A large, leafy tree stands in a grassy field. Sunlight filters through the branches, creating a warm, golden glow and visible rays of light. The foreground is filled with tall grasses, some in focus and some blurred. The overall atmosphere is peaceful and natural.

Happiness, Healing, Enhancement

your casebook collection for applying
positive psychology in therapy

edited by George W. Burns

Praise for
Happiness, Healing, Enhancement

Filled with good strategies based in research, compelling case material, and most importantly practical advice, this book belongs in the library of everyone interested in what it means to live well. It provides not only ample food for thought, but for action.

Christopher Peterson, PhD

Professor of Psychology, University of Michigan, MI

If you are a therapist or a coach—or if you want to help yourself and others flourish—then this book is a must read. It is an important theoretical and practical contribution to the field of positive psychology—and, in fact, to the field of psychology as a whole.

Tal Ben-Shahar, PhD

Author of *Happier* and *The Pursuit of Perfect*

George Burns and the contributors to this volume have created the most useful manual ever developed for therapists. Strengthspotting, enabling, and developing change the focus of therapy as well as the process and outcome. Using this approach not only benefits clients, but will force the therapist to become healthy as well.

Jon Carlson, PsyD, EdD, ABPP

Distinguished Professor, Governors State University, IL

George Burns has assembled a group of sensitive, seasoned therapist-scholars, like himself, to present a treasure trove of ways to add positive psychology to clinical practice. The approaches are cutting edge. They are what we need to bring our clients to a new level of feeling, functioning, and flourishing.

Michael B. Frisch, PhD

Professor of Psychology, Baylor University, TX

Author of *Quality of Life Therapy* and *Creating Your Best Life*

Join this international assembly of experts on an enlightening expedition that explores a vast panorama of new visions of promoting therapeutic change. Recommended for the novice and the experienced explorer of clinical resilience and hope.

Jeffrey K. Zeig, PhD

Director, The Milton H. Erickson Foundation, AZ

Happiness, Healing, Enhancement

Your Casebook Collection for
Applying Positive Psychology
in Therapy

Edited by

George W. Burns



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*There are many dear friends and family
who contribute so much to my personal happiness,
but it is enriched very specially in the love and contentment
I share with Sue.*

*So, Sue,
this book is dedicated to you
. . . with love.*



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Acknowledgments

One summer's evening I decided to get my head out of pulling the final threads of this book together by having a sunset picnic on a riverbank with Sue—a little practicing what I preach! The sun was a ball of gold. The sky was subtly washed with many hues from pink through blue, and dotted with moody gray clouds brightly rimmed with gold. The reflections of bronzed trees rippled in the water, and ducks made V-shape wakes as they paddled across the river. A pair of eagles soared toward their roost for the night, and a flock of squawking white cockatoos slalomed along the meandering course of the river. The grassy ground felt warm at the end of the day, while the gentle breeze that lightly rippled the river's surface held a refreshing coolness. As I looked at the many parts that made up the scene, each was uniquely beautiful in itself. But each contributed to a big picture that was immeasurably more overwhelming and spectacular than each of its parts.

I confess I was not completely in the moment and had not gotten my head totally out of the book. Here was the metaphor I wanted for these acknowledgments. Like the various elements of our sunset scene, this book has happened through the contributions and efforts of so many beautiful people. Each part, no matter how little or large, has enriched the whole picture.

First, and foremost, I cannot express adequate gratitude to the deeply valued contributors who have so generously given of their time, knowledge, and wisdom with the aim of enhancing the practice of therapy and the lives of their fellow beings. Please accept this as a personal expression of my gratitude to each and every one of you.

Thanks go to our therapeutic clients and research subjects who have shared their stories with us, informed us about life's challenges, and shown us the amazing resilience of human nature. I hope our professions never lose sight of just what a privilege it is to join a fellow being on his or her journey through life's trials and triumphs.

I am not sure how I would survive without Julie Nayda. My professional and personal happiness bear a direct correlation to her skills, competence, and humor. Thank you, Kym Nayda, too, for your input and help with the challenging references. Helen Street, PhD, is valued not only as a contributor but also as a discussant of ideas, peer reviewer of certain chapters, and, along with Neil, Lucia, Molly, and Tess, a dear friend. Sue Thomas has patiently read every word, then reread them some more, correcting grammar, offering

suggestions, and providing loving support. I am also indebted to my endorsers for their most kind words.

They say when you are on a good thing, stick to it. That is how I feel about working with everyone at John Wiley & Sons. This book got off the starting block with Lisa Gebo's helpful ideas and encouragement: I wish you health and happiness. Sweta Gupta picked up the baton: Congratulations on the promotion. Rachel Livsey carried it down the final straight: Thanks for the challenging, creative ideas and pleasant company over our halibut dinner in New York. Kara Borbely and Kim Nir, along with the rest of the Wiley team, have competently seen it across the finish line. Thank you, one and all.

When Tam asked, "Can we be in your book?" I said, "Sure. What do you want me to say?" She dictated simply, "To the four grandchildren of Suzanne Thomas: Sarsha, Tamika, Indiana, and Chloe." You are now as warmly incorporated in my book as I feel warmly incorporated in your family.

Indeed, friends and family can be one of our greatest sources of happiness. And here I feel blessed to be no exception to the statistics. Thank you to all my dear friends for just being who you are. Special gratitude goes to Phyllis and Ken for their generosity, lasting friendship, and love of everything that is important—including our extending family, Philip, PK, Delila, Robbie, and Bella.

But just as the river picnic would not have been complete without the setting sun, so the picture of my life would not be complete without Leah, Ian, Oscar, Taran (who gets his first mention in a book!), and Tom. The love of family is beyond comparison and the joy of grandparenthood is simply the best stage of life.

We know that being grateful, that counting one's blessings, is also good for one's happiness. I feel truly blessed by and grateful to you all . . . and that surely enhances my happiness. Thank you.

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Introduction

George W. Burns

WHAT THIS BOOK OFFERS

“Please present a clear case example of how you translated solid, positive psychology research into sound clinical practices.” This is what I asked contributors when inviting them to submit chapters for this book.

Can we apply the growing body of research from the field of positive psychology to our work with clients who are suffering the distressing challenges that life inevitably seems to present? Can we have therapeutic practices that are positive in their paradigms, applications, and outcomes? How can we assist someone not to just eliminate the symptoms of depression, anxiety, anger, or trauma but also to move on to a life that is flourishing or being well lived? And what are the step-by-step strategies to do so effectively?

Following a workshop I conducted on using positive psychology in therapy, a participant e-mailed me. He wrote:

I often tell the story of seemingly successfully using a CBT [cognitive-behavior therapy] approach to therapy with a young woman with depression some years ago. Her Beck Depression Scale scores had lowered from the severe to the normal range and I was feeling great about a job well done, only to hear her say to me, “I am not depressed anymore, but I don’t feel happy. Can you help me with that too?” I had to confess that I couldn’t and discharged her from our care. In retrospect, it has always seemed such an inadequate response!

His e-mail was one of the stimuli behind the evolution of this book that you now hold in your hands.

The term *positive psychology* was coined by Martin Seligman. Using his 2000 term as president of the American Psychological Association to highlight psychology's traditional focus on pathology and challenge it to examine more about human functioning, he laid a solid, scientific, research foundation to a field that is now burgeoning. While traditional psychology continued to trundle along the freeway of examining and treating the problems and foibles of human misery, Seligman sought to divert the discipline down a path that examined well-being, happiness, flourishing, and the life well lived. This is not to say that psychology and psychotherapy have not had positive orientations prior to Seligman's presidency. Among other approaches, Carl Rogers wrote about self-actualization, solution-focused therapy has—as its name states—actively moved from a problem to solution-oriented approach, and Milton Erickson eagerly sought out resources that clients could utilize toward healthier and happier functioning.

