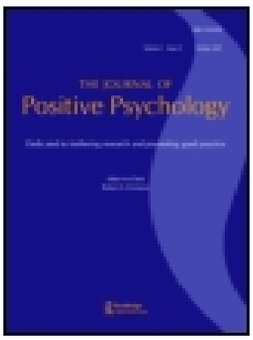

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Character strengths and clinical presentation

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ABSTRACT

Three models are described that attempt to integrate clinical diagnosis with the strengths-based model introduced by Peterson and Seligman (2004). The strengths as syndrome model proposes conceptualizing clinical diagnoses in terms of excesses and deficiencies in strengths. The strengths as symptoms model suggests conceptualizing clinical symptoms as excesses or deficiencies in strengths. After reviewing these two models, we introduce a third. The strengths as moderators model suggests that signature or deficient strengths can serve moderators of clinical presentation within traditional diagnostic categories. This differs from the prior models primarily in offering a complement rather than alternative to traditional diagnostic formulation. A clinical case is provided highlighting the differences. The three approaches are not incompatible with each other, and in combination may provide practitioners a variety of perspectives for employing strength-based concepts in clinical interactions.

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Positive psychology; character strengths; clinical diagnosis; 72 pathologies; diagnostic formulation

Since its inception, one of the recurring topics in positive psychology has been the relationship between a psychology dedicated to the enhancement of strengths and positive experiences, and a more traditional emphasis – at least among clinical sub-disciplines in psychology – on the alleviation of distress and disorder (Seligman & Csikszentmihalyi, 2000). Some commentators have described positive psychology in terms that imply it was intended as an alternative to a psychology historically preoccupied with distress (e.g. Snyder, Lopez, Aspinwall, & Wrzesniewski, 2002). Others have clarified the complementary nature of the two approaches. For instance, Seligman (2002) proposed human strengths as buffers against psychological disorders, and suggested their cultivation in the general public as a potential contributor to population health.

In the past decade, there has also been a growing body of research in positive psychology examining interventions that incorporate strengths to alleviate psychological symptoms and enhance well-being. Positive psychology interventions have been studied among individuals with anxiety (Fava & Ruini, 2003), schizophrenia (Ahmed & Boisvert, 2006; Meyer, Johnson, Parks, Iwanski, & Penn, 2012), depression (Mongrain & Anselmo-Matthews, 2012; Seligman, Rashid, & Parks, 2006; Sin & Lyubomirsky, 2009), and alcohol dependence (Akhtar & Boniwell, 2010), to name a few. Rashid (2015a) has proposed positive psychotherapy as a general approach to intervention based on principles drawn from positive psychology. Recent meta-analyses have reviewed the effectiveness of positive interventions and concluded that these interventions can significantly enhance well-being and reduce symptoms (Bolier et al., 2013; Sin & Lyubomirsky, 2009). It should also be noted that positive psychology is not the only fountainhead for this work. Some popular interventions that are perceived as focusing on personal growth rather than symptom relief, such as mindfulness, emerged independently of the positive psychology movement.

The DSM and the un-DSM

Another area of potential complementarity between positive psychology and clinical work has to do with the issue of diagnosis. The discussion of this topic has been largely informed by the development of the VIA Classification of Strengths and Virtues (Peterson & Seligman, 2004). The VIA Classification has been described many times, but in brief, it models the field of positive personal attributes in terms of 24 dimensions, called character strengths. These are intended to provide a comprehensive perspective on personal characteristics that are considered desirable and are respected across most if not all cultures. The strengths are each considered reflective of one of six broad virtues: Wisdom & Knowledge, Courage, Humanity, Justice, Temperance, and Transcendence. The six virtues were developed through a review of moral texts from eight

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cultural traditions: Confucianism and Taoism in China; Buddhism and Hinduism in South Asia; and Athenian philosophy, Judaism, Christianity, and Islam in the West (Dahlsgaard, Peterson, & Seligman, 2005). These virtues are treated as potentially universal principles underlying culturally valued behavior. The model therefore draws a close connection between strengths of the individual person and virtues valued by the surrounding culture.

