

Although they have been already part of other therapies (e.g., person-centered therapy, motivational interviewing), the psychological needs of self-regulated purpose (autonomy), competence, and interpersonal functioning are profoundly promoted through the PPIs' positive emotion-inducing strategies (Tkach & Lyubomirsky, 2006). This is based on good evidence that supports the broadening role of positive emotions with regard to people's repertoires of thoughts and actions (Fredrickson, 2001), by sparking their urge to explore the environment, to engage in new, diversified activities, to develop more flexible mindsets, to socialize, and to foster prosocial behaviors (Quoidbach et al., 2015). Furthermore, research shows that downregulating negative emotions, which has been traditionally the focus of psychotherapy, is not equal to upregulating positive emotions. Thus, the latter is valuable not only as ends in themselves (i.e., indicators of mental health) but also as a means of promoting personal and even social well-being (i.e., generators of mental health), since positive emotions buffer individuals from psychological distress and increase their resilience (Quoidbach et al., 2015).

In addition to these findings, the SDT's focus on the intrinsic goals brings into treatment the approach-avoidance dimension of goal regulation, which is of particular value in therapy. According to Elliot and Church (2002), approach goals regulation involves trying to orient oneself or maintain a positive, desirable outcome or state, while avoidance goals regulation involves trying to move or stay away from a negative, undesirable outcome or state. In therapy, many clients have a more avoidance-oriented regulatory style (Elliot & Church, 2002), which reflects their need to feel safe from a perceived threat and their desire for stability, certainty, and control, thus hindering them from pursuing psychological change and growth. This is in line with recent evidence that shows how clients' resistance to psychotherapy may be perceived in more affirmative terms as a safeguard of psychological security in the therapeutic interplay (Yotsidi et al., 2019).

Hence, contrary to our tendency to orient ourselves towards avoidance goals for survival reasons, a deliberate shift toward approach-oriented goals within the therapeutic context is worth prioritizing to develop well-being (Cooper, 2019). A positive psychology-informed psychotherapy then may contribute to helping clients to reframe avoidance goals (e.g., decrease symptomatology, reduce anxiety) in terms of approaching positive goals (e.g., build resources, create meaning in life, and strengthen relationships). Such an approach-oriented perspective may also enrich the existing therapeutic methods. For example, positive empathy, which is a type of empathy response that focuses on clients' hidden messages of desire for a better life, has shown promising results in terms of enhancing personal goals and strengths (Conoley et al., 2015). Hence, the integration of positive psychology into the clinical domain is of value both to fulfill our basic psychological needs and to pursue growth goals, given that PPIs adopt the same rigorous evaluation criteria as mainstream clinical interventions.

Effectiveness of Positive Clinical Interventions

Interestingly, the positive psychology movement started exactly when the empirically-supported treatments (ESTs) list was also established in the mental health field (Castelnuovo, 2010). It was more than a topical issue then for positive psychology scholars to determine through consistent empirical evidence that the new approach could be applied as a "well-established" or a "probably efficacious" treatment. Thus, numerous positive psychology interventions were subjected to rigorous testing by following the royal road of the random-assignment placebo-controlled (RCT) design. Moreover, in line with the current recommendations for a revised set of criteria for ESTs that will utilize existing systematic reviews of all of the respective literature (Tolin et al., 2015), a number of meta-analyses and systematic reviews of the PPIs have also been conducted over the last few years. These studies are the focus of this paper taking also into account some critical conceptual and practical implications of the available research.

Empirical Concerns about Evaluation Studies on PPIs

Prior to the positive psychology movement, Fordyce (1977, 1983) had paved the way with seven control randomized trial studies examining the effects of fourteen activities to increase the happiness of community college students, with the provision of follow-up data from 9 and 18-months later. The results of these studies were encouraging since participants in the intervention group reported higher levels of happiness and lower levels of anxiety and depression symptoms than participants in the control groups. In the clinical field, a similarly innovative, though small and uncontrolled, study on a 15-week positive psychology intervention to clinically-diagnosed depressed patients (Grant et al., 1995) found that the majority of the participants were without symptoms after the intervention as well as a week later. In the following years, a proliferation of studies on both general public and specific populations rapidly advanced the knowledge on the efficacy of PPIs to fostering well-being and reducing distress. Nevertheless, such a pioneering work did not come without limitations.