What is new is that we have now gathered a strong body of research evidence in fields such as optimal functioning, hope, altruism, goal setting, and strengths that can usefully inform therapeutic practice. However, there seems to be a gap (which perhaps widens to a chasm at times) between the growing body of knowledge on one hand and the therapeutic applications on the other. Some invited contributors to this book came back with such comments as “I research, write, and teach positive psychology but I don't do cases.” One said, “There are two groups in this field: those that know and don't do, and those that do but don't know.” While there may be *some* truth in this, I hope the contributions in the following pages will show that the field is certainly not as bipolar as suggested.

THE CONTRIBUTORS

The contributors of chapters include researchers and teachers who are keen to see their well-informed evidence communicated into helpful therapeutic practice. There are also clinicians whose work is well informed and well grounded in both scientific evidence and wisdom. I have invited some whose names are well known in the field and others who may be less well known but who are doing good and valuable work at the interface of therapy and research.

The e-mail from my workshop participant raises important questions about the goal of therapy. Is therapy's purpose to reduce suffering and pathology, as my colleague had done successfully with his depressed client, or is the goal of therapy to enhance flourishing, happiness, and well-being, as his client requested? How you answer this, what you focus on, and what your own philosophies of life are will determine not only how you do therapy but also what outcomes your clients are likely to receive. However, the question may not be as dichotomous as suggested in his e-mail or as I have reproduced it here. Reducing suffering and pathology does not necessarily increase optimism, hope, and happiness. Eliminating the negative does not necessarily give the skills to create the positive. Yet building skills in the positive may well reduce or eliminate the negative. If therapy is oriented toward happiness, healing, and enhancement, clients are likely to gain freedom from their presenting problems *and* gain a happier life.

If this is the case, the question then becomes: How can we as therapists best facilitate a happier life or a greater sense of well-being for our clients? “Show our readers how you do this,” I asked the contributors. “Give them the evidence your work is based on and take them step-by-step through your processes for applying this in a real case example.” In doing so, contributors were asked to adhere to the American Psychological Association’s ethical principles and code of conduct regarding confidentiality. They may have obtained client consent, appropriately disguised identifying features of the case, or compounded material from several cases. Unless stated, we do not know what approach each contributor has taken, and that further adds to the confidentiality.

THE STRUCTURE OF THIS BOOK

The title, and corresponding three sections, of this book, *Happiness, Healing, Enhancement* represents three core processes and outcomes in the application of positive psychology into psychotherapy, counseling, and coaching practice. Part One, *Happiness*, moves beyond traditional therapy’s aim of eliminating dysfunctional symptoms. Happiness here refers to more than hedonic pleasure. It is perceived in a eudaemonic sense, including Seligman’s concepts of pleasure, engagement, and meaning. Subsections discuss how to assess your clients positively and orient them toward happiness, how to instill hope, and how to access and use client resources.

Part Two, *Healing*, offers ways to assist your clients to make the transition from unhealthy psychological, physical, or psychophysiological states to the attainment of health and well-being. Its subsections provide samples and strategies for how to move from depression to happiness, how to build mindfulness and acceptance, and how to transform trauma and pain into well-being.

Part Three, *Enhancement*, explores the means to help clients discover better ways of being, enjoying life, and flourishing. The subsections cover novel approaches in ecotherapy, neuroscience, and play therapy, finding beneficial tools and techniques, and effectively communicating positive therapeutic messages.

Of course, there is much overlap between the book’s three parts and the titles I have allocated to them. They are offered merely as a guide, and the division of chapters into each section is not intended to suggest that this is their sole function. Enhancement, for example, can and does contribute to a person’s happiness and, in turn, to healthier attitudes and behaviors. Likewise, happiness is known to have direct benefits on both psychological and physical health and, indeed, enhances the quality of our lives.

At the end of each chapter, the contributors and I have worked collaboratively to add a text box titled “Putting It into Practice.” This box takes the main therapeutic applications presented in the chapter and presents them in a point form for practitioners to follow easily and replicate quickly.

Another feature of the book is two *Quick Reference Guides* at the beginning. If you wish to quickly access information about dealing with a particular clinical problem or use a specific intervention, this section directs you to the relevant chapters.

On the right-hand edge of the pages you will find tabs to each section. These are included to allow you to access a section or chapter quickly, such as just before seeing a depressed client to look at how others have applied positive psychology in similar cases.

I hope you find as much enjoyment and benefit for you and your clients in reading this book as I did in reading, editing, and compiling it . . . and then in applying the new things I had learned with my clients, and in my own life.

A black and white photograph of a large tree in a field of tall grass. Sunlight filters through the leaves, creating a soft, ethereal glow. The scene is peaceful and natural.

PART ONE

Happiness

CHAPTER 1

Strengthspotting

Finding and Developing Client Resources in the Management of Intense Anger

P. Alex Linley and George W. Burns

MEET THE CONTRIBUTORS

P. Alex Linley is the founding director of the United Kingdom-based Centre of Applied Positive Psychology (www.cappeu.com), focused on the applications of strengths in organizations and schools as well as to individual and community development projects in the United Kingdom and Kolkata, India, through the charity The Strengths Project, of which Alex is a founding trustee. Alex holds the position of visiting professor in psychology at the University of Leicester and is an international speaker on strengths and positive psychology, having delivered keynote presentations throughout the United Kingdom, Europe, the Caribbean, the United States, and India. He has written, cowritten, and/or edited more than ninety research papers and book chapters and five books, including *Positive Psychology in Practice* (Wiley, 2004) and *Average to A+: Realising Strengths in Yourself and Others*

(CAPP Press, 2008). His time outside work is spent with his wife and four children, listening to The Cure, and supporting the Nottingham Forest Football Club.

George W. Burns is an Australian clinical psychologist whose innovative work as a practitioner, teacher, and writer is recognized nationally and internationally. The author of numerous articles and book chapters, he has authored or edited seven books that have been widely translated, including *Nature-Guided Therapy*, *101 Healing Stories*, and *Healing with Stories*. He is director of the Milton H. Erickson Institute of Western Australia and the Hypnotherapy Centre of Western Australia, is an adjunct senior lecturer at Edith Cowan University, and has a busy private practice with a brief, solution-focused, positive psychology orientation. He has served on the Practitioners Advisory Board of the
(Continued)

(Continued)

first and second Australian Positive Psychology and Well-Being Conferences and was a presenter at the First World Congress on Positive Psychology. As a keen traveler, George enjoys combining his

passions for nature, cultural tales, and psychotherapy into workshop/study tours for colleagues that venture into remote areas, such as the Himalayan kingdom of Bhutan.

Is psychotherapy a place where clients would consider going to talk about their strengths? Is psychotherapy a place where therapists would routinely inquire about a client's strengths as a part of their initial assessment and ongoing therapy? It is unlikely this is what Emma was expecting when she presented to therapy with a slight weight problem, saying "I eat when I am bored, frustrated, anxious and angry—for psychological reasons. It makes me happy." However, it was not until the second session that she revealed the real, embarrassing, and distressing reason for attending.

What she believed made her happy was quite specific: chocolate. With almost any emotional swing she would gorge on a family-size block of chocolate, a full package or two of chocolate cookies, or a container of chocolate milk. Trying to stop any long-established behavior can be difficult, especially if it is an approach behavior, meets a psychological need, and offers such strong rewards as the chocolate was doing for Emma. It provided instant pleasure when she was in distress, and she had empowered it with the ability to "make" her happy. To direct therapy toward stopping something that served as an effective, though maladaptive, coping strategy with such powerful rewards was obviously going to be an uphill battle.