Peterson and Seligman's (2004) *Character Strengths and Virtue: A Handbook and Classification* provides the most thorough discussion of the VIA Classification to date. In this book, they described the methodology used to generate the list of strengths, enumerated and described each of the strengths, proposed the categorization of the strengths in terms of the six virtues, and introduced the VIA Inventory of Strengths (VIA-IS) as a method for assessing the strengths in adults. The VIA Classification as outlined in their book is provided in Table 1.

The authors explicitly intended the VIA Classification as a positive psychology complement to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; American Psychiatric Association [APA], 2013), and Peterson (2006) subsequently referred to it, perhaps flippantly, as the 'un-DSM.' Where the DSM attempts comprehensive description of psychological illness and pathology, Peterson and Seligman (2004) proposed the VIA Classification as a similar tool for characterizing people in terms of their best attributes. This characterization in turn could contribute to the understanding of a variety of positive dimensions, including well-being and wellness. Between them, the VIA Classification and DSM could potentially be used to characterize the breadth of human experience, from negative to positive.

Table 1. The VIA classification of strengths and virtues.

Virtues	Character strengths
Wisdom & Knowledge	Creativity [originality, ingenuity]
	Curiosity [interest, novelty-seeking, openness to experience]
	Judgment & Open-Mindedness [critical thinking]
	Love of Learning
	Perspective [wisdom]
Courage	Bravery [valor]
	Perseverance [persistence, industriousness]
	Honesty [authenticity, integrity]
	Zest [vitality, enthusiasm, vigor, energy]
Humanity	Capacity to Love and Be Loved
	Kindness [generosity, nurturance, care, compassion, altruistic love, 'niceness']
	Social Intelligence [emotional intelligence, personal intelligence]
Justice	Teamwork [citizenship, social responsibility, loyalty]
	Fairness
	Leadership
Temperance	Forgiveness & Mercy
	Modesty & Humility
	Prudence
	Self-Regulation [self-control]
Transcendence	Appreciation of Beauty and Excellence [awe, wonder, elevation]
	Gratitude
	Hope [optimism, future-mindedness, future orientation]
	Humor [playfulness]
	Religiousness & Spirituality [faith, purpose]

Notes: From *Character Strengths and Virtues: A Handbook and Classification* (p. 29), By C. Peterson and M. E. P. Seligman, 2004, Washington, DC: American Psychological Association. Copyright (2004) by the Values in Action Institute. Adapted with permission.

The purpose of this article is to review two models that have already been proposed for integrating diagnostic information and information about character strengths. We will refer to these as the 'strengths as syndromes' model (SaDx) and the 'strengths as symptoms' model (SaSx). We will then introduce a third perspective, which we will call the 'strength as moderator' model (SaM). Our goal is to offer clinicians, coaches, and researchers a variety of perspectives from which to explore the implications of strengths theory for clinical intervention.

Strengths as syndromes

Perhaps the first attempt to draw a relationship between positive psychology strengths theory and clinical diagnosis was offered by Peterson (2006), who asserted that the study of psychopathology could be enriched by considering pathologies in the strengths as an alternative approach to describing problems in life. Specifically, he argued that problems with the use of strengths might represent the true problems with living. To quote Peterson (2006, p. 36): 'Consider the possibility that mean-spiritedness, social estrangement, or pessimism are the real disorders that should be of concern to psychology.' To put it another way, perhaps the focus in clinical diagnosis should be on failings in interpersonal and intrapersonal functioning rather than on symptom clusters.

He proposed the VIA Classification as a set of dimensions that offers a potential alternative to the categorical DSM structure for conceptualizing distress. Recent events suggest this may be a propitious time for exploring dimensional approaches to psychopathology. Section III of the most recent version of the DSM (APA, 2013), *Emerging Measures and Models*, introduces a five-domain approach to dimensional assessment of personality disorders, comprised of negative affectivity, detachment, antagonism, disinhibition, and psychoticism. The section also lists 25 personality facets relevant to these disorders. This model was informed by earlier work on relationships between the Five Factor Model of personality and personality disorders (see Widiger & Presnall, 2013), and may signal an eventual shift from a categorical to dimensional approach for identifying personality disorders. Similarly, the Research Domain Criteria (Insel, 2014) represent an attempt to enrich the

understanding of diagnostic categories with dimensional biomarkers (e.g. Ivleva et al., 2013).