First of all, the evidence with regard to the effectiveness of PPIs on mental health stemmed mainly from intervention studies with non-clinical samples, though overall findings show beneficial effects on increasing happiness as well as relieving depressive symptoms (Bolier et al., 2013). Subsequently, all respective systematic reviews and meta-analyses, except for a recent one (Chakhssi et al., 2018), included both non-clinical and clinical populations. Furthermore, other interventions with a positive approach and with the aim to enhance well-being, though not strictly developed within the premises of positive

psychology (e.g. mindfulness interventions, forgiveness interventions, acceptance and commitment therapy, life-review) were also included in the respective reviews. However, such inclusion of all PPIs studies under a common framework reduces the robustness of the efficacy results for pure clinical positive psychology interventions (Bolier et al., 2013).

Another issue of consideration when examining the benefits of applying PPIs in clinical settings concerns the great diversity in their delivery mode, intensity, and content. For example, PPIs may take the form of (a) a single-component approach based on a particular exercise (e.g. three good things, gratitude visit, acts of kindness), (b) a single-component approach based on a standardized pool of multiple exercises (e.g. goal setting and planning interventions, hope therapy, meaning-centered group approach), and (c) and a multi-component, multi-exercise, approach based on PPI therapy programs (e.g. positive psychotherapy, well-being therapy, quality of life therapy). It is also striking that, although they target common components, some approaches are designed to be applied to clinical populations (e.g. compassion-focused therapy-CFT; Braehler et al., 2013; Gilbert, 2009), while others may equally be applied either to the general public or to people with mental health problems (e.g. self-compassion interventions).

In any case, several evaluation studies (see Ruini, 2017 for a review) have demonstrated that even single-component positive psychology interventions, including «*using personal strengths*», «*counting your blessings*», «*expressing gratitude*», «*practicing kindness*», «*setting personal goals*», and «*best possible self*» just to mention some, are efficacious to enhance well-being (Emmons & McCullough, 2003; Green et al., 2006; Otake et al., 2006; Seligman et al., 2005; Sheldon & Lyubomirsky, 2006). The efficacy of these activities in clinical samples in terms of improved well-being and decreased psychological distress has been demonstrated in mildly depressed individuals (Seligman et al., 2005), in patients with mood disorders (Rashid, 2015; Rashid et al., 2014), in patients with psychotic disorders (Meyer et al., 2012; Schrank et al., 2014), and adults with intellectual disabilities (Tomasulo, 2014).

Moreover, socially anxious individuals who implemented acts of kindness for 4 weeks reduced more the avoidance goals compared with both the control group and the exposure group (Trew & Alden, 2015). Along the same lines, a recent randomized controlled trial on gratitude writing (Wong et al., 2016) demonstrated that when psychotherapy clients wrote a gratitude letter to somebody whom they felt they haven't thanked well (without necessarily delivering the letter to the recipient), their mental health state at the end of the treatment was better off compared with the control group. Similarly, exercises that elicit forgiveness have been found to assist older adults with psychosocial and interpersonal difficulties (Silton et al., 2013) as well as caregivers of dementia patients (DeCaporale-Ryan et al., 2016). Finally, therapeutic interventions designed to elevate self-compassion have been shown to produce decreases in self-criticism, depressed mood, rumination, and anxiety (Neff et al., 2007). In addition, self-compassion was found to moderate the association between self-rated health and depression in older adults (Homan, 2016). Notwithstanding the well-grounded clinical utility of several positive psychological exercises, such a conceptual and practical heterogeneity in positive psychology renders any effort for a systematic review of the available evidence quite a challenge.

Clinical Findings from Meta-analyses on PPIs

A substantial number of literature reviews of positive psychological interventions (e.g. Mitchell et al., 2010) as well as, meta-analyses with regard to specific positive components, such as forgiveness interventions (e.g. Lundahl et al., 2008; Wade et al., 2014), gratitude interventions (e.g. Wood et al., 2010), mindfulness interventions (e.g. Bohlmeijer et al., 2010; Gotink et al., 2015; Khoury et al., 2013; Strauss et al., 2014), and

reminiscence interventions (e.g. Bohlmeijer et al., 2007) has examined the available empirical evidence of the impact of the PPIs in clinical domains. According to the findings from these studies, the clinical application of PPIs was found to be beneficial compared with controls or with no-treatment and placebo groups. Especially with regard to depression, several meta-analyses have shown that expressing gratitude and optimism (Malouff & Schutte, 2017), cultivating a compassionate mind as a means to reduce high levels of shame and self-criticism (Kirby et al., 2017), increasing purpose in life and projecting oneself into the future (Roepke & Seligman, 2016) as well as enhancing resilience (Waugh & Koster, 2015), may all have substantial benefits for preventing and treating depression symptoms.