With the exception of one or two therapeutic approaches, such as Ericksonian or solution-focused therapy, or with the occasional therapist, few therapies or therapists have oriented themselves toward spotting, enabling, and developing client strengths. Therapists and therapeutic models usually are very well versed in, and have good clinical strengths in, problem-spotting and weakness-spotting.

This being so, what might psychotherapists need to know about strengths, how might they go about spotting strengths in the therapeutic session, and what can they do with those strengths once they have been spotted? And, perhaps most important of all, is there any evidence that it is worthwhile for them to do this with clients like Emma in the first place?

In this chapter, we first offer some evidence to show why it is worthwhile spotting, enabling, and developing strengths in the context of therapy. Then we explore several questions relevant to this: How do you spot strengths in a client? How do you help a client spot strengths? How do you enable and develop strengths? Most of the discussion in answer to these questions is provided by Alex (PAL) while a therapeutic example (the evolving case of Emma) is presented by George (GWB).

When talking of strengths, we are using this definition: "a strength is a preexisting capacity for a particular way of behaving, thinking, or feeling that is authentic and energizing to the user, and enables optimal functioning, development and performance" (Linley, 2008, p. 9). Simply put, strengths are natural propensities that each of us have—so natural, we argue, that they are evolved adaptations. When we are using our strengths, we are feeling in touch with our "true selves," are doing the things that are right for us to do, and

from them we derive a sense of energy as a result. When these factors coincide, as they do in strengths use, optimal functioning is enabled. Given that psychotherapy often is focused on undoing dysfunction and enabling more optimal functioning, helping clients to identify and use their strengths more would seem to be indicated.

WHY IS STRENGTHSPOTTING WORTHWHILE?

In a study with 214 university students, Reena Govindji and I (PAL) were interested in the question of whether using strengths was associated with greater levels of well-being, self-esteem, and self-efficacy. We found that it was: People who used their strengths more reported higher levels of self-esteem, self-efficacy, subjective well-being, psychological well-being, and vitality (Govindj & Linley, 2007). Further, they reported higher levels of organismic valuing, the Rogerian concept of being in touch with one's inner nature and organismic valuing process (Joseph & Linley, 2006).

When we statistically controlled for self-esteem and self-efficacy, the use of strengths was still a significant predictor of psychological well-being and subjective well-being, indicating that the effect of using one's strengths on well-being went over and above existing levels of self-esteem and self-efficacy. This is good news for psychotherapists, since it suggests that whatever a client's current level of self-esteem and self-efficacy, using strengths is likely to lead to increased levels of well-being.

Further, in a study of positive psychotherapy with a clinically depressed population, Seligman, Rashid, and Parks (2007) found that identifying one's signature strengths and finding ways to use them more led to clinically significant and sustained decreases in depression. And in my own (as yet unpublished) research, I (PAL) have been able to demonstrate that people achieve their goals more effectively when they are using their strengths. While, of course, it is still in the early days, the emerging evidence suggests that strengths may well have a place to take in the therapy room.

Given this evidence, mobilizing Emma's strengths toward more desirable behaviors for managing her emotions and eating patterns seemed an appropriate therapeutic direction. To this end, I (GWB) first needed to spot what strengths she had. In the process, I learned that after graduating college, she committed herself to developing an academic career before having children. She had been married for 12 years and was in her late 30s when she had her first child. She was now a full-time mother of a 4-year-old-daughter, Samantha, and 1-year-old son, Jason.

HOW DO YOU SPOT STRENGTHS IN A CLIENT?

Listen for Strengths

Hearing the passion and energy that strengthspotting ignites in people, I (PAL) began to wonder what strengths "sound like." Are there identifiable differences that we can listen for when people are talking about strengths, compared to other topics or other types of conversation? To explore this, I developed an exercise for a class that I used to teach by telephone to members from half a dozen countries around the world. First, I asked someone to speak for five minutes about a weakness or about something with which they were struggling. Then I asked them to spend the same time talking about a strength or about when

they are at their best. As the exercise was by telephone, there were no additional physical cues, such as body language or facial expressions (Linley, 2008).

Other listeners in the telephone class were asked to describe their observations of what characterized the answers. In sum, they noticed that when people are talking about weaknesses, they are more negative, hesitant, and disengaged. Their energy levels drop and they sound more withdrawn. If we have access to body language, we might also notice they are more closed and defensive, and their attentional focus is narrowed.

When asked what she was good at, Emma replied in the negative. “Not much. All I seem to do is change pooey diapers and think about what to feed the kids next.” Her voice was flat and monotonal, her arms folded across her chest, her body hunched forward.

When people are talking about strengths, however, they are more positive, energetic, and engaged. They sound happier, more confident, and more relaxed. There is a passion in their tone, their conversation is free flowing, and they explain things graphically. If we were to observe body language—as one can in therapy—it is likely to be open and receptive.

When discussing singing, one of Emma’s strengths, there was a marked difference. Her voice was animated, her energy levels increased, she sat more upright and made eye contact—all signs of greater engagement and confidence.

Listening for, and observing, these shifts in your clients’ conversation and body language is a good indicator of when they are revealing a strength. However, this leads us to an important caveat. While there are certainly remarkable consistencies across these different groups and diverse populations, there can also be important individual differences. Not everyone responds in the same way, and it is very important to keep this in mind. If we do not, we run the risk of misinterpreting the responses of people who are simply different. Psychological research is almost always nomothetic in that it seeks to create generalized laws that apply across the majority of people. These laws, in turn, are generally applied in idiographic ways that are specific to a given individual—such as in a therapy session. As therapists we need to (a) be aware of the general trends and (b) be conscious that the person sitting with us in any one session may respond quite individually.

Inquire about Self-Perceived Strengths

A simple way to find out about a person’s strengths is to ask—just as you would discover a person’s history by asking standard questions about family of origin, education, relationships, and the like. All that is different with strengthspotting is that the nature and orientation of the questions shifts the therapeutic dialogue to a greater focus on strengths. Here are some of the questions that we have used to elicit strengths with people in challenging life circumstances:

- What are you good at?
- What do you enjoy doing?
- Tell me about the best experience you have had.
- What do you admire about other people? Do you see any of that in yourself?
- When do you think you have been at your best? What enabled that to happen?
- What are your aspirations for the future? What can you do to make them happen?

When Emma responded to the first question by saying she was not good at much (in the present tense), I (GWB) shifted direction to inquire about what she had been good at in the past.

“I think I was good at supervising research,” she answered. “I loved to challenge students, to ask questions, to ensure that their research design was sound. I think I was also good at lecturing. My courses were commonly rated highly by students, and I achieved several teaching awards.”

“Congratulations,” I validated, and leaned over to shake her hand as an action of affirmation for her abilities. With each strength she described, we spent some time discussing and affirming it before moving onto the next question.

“What would you say you enjoy doing most?” I continued.

“Research and supervision have to be high on the list. I enjoy the intellectual challenge. But I think my greatest enjoyment came from singing. I belonged to the university choir, and a quartet from the choir formed a small group. We used to sing for weddings, conference dinners, and those sorts of things.”

“When do you think you have been at your best?”

“Definitely when I was singing. I used to get a bit nervous before a performance, but once I started to sing it was like every other worry and thought just floated away.”

“That sounds like an important skill to have. How did you enable that to happen?” I asked.

“The four of us in the quartet were great friends, we had a lot of fun rehearsing and practicing and, I guess, I was so focused into what we were doing.”

“And what are your aspirations for the future?”