The central hypothesis underlying the SaDx model is that clinical phenomena can be understood in terms of excess or insufficient use of a specific strength, or acting in contradiction to the strength. This concept of multiple styles of socially undesirable functioning has a long history. Aristotle is often credited with the proposition that virtues represent a middle path or mean between deficiency and excess in behavior, a concept that has been associated with the idea of a 'golden mean' for virtue use (Bartlett & Collins, 2007). In fact, Aristotle's position reflected a much older respect for moderation in the Greek tradition, illustrated by the aphorism 'nothing in excess' carved into the temple to Apollo at Delphi.

Aristotle was interested in deviations from the middle way as a moral issue, having to do with vices. In recent times, various researchers have explored similar issues descriptively, demonstrating that optimal functioning can represent a middle way between extremes of behavior. Influenced by Coombs' (1964) ideal-point model, some psychologists have compared dominance models of measurement, which assume a monotonic relationship between scale score and relevant outcomes, with curvilinear models that allow for an optimal fit between predictor and criterion.

E.g. Carter et al. (2014) examined the relationship between conscientiousness and job performance. They found that excessively conscientious individuals reported more counterproductive work behavior (e.g. perfectionism), while moderately high conscientiousness tended to be most adaptive in terms of productivity. Inverted-U relationships have also been explored between personality traits and other factors related to job performance (Day & Silverman, 1989; Le et al., 2011), alcohol withdrawal (Smith, Burgess, Guinee, & Reifsnider, 1979), creative thinking abilities (Soueif & El-Sayed, 1970), leadership behavior (Kaiser & Hogan, 2011), substance use (Walton & Roberts, 2004), and academic performance in graduate school (Shen & Comrey, 1997). Grant and Schwartz (2011) provided additional examples. Based on such studies, Schwartz and Sharpe (2006) criticized the VIA Classification for the potential implication of a purely linear relationship between character strengths and consequential outcomes, undoubtedly unaware that Peterson (2006) was concurrently exploring the possibility of a curvilinear relationship between level of strengths and psychological functioning.

Peterson (2006) advanced this curvilinear approach further in two ways. The first has already been discussed, proposing that clinical pathology could be understood in terms of problematic strength expression. Second, he divided deficiency into two components: The absence (or at least insufficiency) of the strength, and acting in opposition to the strength. For example, he described the absence or insufficiency of curiosity as disinterest, a tendency that could lead to stagnation in relationships, work, and school. Following Peterson's logic, deficiencies in curiosity could manifest in a variety of clinical symptoms and syndromes, including narcissism, social anhedonia, and depression (APA, 2013). Its exaggeration, which Peterson labeled 'morbid curiosity,' is described as excessive inquisitiveness with a tendency to sacrifice sensitivity, social boundaries, and other interests in order to satisfy one's curiosity. The result is often defensiveness and vigilance among the targets of that curiosity. Morbid curiosity might manifest in individuals who demonstrate an obsessional preoccupation with others, with stalkers representing the extreme.

The identification of three pathological variants for each of 24 strengths allowed for 72 dimensions of pathological functioning (though Peterson, 2006; identified only 71, as will be discussed shortly), which Seligman (2014, p. 4) later labeled the 'Peterson pathologies.' An updated version of this taxonomy, provided by Seligman (2014), presumably reflecting the evolution of Peterson's thoughts on this topic prior to his death in 2012, is included in Table 2.

While the generation of 72 dimensions of pathology emerging from character theory was an innovative and intriguing way to connect the character strengths with clinical phenomena, the model can be criticized in several ways. First, some of the deviations from the mean listed are clearly relevant to clinical phenomena. Cruelty has been empirically associated with aggressive and externalizing behaviors in children and adolescence (DeGue & DiLillo, 2008; McEwen, Moffitt, & Arseneault, 2014; Walters & Noon, 2015). Impulsivity is a core component of clinical issues as distinct as trichotillomania (Ferrão, Almeida, Bedin, Rosa, & Busnello, 2006) and anger control issues (Vogel & Barton, 2013). Lifelessness and despair are clearly relevant to depression, among other disorders.

Many of the Peterson pathologies are of questionable relevance to clinical phenomena, however, as noted by Seligman (2014). Though nosiness could result in interpersonal distress if excessive, its centrality to a theory of clinical phenomena is dubitable. Oblivion, orthodoxy, gullibility, or buffoonery are similarly unpalatable but rarely pathological.