Along with these component-focused reviews, to the best of our knowledge there are six meta-analytical reviews (Bolier et al., 2013; Chakhssi et al., 2018; Hendriks et al., 2019; Sin & Lyubomirsky, 2009; Weiss et al., 2016; White et al., 2019) of the evidence for the efficacy of the PPIs, so far. All of these studies reviewed PPIs for both the general public and individuals with specific psychosocial problems, except Chakhssi and colleagues' (2018) meta-analysis, which examined the effects of PPIs on well-being (primary outcome), depression, anxiety, and stress (secondary outcomes) in clinical samples with psychiatric or somatic disorders. Also, the meta-analysis of Weiss and colleagues (2016) left aside the evaluation of further clinical indicators and focused exclusively on the well-being of clinical and non-clinical populations, which was found to be significantly increased as a result of the PPIs.

Another important issue that urges caution prior to drawing clinical conclusions from the meta-analyses of PPIs, is that several methodological shortcomings (e.g., small sample size bias, different study designs) may blur the effect sizes found in the PPIs' efficacy studies, a concern that has also been raised in relation to the effects of psychotherapy for adult depression (Cuijpers et al., 2010). Along these lines, the meta-analysis of White et al. (2019) showed lower and often not statistically significant (i.e., in the case of depression) effect sizes than initially reported by Sin and Lyubomirsky (2009) and by Bolier et al. (2013), when small size bias was taken into account. Also, the meta-analysis of 50 RCTs on the efficacy of multi-component positive psychology interventions (Hendriks et al., 2019) showed that studies from non-Western countries reported larger effect sizes than studies from Western countries, especially with regard to depression, a finding however that was attributed to regional differences in the study quality, and particularly, in the small sample size bias (i.e., studies from non-Western countries had smaller sample sizes than the ones from Western countries). Interestingly, this meta-analysis found only six PPI studies conducted in the period 1998-2018 among clinical populations. Hence, although most of the current evidence shows that PPIs are efficacious in improving well-being and mental health, it is of utmost importance to ensure the increase of well-conducted research, particularly among clinical and culturally diverse populations, before any definite conclusions of the effects of PPIs can be made.

Having said that, the initial meta-analysis of Sin and Lyubomirsky (2009) encompassed 51 PPIs provided between 1977 and 2008 to 4,266 individuals. From these, a meta-analysis for depression that included 25 separate studies with a total of 1,812 individuals showed that PPIs significantly reduced depressive symptoms ($r = 0.31$, Cohen's $d = 0.65$). Based on results from moderator analyses, the researchers claimed that positive psychology techniques were particularly effective for depressed clients who were relatively older, or highly motivated to improve and that PPIs were more beneficial when delivered at an individual than a group basis and with a relatively longer duration. Nevertheless, the results of this meta-analysis derived from both randomized and quasi-experimental studies, while study quality was not addressed as a potential effect moderator.

With the aim to overcome these limitations, the second meta-analytical review of the evidence for the efficacy of the PPIs' by Bolier and colleagues (2013) included only RCTs by also taking into account the methodological quality criterion. From a total number of 39 studies conducted in 1998–2012 with 6,139 participants (4,043 in PPI groups and 2,096 in control groups), 14 studies measured depressive symptoms as an outcome, while seven studies evaluated the efficacy of individual and group positive psychotherapy (Seligman et al., 2006), hope therapy (Cheavens et al., 2006), well-being therapy (Fava et al., 1998; Fava et al., 2005), and self-management positive interventions to older people (Frieswijk et al., 2006; Kremers et al., 2006). Although the majority of the PPIs in the meta-analysis included self-help interventions with a varied duration from 1 day to 16 weeks, the intensity of the seven PPIs to people experiencing certain psychosocial problems was 6-16 weeks and only one was delivered in the form of self-help.