“I am planning to go back to teaching next year perhaps part time, and it would be nice to start singing again. But I don’t know if I’m going to have time now that I am a mom.”

Watch for Telltale Signs of a Strength

As you listen for and inquire about strengths, it is helpful to watch for the telltale signs of a strength, such as:

- A real sense of energy and engagement when using the strength
- Losing awareness of time because the client is so engrossed and engaged in the activity
- Very rapidly learning new information, activities, or approaches that are associated with the strength
- A repeated pattern of successful performance when using the strength
- Exemplary levels of performance when using the strength, especially performance that evokes the respect and admiration of others
- Always seeming to get the tasks done that require using the strength
- Prioritizing tasks that require using the strength over tasks that do not
- Feeling a yearning to use the strength while also feeling drained if you have not had the opportunity to use it for a time
- Being irrevocably drawn to do things that play to the strength—even when you feel tired, stressed, or disengaged (Linley, 2008, pp. 74–75).

In conversation, not only did Emma reveal a number of strengths, but she affirmed them through the telltale signs. There had been a shift in the tone of her voice and the degree of animation that she showed. It was possible to hear the difference between when she was talking about changing kids’ diapers and when she was talking about singing in her quartet. The signs were there in the sense of energy and engagement that was communicated about

using her strength of singing. She spoke of being engrossed and engaged in her activities of supervision, teaching, and singing.

These telltale signs are not necessarily always found together, at least at any given moment in time. Over time, however, it is likely that patterns will emerge. Thus, throughout the course of a series of psychotherapy sessions with a client, as therapists we have ample opportunities to become effective strengthspotters.

In each of these steps—listening for strengths, inquiring about self-perceived strengths, and watching for telltale signs of a strength—the therapist’s ear is attuned for any response that offers a glimpse into another, more positive side of their clients than that which brought them into therapy in the first place. While we know that negative mood primes negative memories, shifting our focus onto strengths and success helps engender more positive emotions that, in their own turn, prime more positive memories and more positive aspirations for the future.

A SURPRISING REVELATION

It was at the second consultation that Emma revealed the embarrassing and more pressing problem. She had unsuccessfully tried to keep it secret from her husband and had not told anyone else. It is hard to know, of all the things that happen in a therapeutic session, just which factors may influence a person to reveal and talk about a difficult subject or not. We would like to think that taking a positive, strengthspotting approach in the initial consultation gave Emma both the confidence and the hope to be able to approach the topic. Tearfully, she revealed that there were times when she got angry with her daughter, Samantha, her behavior contradicted all her principles and conflicted with the image that she had of herself as a mother. So difficult was this subject to discuss in detail that she had put it into writing and passed me the handwritten letter.

“Life fucking sucks,” I read. “Anger is everywhere. The rage has got to go. I hate this, I am out of control and our kids are copping it. I don’t have the energy or feel that I care (but I do very much). I hate this. Samantha is being yelled at, screamed at, pushed, shoved, poked. Gosh, no wonder she doesn’t know how to handle herself when she gets frustrated. What is going to become of our family? It’s not feeling very good at the moment. I have to change or I am going to have to leave for the sake of the children. Samantha needs her space and it’s only going to get worse as she gets older. I can’t keep it all together, our poor darling Samantha. Please let this stop!!”

A prime concern here in terms of one’s professional and ethical duty of care is, without question, the protection of the child. While Emma’s letter referred to pushing and shoving Samantha around, I was assured by the conviction of her comments to my inquiries that she had never hit or struck her, and vowed she never would. Herein was perhaps an indication of another of Emma’s strengths: She could choose how far she went in her anger and when she stopped. She had the strengths of choice and control at a particular given point, despite the level of her rage. She was not concerned about physically harming Samantha but rather about psychologically harming her. Two key questions in regard to client care and professional responsibility are to ask yourself: Does this issue fall within my field of professional competence? and, Can I provide the best source of assistance to this client? If there had been any question of physical abuse, my response to those questions then, or at any stage during therapy, would have been to refer her immediately to an agency that could ensure the protection of the child.

HOW DO YOU HELP A CLIENT SPOT STRENGTHS?

Strengthspotting can be a highly engaging activity for therapists and also for clients. However, while it is one thing for therapists to be able to spot strengths in their clients and communicate their observations to them, it may be another thing altogether for clients who have a long history of self-effacement or self-denigration to spot, acknowledge, and employ their own strengths. Yet therapy is surely at its most effective when it can teach clients the skills to discover, use, and enjoy their own strengths without being dependent on a therapist or others to point them out. This being the case, how do we go about helping a client like Emma to spot her own strengths? How do we teach our clients the ongoing skills to live an optimally functioning life? Let us offer two areas of possibility.

Teach Your Clients to Look for Strengths in Others

Teaching clients to look for strengths in others can hold four advantages.

1. It helps them to look for, be aware of, and acknowledge strengths in general.
2. This awareness of the positives and strengths around them is likely to enhance their own sense of well-being.
3. By looking for strengths in others, rather than seeing the negatives, they are likely to form the basis for more positive relationships with people such as spouses, partners, friends, children, and work colleagues.
4. Getting into the enjoyable habit of spotting strengths in others means they are more likely to spot strengths in themselves.

How do you get clients to look for strengths? One way is by what we call day-to-day strengthspotting. Just as you have learned to do as a therapist, ask your client to (a) listen for strengths; (b) inquire about strengths; and/or (c) watch for telltale signs of a strength as they share a meal with a spouse, discuss a project with a colleague, listen to their child recounting the events of a day at school, stand in line at a supermarket checkout, or hear an athlete being interviewed on television. It is hoped that clients will discover that strengths can come to the fore at any time, from anyone—possibly even from unlikely people in unlikely places.

What does it take to be a strengthspotter? In essence, spotting strengths in whatever we are doing, wherever we are, and whoever we're with requires just a simple orientation of mind—a mind prepared to look out for and acknowledge a strength when it has been “spotted.” To help this orientation, you could ask clients to carry a notebook with them between now and the next session, daily noting the strengths they spot in other people and what led them to define it as a strength.

Emma was asked to spot and note the strengths she saw in Samantha—just three things per day to start with. At first the request took her by surprise, as she had been so focused on the negative, problematic aspects of her daughter's behavior. Often what we focus on is what we see. As Emma started to shift her attention, she began to see a different child. She began to speak of her daughter's independence and determination as positive qualities. She became more aware of Samantha's playfulness, creative engagement, and laughter. Samantha, as any child is likely to do, responded to the positive attention with more positive behaviors, and the mother-daughter relationship quickly began to improve.

Teach Your Client to Look for Strengths in Him- or Herself

Having you, the therapist, as a model of strengthspotting in therapy is one way your clients can learn to replicate this skill. Another that we use is the Individual Strengths Assessment (ISA) (Linley, 2008). The questions that make up the ISA are all designed to encourage people to talk about their great experiences, their enjoyment, their best successes, who they are at their core, and when they are at their best—to look for strengths within themselves. They cover each of the emotional, thinking, and behavioral aspects of people, and range over the past, present, and future, always looking for consistent themes that would indicate the presence of a strength.

Rather than being an inventory or psychometric scale, the ISA is more of a guided conversation and does not work according to a script. It is, unfortunately, not a foolproof process, whereby anyone can read the questions from the list and determine what someone's core strengths are. In contrast, it is a subtle but powerful combination of the ISA questions and the expertise of the strengthspotting therapist. The questions orient people into the right territory to be thinking about their strengths. The therapist's objectives are, first, to draw strengths out through the guided conversation and, second, to feed them back to the client in such a way that the client understands, values, and engages with the strengths.