Second, many of the labels are problematic in various ways. Peterson (2006) acknowledged that the labels he had chosen to describe the 72 pathologies were a mixed lot of terms derived from psychology and lay vernacular. The distinction between 'footless self-esteem' and 'arrogance' is perhaps a distinction without a difference. Others such as 'Pollyannaism' can be perceived as overly disparaging. The inclusion of a culturally bound concept such as psychobabbling undermines the cross-cultural value of

Table 2. The 72 pathologies of character strengths: strengths as syndromes.

Virtue	Strength	Absence	Opposite	Excess
Wisdom & Knowledge	Creativity	Conformity	Triteness	Eccentricity
	Curiosity	Disinterest	Boredom	Nosiness
	Judgment/ Critical Thinking	Unreflectiveness[a]	Gullibility	Cynicism
	Love of Learning	Complacency	Orthodoxy	'Know-it-all'-ism
	Perspective	Shallowness	Foolishness	Ivory Tower[b]
Courage	Bravery	Fright	Cowardice	Foolhardiness
	Persistence	Laziness	Helplessness	Obsessiveness
	Authenticity	Phoniness	Deceit	Righteousness
	Vitality	Restraint	Lifelessness	Hyperactivity
Humanity	Capacity for Love	Isolation/ autism	Loneliness	Emotional Promiscuity
	Kindness	Indifference	Cruelty	Intrusiveness
	Social Intelligence	Obtuseness	Self-Deception	Psychobabbling
Justice	Citizenship/ Teamwork	Selfishness	Narcissism	Chauvinism
	Fairness	Partisanship	Prejudice	Detachment
	Leadership	Compliance	Sabotage	Despotism
Temperance	Forgiveness	Mercilessness	Vengefulness	Permissiveness
	Modesty/ Humility	Footless Self-Esteem	Arrogance	Self-Deprecation
	Prudence	Sensation-Seeking	Recklessness	Prudishness
	Self-Regulation	Self-Indulgence	Impulsivity	Inhibition
Transcendence	Appreciation of Beauty	Oblivion	Criticism	Snobbery
	Gratitude	Rudeness	Entitlement	Ingratiation
	Hope	Present Orientation	Despair	Pollyannaism
	Humor	Humorlessness	Dourness	Buffoonery
	Spirituality	Anomie	Alienation	Fanaticism

Notes: From 'Chris Peterson's Unfinished Masterwork: The Real Mental Illnesses,' by M. E. P. Seligman, 2014, *Journal of Positive Psychology, 10,* p. 5. Adapted with permission.
[a]Seligman (2014) labeled this cell *Uneffectiveness*. Peterson's (2006) original *Unreflectiveness* seems more appropriate.
[b]Peterson provided no label for this cell.

the system, which is one of the strengths of the original VIA Classification.

Third, as Seligman (2014) pointed out, some of the concepts in the table need work. We may question whether an excess of social intelligence is accurately described as psychobabbling. Perhaps a better option would indicate someone whose efforts and/or ability to sense other people's emotional states exceed their interest in others, an attribute more akin to Machiavellianism (Jones & Paulhus, 2009). Similarly, hypervigilance or inaction under uncertainty might be better markers of excess in prudence than prudishness. This last example also suggests the possibility of multiple distinct outcomes when an excess or deficiency in a strength is evident, perhaps expanding the pathologies beyond 72.

A final issue for this approach is whether there are certain strengths for which the relationship with optimal functioning is strictly monotonic, contrary to the expectation based on the concept of the golden mean. According to Peterson (2006), it is impossible to use perspective too much, so he did not provide a pathology of excess. In contrast, Seligman (2014) added the concept of 'ivory tower' to capture the exaggeration of perspective. Aristotle discussed the concept of *phronesis*, often translated as practical wisdom, which refers to the wise and measured application of virtue to specific circumstances (Bartlett & Collins, 2007). At least three of the strengths capture elements of this concept: Judgment, perspective, and prudence. From an Aristotelian perspective, then, it could be argued that at least these three strengths, if accurately measured, would never be in excess.

Taken together, these criticisms would suggest the case remains open on whether Peterson's (2006) SaDx approach offers the basis for a true alternative to the DSM, or is best seen as a potentially informative but incomplete attempt to integrate strength-based and syndrome-based approaches to understanding pathology. This question probably is immune to resolution until a body of work emerges that resolves at least some of the issues raised previously.