Overall, the results of the second meta-analysis showed that the PPIs can be efficacious in increasing well-being and reducing depressive symptoms with effect sizes in the small to moderate range (Bolier et al., 2013). Specifically, the post-test effect sizes for depression symptoms were found to be significant but small (d = 0.23 (95% CI [0.09, 0.38], p < .01). At follow-up from three to six months, effects for depression were found to be non-significant (d = 0.17, 95% CI [.0.06, 0.39], p = .15) in comparison with the control groups, contrary to the rather sustainable effects for subjective well-being (d = 0.22, 95% CI [0.05, 0.38], p <.01) and for psychological well-being (d = 0.16, 95% CI [0.02, 0.30], p = .03). Furthermore, in examining the moderating variables of the PPIs' impact on depression, significantly higher effect sizes were found for interventions longer in duration and delivered on an individual basis after a referral from a practitioner or hospital, and for interventions with a low quality study design that targeted people with specific psychosocial problems. Noteworthy, these variables were not found to significantly moderate subjective and psychological well-being, indicating that enhancing well-being and reducing depression symptoms may entail related but discrete practices.

As the researchers recommended, the impact of PPIs on reducing depressive symptoms is expected to increase with more intense (i.e., with at least a 4-week duration and preferably of more than 8 weeks), face-to-face and client-tailored interventions that would be based on a selection of positive psychology exercises combined with evidence-based interventions aiming at well-being (Bolier et al., 2013). These recommendations are in line with findings that demonstrated increased levels of well-being to 1,364 participants in PPIs who received a selection of six positive psychology exercises (compared with a selection of 2 and 4 positive exercises), and who continued to practice them voluntarily six weeks after the end of the intervention (Schueller & Parks, 2012).

The most recent meta-analysis on the efficacy of PPIs in clinical settings (Chakhssi et al., 2018) confirmed the moderating effect of the intervention duration. Examining PPIs with a duration range from 3 days to 16 weeks, this meta-analytic review was based on a total number of 30 controlled studies of PPIs in clinical samples with psychiatric and somatic (e.g., cancer) disorders, conducted in 1998–2017 with 1,864 (960 in the PPI conditions and 904 in the control conditions) adult patients. According to the findings, PPIs had a small but significant post-intervention effect on patients' well-being (Hedges' g = 0.24) and depression (g = 0.23), and a significant moderate effect on anxiety (g = 0.36) compared to control conditions. At follow-up, from two to three months after the intervention (i.e., 8-12 weeks in the 12 studies that included a follow-up evaluation), significant moderate effect sizes of PPIs on well-being (g = 0.41, 95% CI: 0.08 to 0.74, p = 0.014) and anxiety (g = 0.35, 95% CI:0.12 to 0.59, p = 0.004), and a significant small effect size on depression (g = 0.21, 95% CI: 0.05 to 0.37, p = 0.011), were observed. Interestingly, no significant differences in effects were found for empirically validated PPIs *vs* other PPIs, individual *vs* group

format, or PPI therapy programs *vs* single-component PPIs. However, the effects of PPIs on depression and anxiety symptoms were moderated by the low to medium methodological quality of the included studies. As mentioned earlier, this review also indicated that an intensive delivery of PPIs (i.e., more than 8 weeks) is more beneficial to clinical samples, since PPIs with a shorter duration did not have a significant effect on well-being. Additionally, therapist-guided PPIs were found to be more efficacious compared with self-help interventions (Chakhssi et al., 2018).

Thus, despite the early exclamation that "happiness levels could be increased by "shotgun" interventions involving multiple exercises" (Seligman et al., 2005, p. 10), recent evidence indicates that intervention intensity and therapist guidance are necessary elements in PPIs, at least to those delivered to clinical populations. On the other hand, both global PPI therapy programs and the combination of several single positive exercises have been found efficacious to increase well-being and to reduce distress, through eliciting positive feelings, cognitions, or behaviors. As Layous and Lyubomirsky (2014) suggested, a greater variety of different positive exercises assigned to participants in combination with the continuous voluntary implementation of them beyond the required period of intervention, lead to better outcomes. Hence, the question regarding the intersection between the individual and the positive activity that might produce an optimum «*person-activity fit*» (i.e., the extent of matching an individual's preferences and needs with a positive psychology intervention) remains as yet open.