Here are some sample ISA questions. You may wish to consider your own answers as you read through them and to see what strengths your responses may lead you to identify in yourself. You might also want to try them out with some of your current clients, seeing what sort of responses you receive and what you can glean about that person from how they respond. This is a good way to see if this approach to therapy fits for both you and your clients.

- What sort of everyday things do you enjoy doing?
- What makes for a really good day for you? Tell me about the best day that you can remember having.
- What would you describe as your most significant accomplishment?
- When you are at your best, what are you doing?
- What gives you the greatest sense of being authentic and who you really are?
- What do you think are the most energizing things that you do?
- Where do you gain the most energy from? What sorts of activities?
- What are you doing when you feel at your most invigorated?
- Tell me about a time when you think that “the real me” is most coming through.
- Do you have a vision for the future? What is it about?
- What are you most looking forward to in the future?
- Thinking about the next week. What will you be doing when you are at your best?

All of these questions are designed to open up the dialogue around strengths, what energizes and invigorates people, what gives them a sense of authenticity, and what enables them to be at their best. Strengthspotting therapists are always at liberty to tailor the questions to fit within the context and flow of the conversation as well as the needs and expectations of the client. The questions should be used as a helpful framework and prompt rather than as an exercise that constrains and gets in the way of what would otherwise be a nicely flowing conversation.

Wanting to tailor questions specifically to her maternal strengths, I asked Emma, “When do you feel you are best as a mother? When are the times that you feel really good in your mothering role, the times that you feel that the real you is shining through?”

“Not too often at the moment,” she answered.

“I wasn’t asking how often they occurred,” I responded, “but rather what those times and feelings are like when you do have them.”

“I guess they are the loving kind,” she said. “The times when the day hasn’t gone too bad, and I lie beside her to read her a story and feel her falling asleep in my arms.”

“Are there other such times when you feel really good about your role as a mom?” I inquired.

“The playful times. The times when we are just fooling around and she does those funny things that have me laughing out loud.”

To facilitate client skills of personal strengthspotting, it is very often helpful to conclude by asking what, on the basis of the conversation, they think their strengths are. This can also be a good opportunity to inquire about what formal or informal feedback they have had about their strengths from other people and whether that feedback is consistent with what they have started to identify through the ISA conversation. They may also keep that notebook with them to record further personal strengths as they spot them.

When we start to explore strengths, we often find that clients ask, “What are my top strengths?” Paradoxically, answering this question without appreciating the wider context and implications for it can be unhelpful. There is no fixed number and no set hierarchy of strengths. It is an open question as to how many strengths a given individual has or needs, and also an open question as to how many of those strengths are “top strengths.” In addition, strengths may shift, some moving into the foreground and others receding into the background, as the context and need changes.

HOW DO YOU ENABLE AND DEVELOP STRENGTHS?

Questions we have found that almost inevitably come up at the end of an ISA conversation include, “What next? I have spotted my strengths. Where do we go from here?” If the client doesn’t ask them, however, it is important for the therapist to do so. Knowing one’s strengths may be interesting; putting them to use is what creates change. These questions are about helping clients to find or create situations where they can deploy their strengths more or explore ways in which they can have conversations with others (spouse and supervisor being classic examples) about what they would like to do to maximize their strengths more in the future.

Emma had spotted many strengths in herself as a person, an academic, a singer, and a mother. How could she now enable and develop those strengths for the ongoing benefits of herself, her daughter, and their relationship? She had successfully defined *what* her strengths were; the task now became *how* to put them into practice or facilitate them more frequently, and *when* she could do so.

This enabling process revolved around questions such as: How can you enable and develop these loving and playful strengths in your role as a mother? How can you create more of the intellectual challenge you are good at and miss? How can you recapture that mindful engagement you have when singing?

When she said she was most looking forward to getting back to work and singing, I asked, “Then *how* and *when* do you see you might start to resume those things?”

“I would feel guilty about putting the kids into child care. I would feel that I failed as a mom,” she said.

“But aren’t you feeling guilty and a failure at the moment?” I asked, confronting her gently. “What would be the difference?”

Within a couple of weeks, she had enrolled Samantha and Jason in a day care facility for two half days a week, arranged to resume some part-time PhD supervision, and rejoined the quartet’s evening rehearsals while her husband looked after the children. As she started to utilize her strengths again, she began to feel better and happier in herself. This, in turn, seemed to have her relating with the children in a happier and more relaxed manner. Samantha blossomed in the day care facility, especially through the social interactions with other children of her age. And Emma seemed to be progressing so well after five sessions that we did not arrange any further consultations, leaving the option open for her to contact me if she felt the need in the future.

Almost always—and almost inevitably—the conclusion of a strengthspotting session is characterized by clients’ realization of a deeper insight and understanding of themselves, particularly when they are at their best, and what they can do to achieve that best more often. There is also a marked shift in realization toward the practical steps that can be taken to reshape and refine their life and work on this basis.

WHAT WAS THE FOLLOW-UP?

About three months later, Emma called requesting an urgent appointment. Fortunately, I was able to offer her a cancellation. Again she handed me a handwritten letter. It read: “Bad, bad blow-up with Samantha yesterday. Had just come home from shopping. She wasn’t well with a throat infection and started screaming. I swore and went ballistic for no reason at all. I didn’t touch her; I was just very violent in my body language and voice. I got her into her room behind closed doors as quickly as I could to remove myself from her. I have been doing well, so well, that I think I blew it all in one go. I plugged in my MP3 player and started singing along, then went out and hung out the washing while I was singing. Later I came back and calmly apologized to Samantha. I was so deeply sorry for scolding her. It had been a long while since I had done this.”

While it was troubling that Emma had “gone ballistic,” it was good news that it had not happened for a long time. It was also good to note that she was (a) aware of her own behavior, (b) able to take action about it by separating herself from the situation, and (c) could tap in to her strength of singing. This enabled her to relax, review her reaction from a more distant perspective, and deal with the situation more appropriately. I sought to reassure her about the strengths that she had exercised in this situation and reinforced the fact that once we are capable of doing something, we have clearly demonstrated to ourselves that we are capable of doing it again. If she had been able to go for several months without exploding into her former anger, it was possible to do it again. If anger did arise, she knew that she was capable of picking up on the triggers and taking action to spot and utilize her strengths. Indeed, her management of it was proof of even more strength.

And what of the chocolate consumption? After the first session, Emma made no mention of it again, and nor did I. My guess was she had found other, more adaptive ways to experience happiness.

Strengthspotting is a tremendously powerful way of opening up a conversation about strengths and enabling people to talk in ways that allow the expert therapist to identify and draw out the core strengths people are describing through their responses. Through spotting, enabling, and developing clients' strengths, psychotherapists have another powerful approach in their repertoire to help them help their clients improve functioning and achieve life goals. We hope that one of the many contributions of positive psychology to psychotherapy will be the reenvisioning of psychotherapy from a process of problem-spotting to one of strengthspotting. In time, psychotherapy really may become a place where people like Emma go to talk about their strengths and empower themselves to great achievements.