Strengths as symptoms

Rashid (2015b) offered a second approach to connecting the VIA Classification to pathology. Like Peterson's model (2006), the SaSx model also derives from the golden mean and concepts of strength excess and deficit. However, where Peterson focused on dysfunctions in the strengths as an alternative way to diagnose people's problems, Rashid instead used strengths to understand specific symptoms of well-established clinical states. That is, his goal was not to replace traditional diagnosis, but rather to replace the traditional description of the symptoms associated with those diagnoses. Table 3 provides an example of the SaSx model, reframing the symptoms of bipolar disorder in terms of deficits or excesses in strengths. Reframing symptoms in terms of strengths, he suggested, can:

- avoid stigmatizing patients in terms of pathology and deficiency,
- provide an understanding of the individual's resources that can inform treatment planning,
- suggest alternate treatments that focus on increasing positive states rather than eliminating negative states,

Table 3. Strengths as symptoms: Bipolar disorder.

Symptom	Strength deficit/excess
Elevated, expansive, or irritable mood	Deficit: equanimity, even-temperedness, level-headedness Excess: composure, passion
Grandiosity	Deficit: humility, social intelligence Excess: will-power, introspection
Talkativeness	Deficit: reflection, contemplation Excess: zest, passion
Excessive pleasurable activities	Deficit: moderation, prudence, simplicity Excess: passion, self-indulgence
Risky behaviors	Deficit: self-regulation, perspective, balance, humility, emotion regulation Excess: self-care, zeal, gratification

- change the focus of treatment 'from remediation to nurturance of resilience and well-being' (p. 521), and
- encourage the development of protective factors in the individual.

Besides the focus on diagnosis vs. symptoms, the SaDx and SaSx models can be contrasted in several other ways. First, Peterson (2006) draws a distinction between 'deficiency in' vs. 'opposition to' the strength; Rashid (2015b) seems to be combining these as strength deficits. Second, where Rashid attempts to provide strength-based reformulations for specific symptoms, Peterson did not attempt to achieve a one-to-one correspondence between his pathologies and DSM diagnoses. Third, Rashid's interest in reframing specific symptoms led him to multiple possible explanations for a single symptom. These last two features of the SaSx model may be contributed to a fourth difference, which was Rashid's expansion of the set of strengths used in the model far beyond the 24 to which Peterson restricted himself. Besides examples in Table 3, other strengths external to the VIA Classification used in Rashid's formulation included cautiousness, equanimity, passion, contentment, and mindfulness. Finally, SaSx can be considered a less radical approach to integrating the strengths literature with psychopathology. It does not reject traditional diagnosis, just the framing of the features of those diagnoses in strictly negative terms.

The SaSx model can be criticized in several ways. A reconceptualization of every disorder in terms of strengths would be a tremendous undertaking; extending that effort to encompass every symptom would be far more grueling. Validation of the multiple strength-based reinterpretations possible for each symptom would require a massive research program. It would also tremendously increase the vocabulary needed to describe clinical phenomena. Redefining clinical syndromes in terms of strengths would seem a potentially overwhelming task. Extending that effort to all clinical symptoms and consideration of strengths outside the VIA Classification might seem intractable given limited resources. The expansion beyond the VIA Classification may also have resulted in the inclusion of terms that are poor candidates for character strengths, such as self-indulgence.

Second, to the extent that diagnoses are seen as coherent sets of symptoms while the corresponding reframing appears to be a 'bag of strengths,' to paraphrase Kohlberg's criticism of character education (e.g. Kohlberg & Mayer, 1972), the result may be less useful descriptions of disorders. In response, though, it may be argued that, given the polythetic nature of DSM diagnoses, any sense of coherence among the symptoms is probably at least in part a function of familiarity and comfort with traditional diagnostic practices (e.g. Boschloo, Schoevers, van Borkulo, Borsboom, & Oldehinkel, 2016; Cooper, Balsis, & Zimmerman, 2010; Olbert, Gala, & Tupler, 2014).