With positive interventions being applied either systematically or in isolation at the therapists' convenience, there is still much room for new empirical research on identifying the fine-detail of how the PPIs can be efficacious in clinical settings. For example, it is necessary to strengthen the implementation of PPIs in a multi-cultural context that would take into consideration the needs of people with different ethnic/cultural backgrounds, as evidence-basis for further adjustments in positive clinical practice. In addition, systematic follow-up data that would examine the lasting positive changes as an outcome of a PPI as well as, effectiveness studies that would take into account the challenges of clinical reality (e.g., comorbidity issues) are still scarce in positive psychology research. Similarly, another issue that warrants further clinical research includes the optimal combination(s) of positive psychology components and exercises either for a stand-alone positive psychological intervention to be developed, or instead, for serving specific therapeutic goals as an add-on intervention. The latter raises also the question of whether PPIs can supplement traditional treatment interventions (e.g. CBT), or whether it could be additive to incorporate PPIs in mainstream therapies so as to actively address both sides of human existence, the darks and the lights ones (Layous & Lyubomirsky, 2014). Two such empirically supported treatments are presented below to further exemplify the ways of integrating PPIs into clinical practice.

Examples of Evidence-based Clinical Positive Psychology Interventions

In recent years, several positive psychology treatments have been developed in clinical settings with robust evidence (see Ruini, 2017 and Stalikas & Boutri, 2018 for reviews). Despite their certain differences, the following two pioneering PPIs, namely the integrative positive psychological intervention for depression (IPPI-D; Chaves et al., 2019) and the well-being therapy (WBT; Fava et al., 1998), have already proven to be as effective as other evidence-based treatments for clinically depressed patients (i.e., CBT). Additionally, they both adopt a balanced approach between positivity and negativity by incorporating the aforementioned theoretical premises of a comprehensive positive clinical psychology that primarily targets the promotion of well-being but also the decrease of mental distress (Wood & Tarrier, 2010).

Particularly, IPPI-D is a manualized 10-session therapeutic program delivered weekly in a 2-hour group format that combines several well-being components with the aim "to nurture positive resources, while attending to and validating suffering" (Chaves et al., 2019, p. 3). The program includes a series of empirically-validated in-session and homework exercises with the following characteristics: (a) they address both hedonic (e.g., positive affect, life satisfaction) and eudaimonic (e.g., purpose in life, positive relationships) components of well-being, (b) they are agentic and self-reinforcing as they are easily integrated into one's daily routine for participants to continue them on their own, (c) they are based on a psychoeducational and didactic module that helps participants focus on positive emotional and cognitive functioning, (d) they are based on contextual, experiential and narrative strategies (e.g., metaphors, poems, songs, video-clips), and (e) they directly aim at identifying, generating and managing positive experiences, instead of focusing on negative thoughts and behaviors.

Along these lines, after the first session which delineates the treatment goals and rationale as well as what depression is from a positive mental health perspective, the participants are encouraged to pursue well-being goals by becoming aware of the positive emotions they may experience during the next week. The following two sessions are dedicated to hedonic well-being by placing emphasis on: (a) positive emotions (e.g. practicing the ability to name, differentiate and regulate positive emotions), and (b) savoring (e.g. mindful breathing, body scan, savoring a piece of chocolate, attentive walk). The topics of the sessions 4-9 include exercises that promote gratitude and optimism, positive relationships, compassion, personal strengths, personal goals, and purpose in life, as well as resilience. In the last session, participants are asked to retrospectively analyze the gains achieved during the program, while different ways to prevent relapses and minimize hedonic adaptation are also discussed. Finally, participants celebrate their graduation from the program (Chaves et al., 2019). In a comparative study with a CBT intervention group (Chaves et al., 2017), the effects of the IPPI-D on depression symptoms have been found to be of a large size (Cohen's $d = -0.96$ for the IPPI-D and $d = -1.09$ for the CBT), while the overall satisfaction with the intervention as well as the average pre-post effect size on positive functioning variables was larger for the IPPI-D ($d = 0.44$) than for the CBT program ($d = 0.26$). Additionally, IPPI-D has been rated with the highest quality score among all the studies included in the aforementioned meta-analysis of PPIs in clinical samples (Chakhssi et al., 2018).