Putting It into Practice

1. Spot the strengths in your clients.
 - a. Listen for the differences when clients are talking about strengths compared to other topics, like when Emma was discussing her singing as compared to changing diapers. How can you use that observation to alert you to the presence of a strength?
 - b. Inquire about self-perceived strengths, remembering that the type of questions you ask will determine the type of answers you get and, in turn, the things that your clients discover about themselves. Ask what people are good at, when are they at their best, when are they functioning most optimally.
 - c. Watch for the telltale signs in a person's engagement, energy, loss of time, heightened learning, and so on. Discussing supervision and singing produced a new level of animation and body language for Emma. What can you look for in your clients?
2. Help your clients spot their own strengths.
 - a. Teaching your clients to spot strengths in others has a number of payoffs for them. For Emma, it opened up a fresh perception of, and relationship with, her daughter. Coach your clients to do this, perhaps even carrying around a strengths notebook.
 - b. Teaching clients to spot strengths in themselves helps them discover the sounds and signs of their own strengths and to keep building on their discoveries. Emma unveiled a number of strengths she had let slide by the way in her commitment to full-time mothering and even some she had not realized in her outbursts of anger. Let yourself be curious and open to the things your clients may discover.
3. Use the Individual Strengths Assessment.

The ISA is a useful tool to engage in strengthspotting conversations with your clients. We encourage you to experiment with it. Try it out. See how it fits for you and your clients. Observe the responses and how you might use them in moving toward the therapeutic goals.

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4. Enable and develop the spotted strengths.

While strengthspotting may hold intrinsic value for clients and help mobilize them, the art of good therapy is about enabling and developing those strengths toward the attainment of the goal. Ask your clients: Now that you have discovered what your strengths are, how can you use them beneficially? and When can you begin to do so? This, in part, is about getting commitment to action.

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CHAPTER 2

We Will Be Laughing Again

Restoring Relationships with Positive Couples Therapy

Maria de Fátima Perloiro, Luís M. Neto, and Helena Águeda Marujo

MEET THE CONTRIBUTORS

Maria de Fátima Perloiro, MA, is a Portuguese psychologist with three main professional interests: positive psychology, family and couples therapy, and school psychology. She is the coordinator of a school psychology department at the Lisbon Jesuit School, works as a private practitioner with systemic and positive psychology principles, and teaches positive psychology and couples interview and questioning techniques to master's students at the Lisbon and Porto Catholic universities. Married and with a nine-year-old son, Maria spends her leisure time surfing with the family at the seaside. She has a love of photography and reading, and sings in a choir.

Luís M. Neto, EdD, is a psychologist and family therapist with academic degrees from Lisbon (Licenciatura), Seville (master's), and Massachusetts (EdD) universities. He teaches psychology at Lisbon University and was an external examiner for Luton University from 1996 to 1999.

Luis has become involved with almost everything new and consistent within psychotherapy: cognitive-behavior therapy in the early 1980s, systemic family therapy in the 1990s, and solutions work and appreciative inquiry since 2000. He sees positive psychology as a benevolent scientific utopia that might bring psychology back to the center of cultural life, as it was at the end of the 19th century and during the 1960s. He loves to run marathons and swim in the sea in front of his house, every single day.

Helena Águeda Marujo, PhD, teaches in the Psychology Department, Lisbon University, where she obtained her PhD in psychotherapy and educational counseling. She was both a Fulbright scholar and visiting researcher at the University of Massachusetts. She has been training health professionals, parents, and teachers in positive psychology for the last decade. With the other authors of this chapter she wrote a book titled *Educating for Optimism*, and has
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been an invited speaker on three continents. She has a weekly TV show called *Well-being*, is a member of the board of directors of the International Positive

Psychology Association, and teaches a positive psychology class to 250 students. The mother of two marvelous boys, she enjoys singing, dancing, and sharing laughter.

Pedro had an affair. Ana discovered this while she was seven months' pregnant with their first child. Ana found it hard to forgive and forget. Pedro wanted to put it behind them and move on with the relationship. For three years they had limped on with a host of mixed emotions: guilt, doubts, sadness, anger, despair, and ambivalent love. Both cared deeply for their son. In confusion, they sought psychotherapy. What could we offer that might be helpful for them and their relationship? Did positive psychology have a place here in couples therapy?

POSITIVE PSYCHOLOGY AND COUPLES THERAPY

Fortunately for Ana and Pedro, we have evidence that psychotherapy works (Seligman, 1995). However, we continue to investigate the *specifics* and the *nonspecifics* that make it successful, robust, and valuable (Brown, 1987; Howard, Orlinsky, & Lueger, 1994). Seligman (2002b) lists two types of effective nonspecifics of good therapy: *tactics* and *deep strategies*. Tactics include factors such as attention, authority figure, rapport, alliance, tricks of the trade, paying for services, trust, opening up, and naming the problems. For deeper strategies, he described two ingredients for efficacy: *the building of buffering strengths* and *instilling hope* (Duckworth, Steen, & Seligman, 2005). Both of these will be discussed and applied in this chapter, which aims to contribute to the discussion on the relevance of positive psychology to therapy, particularly with couples.

Following a general tendency in psychology, most of the work done so far in the science of positive psychology has centered on an individual perspective, either on the study of positive subjective experience or around positive individual traits (Marujo & Neto, 2008; Seligman & Csikszentmihalyi, 2000). Clearly, exploring positive institutions, systems, and relationships needs more investment from scientists and practitioners, and deserves to be a more vital part of the research and applied agenda. To do this, these areas should be explored not only when couples and families are in optimal, flourishing relationships but also when relationships have been touched by suffering and pain, or are not benign.

Having good-quality relationships with others is universally recognized as central in optimal living (Ryff & Singer, 1998, 2002). This seems particularly important inside the relational family system. When people come to therapy, they usually have a desire to change in order to blossom and feel happier. They frequently want to rebuild relationships. Couples therapy, in particular, can be used as an instrument of hope, as an avenue for a new, more positive future. When seeking therapy together, couples usually indicate a desire for reconciliation, renewal, and a rebirth of their relationship. They just feel they do not know how to do it without external help.

The focus of this chapter is on building competency and blooming in a couple who came to therapy with the courage and strength to reconstruct a deeply wounded relationship. Our approach

is on the amplification of strengths and co-construction of a new, more positive future in the course of positive couples therapy. The approach is built on the integration of five approaches:

1. Positive psychology, in particular the work on character strengths (Park & Peterson, 2007; Peterson & Seligman, 2004)
2. Solution-focused brief therapy (de Shazer, 1991, 1994)
3. Circular questioning (Boscolo, Cecchin, Hoffman, & Penn, 1987)
4. Reflexive questioning (Tomm, 1992)
5. Appreciative inquiry (Cooperrider, 1998, 2004; Cooperrider & Whitney, 1999)

In addition, language in general, and questioning in particular, is presented as the most powerful tool to promote positive transformation. As we hope you will see, inquiring in a positive, hopeful, strengths- and future-oriented perspective is the structural net for this therapeutic intervention.

MEETING THE COUPLE

Pedro and Ana had been together for 15 years, a 10-year courtship followed by 5 years of marriage. In their middle 30s, they expressed a mixture of doubts, despair, and hope about their relationship and its future. Nonetheless, they held a common wish to get away from the intense pain they were both experiencing.

Pedro was a bank employee and Ana an educational psychologist. They had a 3-year-old son, Duarte, who seemed to be developing well and happily. The presenting problem was the deterioration of their relationship and frequent episodes of intense and open conflict. Feeling he was incapable of handling it any more, Pedro had left the marital home three months before they sought therapeutic support. They attributed their discord to an affair Pedro had when Ana was pregnant. On discovering the infidelity, she was, not surprisingly, angry. The anger remained and she now doubted their capacity to outgrow the negative past. Pedro was depressed, confused, and feeling guilty. He was also angered by Ana's limitation to move forward, by her excessive controlling behaviors, and by the fact that she was constantly bringing the episode into their conversations. He did not know how to regain her trust and love and be forgiven. He wanted to fight for the marriage but at times would give up the effort, describing himself as a person without further strength to cope.