Third, as time pressures increase for therapists, substantially expanding the universe of variables to be assessed can be impractical, particularly in cases where they are perceived as a restatement of a better-known symptom. In recognition of this issue, Rashid (2015b) noted a suggestion by Joseph and Wood (2010) that negatively keyed items on popular measures of psychopathology could be used to gauge positive states without increasing assessment load. However, the validity of those items for that purpose would need to be evaluated, and would require revision of assessment practices in settings that use unidirectionally keyed instruments such as the Patient Health Questionnaire (Spitzer, Kroenke, Williams, & Löwe, 2006).

Fourth, the chapter offers only a sampling of syndromes and symptoms. A good deal more work would be needed before strength dysregulation could be offered as a comprehensive alternative to the existing diagnostic system. Ideally, one would want to see a comprehensive list of strength-based descriptions of common symptoms found in psychopathology.

Finally, as with the previous model, research is needed to test its clinical value. Perhaps stating symptoms in terms of strengths needing to be increased or reined in will provide some patients with a way of conceptualizing their pathology that enhances the ability to engage in behavior change, but this is a hypothesis that needs to be tested.

Strengths as moderators

One other commonality between the SaDx and SaSx models is their use of deviations from the golden mean for a strength are interpreted as elements of psychopathology. Statistically, these models suggest a curvilinear relationship between strengths and optimal health, though Peterson (2006) suggested the possibility of exceptions to that rule. The third model we are about to introduce suggests an alternate statistical parallel, one in which character strengths serve as moderators of clinical presentation.

The fundamental hypothesis underlying the SaM model is that personal strengths can both exacerbate and mitigate clinical syndromes, sometimes even in the same person. The strengths that are most likely to have this effect are strengths that are at a particularly high level in that individual, or strengths that are particularly characteristic of that person. Rather than attempting to redefine clinical syndromes or symptoms in strength-based terms, SaM provides a framework for considering strengths as a contributor to the presentation of existing clinical syndromes.

The SaM model suggests that personal strengths will have an impact on the relationship between symptoms or syndromes and personal functioning. Where the SaDx model raises questions about whether the traditional DSM characterization of mental disorders is optimal, and the SaSx model raises similar questions about whether the traditional characterization of symptoms is optimal, the SaM model does not attempt to replace traditional clinical description. Instead, the goal is to enrich the functional assessment of the individual who is meeting criteria for a particular syndrome that is usually described only in terms of symptom picture. It accepts the existing vocabulary used to describe clinical syndromes and symptoms, but suggests how the person copes with their psychopathology as well as certain elements of how they manifest their psychopathology are shaped by the strengths that are central to them. That is, the goal is to complement rather than reconsider DSM constructs. This allows the strengths to peacefully coexist with DSM while simultaneously encouraging looking beyond the psychopathology.

A clinical vignette can illustrate the SaM model. A male patient diagnosed with depression reported relationship problems with his fiancé. Despite increasing conflict in the relationship, it was very important to him to continue to find ways to repair their relationship, with his rationale being that he was 'not a quitter.' Over the course of treatment, it became apparent that perseverance was one of his more salient strengths, which had benefited him through other tough times in his life. For example, he noted that with no more education than a general equivalency diploma, he was able to successfully develop his own company through persistent hard work. In therapy, he explored the possibility of giving up when the odds of success were poor, including his unhealthy relationship. While the patient previously saw his perseverance only as a benefit, since it had served him well in the past, he was able to recognize the dark side of his strength as well. It is also possible to imagine another depressed patient for whom a deficit in perseverance results in difficulties maintaining goal-directed behavior or sustained effort, including following through on intentions for behavioral change to ameliorate the depression.

Table 4 provides additional examples of instances in which strengths that particularly characterize the individual can moderate the development, presentation, and/or course of their mental disorder. Several comments about this table are worthwhile. First, the examples are not necessarily specific to the diagnoses listed. For example, the resiliency and risk factors associated with hope in the face of depression may well apply to any mental disorder. Second, there can be several strengths that may interact with a specific mental disorder in the same way. Kindness, humor, creativity – in fact, a majority of the strengths – can be effectively used to maintain social support that might otherwise be lost to the individual as a result of symptoms of the disorder. Third, the examples provided are not intended to be exhaustive in terms of the idiographic manner in which each strength functions in the context of a certain mental disorder. For example, some individuals with bipolar disorder may demonstrate social intelligence as a risk factor by using their capacity to read others for purposes of taking advantage of them. The SaM model places the task on the therapist to explore strengths and evaluate how they play a role in each individual's difficulties.