Well-being therapy (Fava et al., 1998; Fava & Ruini, 2003) is a structured 8-session therapeutic program delivered fortnightly on an individual basis with a duration of 40-50 minutes. The total duration of the program may vary according to the overall objectives of the intervention (e.g. may be extended to 12 or more sessions or may be abridged to 4 sessions when it is preceded by CBT). This is also the case for the intensity of the program, which may be weekly or even extended longer when necessary. WBT has been usually implemented as an adjunct treatment to CBT. Furthermore, WBT may be suggested as a first-line treatment for patients with mood and anxiety disorders at the residual or relapse phases (Fava & Tomba, 2009). The ultimate aim of WBT is to promote the five eudaimonic aspects of well-being based on Carol Ryff's model (1989) with the addition of a sixth criterion for positive mental health introduced by Marie Jahoda's (1958), that is one's ability to integrate and balance both inner and outer psychic forces.

Hence, the WBT program promotes the five dimensions of psychological well-being (i.e., autonomy, environmental mastery, positive relationships, personal growth, purpose in life, and self-acceptance) with the aim to reach a balanced level for each one of them, in place of an impaired level or an excessive level, both being considered dysfunctional (Fava, 2016). Client's self-observation and self-reflection, the therapist's active role and homework assignments (e.g. well-being diary, graded task assignment) are the

key methods of the treatment process. The first three sessions are dedicated to train the client on how to monitor well-being experiences and how to identify interfering thoughts and behaviors leading to its premature termination or a distorted interpretation of happiness and well-being. The next 4-6 sessions aim at modifying client's attitudes toward well-being pursuit. Two psychological well-being dimensions are dealt with in every single session. Patients are trained to positive cognitive restructuring and they are encouraged to engage in pleasant and rewarding activities. In the last two sessions, therapists review the patient's progress and clinical state, they stress the importance of adjusting the dimensions of psychological well-being to an individualized optimal balance in line with client's changing needs (Ruini & Fava, 2012), and they provide guidance how to prevent future relapse. Research on the efficacy of WBT in treating affective and anxiety disorders has been robust (Fava et al., 2002; Fava et al., 2005; Fava et al., 2004; Moeenizadeh & Salagame, 2010; Ruini & Fava, 2009). Furthermore, a modified WBT protocol (Child-WBT, CWBT) that combines CBT sessions with sequential WBT sessions has been implemented in a group of children reporting emotional and behavioral disorders, with promising results (Albieri et al., 2009).

Conclusions

In recent years, the importance of clinical practice and research into positive functioning has been acknowledged as necessary to counterpart problem-based preventive interventions and treatment. Along these lines, a shared focus on enhancing well-being along with ameliorating symptoms is perceived to complement rather than to replace traditional psychology, thus orienting clinical work toward a dialectic Aristotelian optimal medium that incorporates both dark and light sides of human functioning. Besides, through its development, positive psychology has turned to adopt a less polarized approach *per se*. Under this perspective, it is apparent that both positive and negative emotions and characteristics can equally become maladaptive at higher or lower levels. Positive psychology interventions may then be used to assist clients to strengthen psychological and social recourses, build up resilience, and develop optimal psychological flexibility in life that dynamically balances positives with negatives.

After a long way of criticism, it has now been recognized that positive psychology can be effectively applied as a choice of treatment for people with common mental health problems (e.g., depression and anxiety), while it can reduce distress and improve well-being in individuals with specific psychosocial needs (e.g., elderly people, people with psychosis, adults with intellectual disabilities). This can take place by implementing PPIs as a first step, low-intensity intervention in a stepped care model (Bolier et al., 2013), as an adjunct treatment (e.g., to clients in remission) in combination with conventional therapies (Ruini, 2017), or as a stand-alone positive psychological intervention (Chakhssi et al., 2018). Furthermore, positive psychology interventions can be used as preventive tools to promote public mental health and to reach large target groups that may not otherwise be reached, for example by implementing psycho-education interventions through the internet or in a self-help format (Bolier et al., 2013).

Despite recent developments, our knowledge with regard to positive psychology applications to the therapeutic context can be further advanced. Particularly, there is still a need for methodological sound and sufficiently powered studies to investigate both the efficacy and effectiveness of PPIs in the clinical domain. Future studies that would include more high-quality randomized-controlled trials, post-treatment follow-up measures, replication of findings in other countries and cultures, and meta-analyses restricted to specific types of interventions are warranted. Moreover, the effectiveness of PPIs to children and adolescents with clinical disorders remains uncharted territory. Additionally, taking into consideration the strong preventive component of positive psychology, a collaboration of positive clinical psychology with

allied disciplines (i.e., counseling psychology) would further advance science and practice (Wood & Tarrier, 2010).