They came into therapy with one of the authors of this chapter who worked in private practice. With an orientation of looking for the positives and strengths in the relationship, the therapist noted one particular positive point: Pedro and Ana had been able to keep the relationship going for three years, which showed their capacity to find some kind of cement and functionality in the relationship.

Wanting to confirm this strength for the couple and help them explore possible solutions or virtuous resources, the therapist asked, "How did you manage to keep together after what might have been experienced as a very painful period in your relationship? What kept you together for such a long time after the episode?"

Ana answered, while crying, "I concentrated on the baby. Duarte was my priority. He was completely dependent on me, and he was a blessing, an angel to soothe my pain. But I would cry desperately while bathing or nursing him. . . . I was so hurt, so mad, so completely destroyed inside . . . as if I was dead. Being betrayed is an unbearable suffering.

I felt that I could never forgive Pedro, particularly when I obsessed over and over about the particular moment that Pedro had chosen to be unfaithful. How could he, while I was carrying our baby? But somehow . . . I don't know . . . I am so confused, we are not what we used to be. At the same time that I hated him, I think I kept being in love with him. But we can never dismiss the past, can we?"

Pedro added, "I did not wish to destroy our family. Neither in that moment, not ever . . . particularly when we were becoming parents for the first time. It was a dream that we had for so long. Having a baby, I mean. The baby was not guilty of my sins. God, I did not know what to do then, and I do not know what to do now. I want our marriage to survive; I did not really want to share my life with the other woman. I felt so uneasy, so blameworthy. And I think I tried desperately at least to be a marvelous father. And so doing, I believe I was trying to have Ana's heart back, her love again, her forgiveness. But I am so lost. It seems that the future is impossible because of this destructive past."

During our practice as marriage therapists, we have noticed that couples tend to come to therapy with very negative and pessimistic narratives about one another, as much as about the relationship itself. Their views about the past, the present, and the future of the relationship—the three temporal dimensions that need to be addressed in therapy—frequently are dominated by negativity. Like a virus, criticisms and hopelessness spread through the narratives, and the positive experiences lived in earlier periods vanish or are neglected. This tendency was clearly present in Ana and Pedro's case as shown by fragments of our discourse during the first session.

The Past

When talking about the past, they often reported negative evaluations, such as Pedro's comment: "Things are not what they used to be."

The Present

They made downbeat references about the present. An example was in Ana's comment: "The way we are living now doesn't make sense and it is unbearable."

The Future

In their future orientation, they made unhelpful or doubtful statements, as in Ana's words: "We don't know how this will work out and what is going to happen."

Observing these responses, the therapist discussed ways by which the couple could reconstruct narratives and perspectives about their relationship around these three time dimensions. What would be more helpful for them to be thinking and saying about their past, present, and future?

THE STRENGTHS AND FULFILLED DREAMS GENOGRAM: A POSITIVE ASSESSMENT OF THE CLIENT STRENGTHS

Wanting to help Pedro and Ana reassess and reframe the temporal dimension of the past, the therapist directed their focus toward the positive contextual and historical features in their families of origin, their son, and themselves. This was done by adapting a standard genogram that

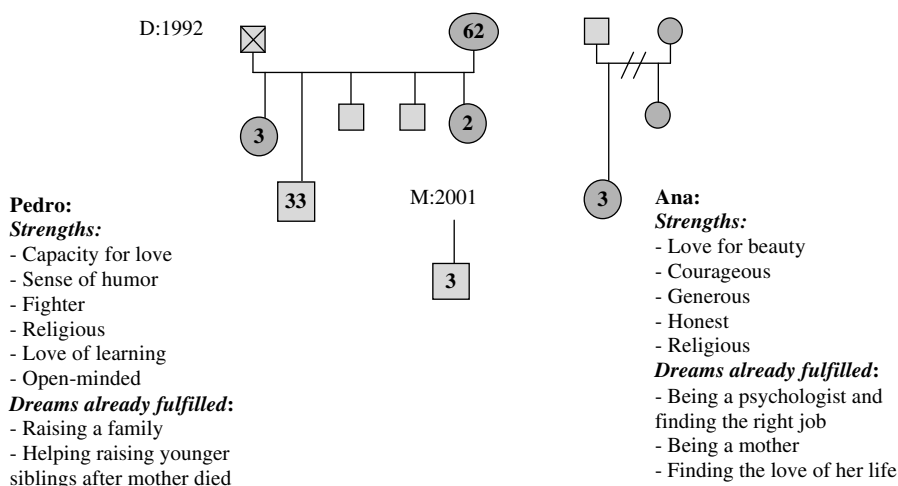


Figure 2.1 Strengths and Fulfilled Dreams Genogram

provides a visual diagram of significant family relationships (McGoldrick & Gerson, 1985). We have modified this into a positive assessment and intervention tool that allows us, and our clients, to recognize talents and strengths. We refer to it as the Strengths and Fulfilled Dreams Genogram (see Figure 2.1). It actively invites clients to acknowledge, discuss, and own the values and character strengths they see in their families and themselves (Peterson & Seligman, 2004).

As the therapist drew the family genogram on a whiteboard, he asked Ana and Pedro, “Which of your relatives appreciated beauty the most? Which one of you appreciates beauty the most? Who has or had the courage to face his or her mistakes? Who has a better sense of humor?” (See the Appendix for a comprehensive list of possible questions to help in this task.)

An example of the answers and reflections that some of the questions provoked in Ana and Pedro can be seen in Ana’s reply to the question about beauty. “I love beauty,” she said, “and I think our son is also like that. He will stop to appreciate a butterfly, a colorful stone, and I will be delighted with a sunset or a poem.”

When asked “Who are you more proud of in your family in terms of strength and courage to fight for wishes and dreams?” Pedro answered, “My father was a warrior. He knew exactly what he wanted, and he would fight for it, no matter what got in the way. After my mother died, he ended up alone with four children, and he raised us all, always courageous. I think I am a little like him, and I would definitely love to be more similar to the way he struggles to fulfill dreams.”

In addition to inquiring about strengths, we also inquire about fulfilled dreams. What are the dreams or goals our clients have had in the past, and what are the dreams they have attained? To know that it is possible to (a) have and (b) fulfill a dream is to have hope that it is possible to both create a new dream for their relationship and have the means to fulfill it.

Using the Strengths and Fulfilled Dreams Genogram and the inquiring conversation, we observed a noticeable shift from the negative, past-oriented attitudes the couple had expressed about their relationship and were able to end the first session on a positive note. We had collectively created a vision of the individual and family strengths to build on during the process of therapy, and Pedro and Ana were able to leave with a validation of themselves and their families and with a sense of being able to achieve dreams and goals.

WHAT DID WE WANT TO ACCOMPLISH WITH ANA AND PEDRO?

Following the first session with Ana and Pedro in which we explored the goals they had for their relationship, it seemed the intervention design needed to consider how to:

- Develop the individual and the couple's strengths
- Facilitate acceptance and gratitude from both partners
- Promote growth through a meaningful reframing of the adverse experience and of the relational stressors
- Create the desired horizons for the future of the relationship
- Discover and enhance what makes the couple happy, proud, and strong in the relationship

Having set the goals, the next question we needed to address was how they could best be achieved. In answer, we planned interventions that included:

- Deep strategies, such as instilling hope (Seligman, 2002b).
- Surface strategies (de Shazer, 1994), such as using humor.
- Practical strategies, such as using appreciative inquiry questions and positive assignments based on the positive psychology literature. This might include the couple noting three good things that had happened that day or defining their ideal day (Seligman, 2002a; Seligman, Steen, Park, & Peterson, 2005).

On the basis of these goals and strategies, we moved into the second session.