The persevering depressed patient described can be used to compare the three models we have summarized. In the initial intake, the patient attributed his emotional difficulties to a tendency to be overly acquiescent in relationships. Since early childhood he avoided confrontation and anger by making few demands on others and trying to please them, which often left his own needs unmet. From the SaDx perspective, the patient demonstrated a pervasive and pathological tendency towards permissiveness, forgiving far too much in others to avoid conflict and abandonment. In contrast, the SaSx model would focus more on the primary markers of his depressive disorder. He demonstrated deficits in hope, joy, and optimism. He was indecisive, potentially reflecting a deficit in determination or an excess in the tendency to be overly analytical. Finally, he demonstrated an excessive sense of humility that he characterized as poor self-esteem.

A key difference between the previous two models and SaM model is that the latter does not provide a reinterpretation of traditional clinical constructs. Instead, it focuses on an idiographic understanding of the interaction between the individual's characteristic preferences for the use of certain strengths with the clinical difficulties they are experiencing. The concept of signature strengths introduced by Peterson and Seligman (2004) plays a central role in the SaM model. These are strengths a person 'owns, celebrates, and frequently exercises' (p. 18). The VIA-IS is often used in practice to identify the respondent's signature strengths, based on the 4–7 strengths associated with the highest scores across the 24 strength scales.

Table 4. Examples of strengths as moderators.

Syndrome	Moderating strength	Resiliency factor	Risk factor
Depression	Hope	Sees the potential for improvement in the future; views current distress as temporary; approaches treatment with a positive outlook	Believes the condition will resolve with minimal effort; may resist dealing with current distress by becoming overly focused on a better time in the future
	Kindness	Kindness to others results in others providing social support	Gives too much to others at personal expense, the 'door mat' phenomenon; may feel used by others; has difficulty confronting others when needed
	Forgiveness	Can forgive themselves and others for offenses	Wants to practice forgiveness even when being used by others; could result in maintaining abusive relationships
	Love	As with Kindness in depression, likely to form strong relationships that can be protective	Resistant to give up a destructive relationship because of strong attachment
	Perseverance	Commits to interventions and treatment, despite moments of emotional distress	Maintains habits and routines that exacerbate feelings of depression
Anxiety	Perspective	Able to manage fearful thoughts by evaluating their reasonableness	Explores a number of perspectives on many issues, interfering with decision-making and effective action
	Curiosity	Fear is counterbalanced by a desire to understand and explore	Exploration takes the place of directed action
Obsessive-Compulsive Disorder	Love of Learning	Seeks to inform themselves about the disorder and the reality of their fears	Becomes mired in trying to achieve perfect understanding of information
Bipolar Disorder	Curiosity	Interested in learning more about their disorder and its implications and treatments	Pursues information manically, in a manner that makes others uncomfortable or results in risky behavior
	Social Intelligence	Can interpret others' perceptions of their behavior effectively and use that input	Can use social abilities to conceal consequences of impulsive behaviors from others
	Kindness	Kindness to others results in others providing social support	May impulsively be overly generous towards others
Eating Disorder	Self-Regulation	Once the eating problem is acknowledged, able to resist eating-related impulses	Proud of controlled eating as evidence of self-control
Intermittent Explosive Disorder	Bravery	May be able to face the harm being done to others forthrightly	Can use anger at perceived mistreatment of self or others as justification for explosiveness
	Self-Regulation	Able to apply these skills to controlling anger more effectively	Considers it unacceptable to express angry feelings until they result in an explosive outburst
Substance Use	Creativity	Can find other adaptive ways to achieve gratification	Considers use of certain drugs to be part of the creative process; considers it a challenge to develop new ways of engaging in substance use without getting caught
	Curiosity	Pursues other interests as an alternative to substance use	Willing to try new and more dangerous substances
Cluster B Personality Disorders	Honesty	Able to reflect truthfully on the nature of their interpersonal difficulties	Can be overly blunt and harsh with others
Narcissistic Personality Disorder	Creativity/Social Intelligence	Can attract others to them	Tends to enjoy inventing clever ways to manipulate others
Dependent Personality Disorder	Love	Can establish loving relationships that are protective	Denies underlying dependency as a manifestation of love
Histrionic Personality Disorder	Creativity	Viewed by others as unique and innovative	Interprets dramatic tendencies as a necessary cost of creativity
	Spirituality	A sense of the spiritual provides comfort	Adopts an overly romanticized connection to living and spiritual entities