In conclusion, positive psychology and clinical psychology have much to offer each other. This review sought to add to the current body of knowledge by providing greater detail into the importance of the integration of positive psychology into the clinical domain as a basis for a comprehensive and dialectic approach in the field. After all, as Joseph Conrad has claimed, «*strictly speaking, the question is not how to be cured but how to live*» (quoted in Welsh & Betancourt, 1996). A positive psychology-informed clinical practice appears to resonate well with this direction and provide clinicians and scientists with tools to pursue such an approach-oriented goal.

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ΒΙΒΛΙΟΓΡΑΦΙΚΗ ΑΝΑΣΚΟΠΗΣΗ | REVIEW PAPER

Η Ενσωμάτωση της Θετικής Ψυχολογίας στο Κλινικό Πλαίσιο: Θεωρητικές, Εμπειρικές και Πρακτικές Διαστάσεις

Βασιλική ΓΙΩΤΣΙΔΗ[1]

[1] Τμήμα Ψυχολογίας, Πάντειο Πανεπιστήμιο Κοινωνικών και Πολιτικών Σπουδών, Αθήνα, Ελλάδα

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

ευημερία,
θετική ψυχολογία,
Θετικές Ψυχολογικές Παρεμβάσεις (PPIs),
κλινική ψυχολογία,
ψυχοθεραπεία

ΣΤΟΙΧΕΙΑ ΕΠΙΚΟΙΝΩΝΙΑΣ

Βασιλική Γιωτσίδη
Τμήμα Ψυχολογίας,
Πάντειο Πανεπιστήμιο Κοινωνικών και Πολιτικών Σπουδών,
Λεωφόρος Συγγρού 136,
176 71, Αθήνα, Ελλάδα
email v.yiotsidi@panteion.gr

ΠΕΡΙΛΗΨΗ

Καθώς η κλινική ψυχολογία τείνει προς μια συνθετική προσέγγιση, η ενσωμάτωση της θετικής ψυχολογίας στο κλινικό πλαίσιο προσφέρει νέες εποικοδομητικές δυνατότητες παρέμβασης. Τα τελευταία χρόνια, έχουν αναπτυχθεί μια σειρά από θετικές παρεμβάσεις με στόχο τη θεραπευτική αντιμετώπιση προβλημάτων ψυχικής υγείας, προάγοντας τη θεραπευτική αλλαγή μέσω της ενίσχυσης της ευημερίας. Στόχος του άρθρου είναι η ανασκόπηση των διαφορετικών εξελικτικών φάσεων της θετικής ψυχολογίας στο κλινικό πλαίσιο κατά τη διάρκεια των τελευταίων είκοσι ετών, καθώς και η διαμόρφωση μίας συνθετικής οπτικής προς μια θετικά προσανατολισμένη ψυχοθεραπεία. Σύγχρονες θεωρητικές, εμπειρικές και κλινικές διαστάσεις της θετικής ψυχολογίας καταδεικνύουν ότι η εισαγωγή της θετικής ψυχολογίας στην κλινική εργασία είναι θεωρητικά και πρακτικά χρήσιμη, καθώς και επιστημονικά έγκυρη. Στο πλαίσιο αυτό, παρουσιάζονται εμπειρικά δεδομένα σχετικά με τις σύγχρονες θεωρήσεις για την ευημερία και τη θεωρία αυτό-προσδιορισμού στην κλινική πρακτική, ερευνητικά ευρήματα για την αποτελεσματικότητα των θετικών θεραπευτικών παρεμβάσεων στον χώρο της ψυχικής υγείας, καθώς και συγκεκριμένα εμπειρικά τεκμηριωμένα παραδείγματα θετικών ψυχολογικών προγραμμάτων στην κλινική πράξη. Μία τέτοια σύνθεση των εμπειρικών δεδομένων αναφορικά με τα αποτελέσματα των θετικών κλινικών παρεμβάσεων αναμένεται να διευρύνει τόσο την έρευνα όσο και τις εφαρμογές της κλινικής ψυχολογίας και να συμβάλει στην ενίσχυση του ρόλου των κλινικών ψυχολόγων στην προαγωγή της ευημερίας, παράλληλα με τη θεραπευτική αντιμετώπιση της ψυχικής δυσφορίας.