Clinical practice consistent with the SaM model would therefore begin with assessment of character strengths with the goal of identifying signature strengths. Results of this assessment would guide discussion of the extent to which these strengths serve as protective factors, as well as the extent they interfere with achieving improvement. That is, the goal of assessing and discussing strengths would be to enhance the individual's awareness of their signature strengths if the person is unaware, and of good and bad roles those strengths play in their clinical presentation.

Though we do not explore it here, we note the possibility exists for other strengths besides the signature strengths to moderate clinical presentation as well. In particular, low levels of certain strengths may also moderate the presentation of a disorder.

Discussion

The SaM model summarized here differs in a number of ways from the SaDx and SaSx models. Where the first two attempt to redefine traditional clinical concepts, the SaM

model is strictly complementary to DSM descriptions and classifications. It attempts to provide an expansion of topics to address in the context of treatment. On a related point, the SaM model is agnostic about whether strengths that moderate clinical presentation are etiologically relevant to the disorder or simply shape its presentation. This compatibility of strength-based and traditional approaches to case conceptualization may make it a more palatable integration of the deficit model underlying DSM with the strength model emerging out of positive psychology.

Finally, the model allows for a clinically relevant use of the VIA-IS. This instrument is already used widely in the context of personal coaching, character development and education programs, and efforts by individuals to expand self-knowledge, resulting in several million administrations since its introduction in 2004. Where the earlier models are more likely to result in reinterpretation of conclusions drawn from clinical assessments, the SaM model creates a potentially valuable clinical role for an instrument the individual may have already completed for other reasons. The likelihood is that at least some patients will have already completed the instrument, and if needed their results can be retrieved through their account on the website of the VIA Institute on Character (https://www.viacharacter.org) or the Authentic Happiness website (https://www.authentichappiness.sas.upenn.edu), the two locations the general public can use to complete the instrument. For patients who have not yet completed the VIA-IS in another context, completion may at the least provide information of interest to the respondent, with the exclusive focus on strengths eliminating the potential for demoralizing feedback possible with clinical instruments. It may also provide insights into how the patient can best address his or her difficulties in a manner that feels personally meaningful.

As a final point, it is worth noting that the three models are in no way incompatible; simply because the SaM model is most consistent with the traditional approach to clinical evaluation does not imply the other two models would not prove clinically useful. At this point there is no evidence available concerning the extent to which patients could benefit from relabeling their syndrome in terms of some key problems with strength use, by considering adjustment of certain strengths as a means of alleviating specific symptoms, or by reviewing the role of their strengths in making problems worse or mitigating their problems.

As noted when discussing the SaSx model, these models also need not be depend upon the VIA Classification alone. The VIA Classification is particularly relevant to discussions of strength misuse, both because of its comprehensiveness, and because of the extent to which it has already inspired a literature reflecting Aristotelian concerns about the overuse and underuse of positive attributes (e.g. Peterson, 2006; Freidlin, Littman-Ovadia, & Niemiec, 2017). There are other models of character strengths available that may provide useful insights into the means by which an individual's strengths can become liabilities, however (e.g. King & Trent, 2013).

An interest in integrating a psychology of strengths with a psychology of deficits to provide a more complete approach to helping people is not unique to the models discussed here (e.g. Edwards, Young, & Nikels, 2017; Rashid, 2015a; Smith & Barros-Gomes, 2015). The SaDx, SaSx, and SaM models are distinctive from other efforts to integrate strength-based concepts with clinical work in two important ways. First, most other literature on this topic focuses on the clinical process. The three models reviewed here focus instead on the diagnostic process, with the goal as serving as a guide to clinical intervention. Second, and more uniquely, where much of the literature treats strengths as purely positive features of the individual, each of the three models explores the possible dark side of strengths as contributors to clinical problems. The result is a potentially more nuanced understanding of what the optimal use of a strength entails, a form of education that may have value for the individual beyond the alleviation of immediate symptoms.

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