CONSTRUCTING THE THERAPY SESSIONS

In a very combustible relationship situation, such as when a couple like Pedro and Ana present in a final effort to save their marriage, we consider hope as a major issue. Positive psychology offers the possibility of hope, and there is no good therapy without hope. Change can happen in a positive way. It is not necessary to take a person through the perils and the details of impotence and suffering to be transformed. Thus, we believe we clearly can—and should—use a positive, strengths-based approach, and the rhetoric of abundance instead of deficit, even when confronted with the worst in life. Focusing on the future and the dreams, instead of working around the “wrong” past and the “sins,” might create a language of possibilities and imaginings and an avenue for appreciative construction.

Given Ana and Pedro's goals for therapy, sessions were organized and structured in accord with Snyder's concept of hope (1995, 2002). This led us to follow two lines of inquiry.

In the first, we wanted to know how Ana and Pedro could generate and maintain the motivation to reach their desired goals. Snyder (1995, 2002) referred to this as agency. It was to assess hope, future horizons, and possible sharing of goals that the therapist asked, “When you think about your relationship, at this precise moment of your life, what is your most important dream, what do you hope for?”

Ana answered, “I wish we could go on and heal this hurt. I am ready to forgive. Maybe that is why I'm here now. I do hope we can heal. But I cannot imagine that we stick together and anything like this is going to happen again! Something has to change.”

Pedro said, “I think I also have to forgive Ana for not trying hard enough to accept my infidelity and continuing to be suspicious about my behavior. I kind of think I am a different man. Above all, I have to forgive myself for provoking suffering in the ones I love the most. But I believe we can go on into the future.”

As can be seen, the most important common dream for Pedro and Ana was to keep the relationship alive and save their marriage. Nevertheless, both wanted a clear reframing of the situation and the negotiation of a new set of rules and reasons to regain confidence in each other.

In the second line of inquiry, we wanted to help the couple generate ways to reach their desired goals (what Snyder called pathways). The therapist therefore inquired, “How do you intend to reach that dream?”

Pedro replied, “Ana should stop talking about that ‘episode.’ I would feel less guilty.”

Ana said, “I need to be sure something like this will never happen again.”

As their responses were not specific, positive, and pragmatic enough to really advance their movement toward the goals, the therapist continued, “I am also interested to know, two years from now, what would be an important thing to happen in order for you to know you are experiencing happiness and well-being in your marriage?”

Ana was very quick to answer. “We would hug and kiss passionately again. I would stop crying all the time and will be laughing, smiling, feeling lighter, less negative, not having trouble to sleep at night. I would regain confidence and stop checking Pedro’s mobile messages. I would not feel that I have to control every act and movement of his because I will be trustful.”

Her response identified specific and achievable pathways.

As a consequence, the therapist asked, “I am also interested in knowing how other people around you would see your positive transformation.”

Pedro replied, “They will see us laughing again, going to dinner, looking relaxed, touching, and being kind.”

Picturing themselves together in the envisioned future is a way for couples to focus on solutions and positive outcomes. Investing in this aim and moving to more concrete solutions and possibilities, the therapist asked, “How do you imagine yourselves as a couple in the future? If you could draw or describe the picture of your marital relationship, how would it be?”

“I see us together,” responded Ana, “in another house. This one has too many negative memories. I will have regained confidence in Pedro.”

“We will be laughing again,” added Pedro.

The therapist then invited the couple to undertake some between-session exercises that integrated positive interventions (Marujo & Neto, 2008; Seligman et al., 2005). Some of these were to be done individually, but most were to be done as a couple. They were intended to convey the idea of the possibility of change and the awareness of what was working in their relationship.

Questioning and listening in a positive, strengths-based, appreciative, solution-focused, and sensible way was the strategic intervention. The questions used were based on three areas:

1. Questions that introduced positive information
2. Questions that induced the search for solutions and exceptions to the problems
3. Questions that followed appreciative inquiry principles (Cooperrider & Whitney, 2005)

All the questions are constructed inside the time dimensions of past, present, and future. The past dimension involved gratitude exercises to help the couple feel connected and thankful for their common history. The present dimension sought to enhance the couple's optimistic view of their current experiences, and the future dimension aimed to develop hope about their ongoing relationship.

WHAT WERE THE INTERVENTIONS USED?

Duckworth et al. (2005) have asserted that the job of the therapist of the future will not be simply to relieve the negative but to help clients build pleasant, engaged, and meaningful lives. To do this, we use questioning as intervention. We believe that questions (a) are a suggestion, (b) direct a client's attention, and (c) engage the client in a process of searching for meaning. As such, questions do not just elicit answers but also may serve as an intervention for change.

Questions that Direct Attention to the Pleasant Life

“What does your partner do that makes you happy?”

“I want you both to watch a home video or revisit a photo album of yourselves together, such as on a holiday. When observing them, note what positive emotions you recall.” (This task was given as a between-sessions exercise.)

“Please choose a place that has good memories for you both. Then go there together in your imagination. Try to remember all the details. Why do you have good memories about that place?” (Again, this can be given as a homework exercise between sessions.)

Questions that Direct Attention to the Engaged Life

“What are the three strengths of character or talents that you most admire in your husband or wife?”

“I want to ask you to write a letter to your husband or wife about the moment when you felt closest to him or her. What made you experience such closeness?”

Questions that Direct Attention to the Meaningful Life

“What made you think you would like to share your lives together?”

“Has your marriage helped you become a better person? In what ways?”

“How could you show your wife or husband, how much she or he means to you?”

“What kind of action could you take that honors the relationship you have?”

Questions that Direct Attention to Developing Strengths and Hope for the Future

“Imagine we are five or ten years ahead in the future, and you look back to this moment. What would you be proud of?”

- “What did you, as individuals and as a couple, learn from this experience?”
 “If you meet a couple in the same circumstances as you, what would you suggest for them to outgrow the problem?”

WHAT WAS THE OUTCOME?

To evaluate the outcome of therapy, Pedro and Ana were invited to respond to a series of questions about the strengths they had developed in their relationship during the course of therapy. Just as we consider that questions can function as interventions, so we believe that evaluation questions can help clients consolidate and generalize the learning and progress they have achieved in therapy. Table 2.1 lists the questions they were asked.

Outcomes were assessed during the sixth (final) session as well as at the three- and six-month follow-up sessions. This helped Ana and Pedro remember and consolidate their therapeutic gains. Pedro returned to the family home. Although initially both were apprehensive, they discovered that being together was what they most wanted. After the positive couples therapy, Pedro decided that he needed to solve personally sensitive issues with his siblings, his father, and the emotional impact of the death of his mother. He began individual therapy, by his choice, but supported by Ana. Their relationship grew closer; they better defined boundaries and identities, and gained an enhanced perspective of themselves.

They both acknowledged that during therapy, an intense change in the quantity and quality of their time together had occurred. They decided to invest in more time together, something they had not had since their son’s birth. The ten rich years of courtship, which both of them cherished with good memories, was an instrument of cohesion and an experience that they sought to replicate.

At the end of the process, another line of questioning was undertaken in order to consolidate the outcomes (see Table 2.2).

Table 2.1 Evaluation Questions

Please write down the strengths that you have developed in your marital relationship due to therapy. Assess each on a 1 to 10 scale, with 1 being the least important and 10 the most important for you.

1. Having the relationship as “our life project”
2. Nurturing our relationship, being grateful and thankful
3. Laughing together
4. Telling what I feel instead of what I think
5. Being attentive to the needs of the other
6. Communicating positively
7. Enjoying doing things together

. . . (The therapists can add their own questions, depending on what the clients define as possible areas of change.)

Table 2.2 Follow-Up Questions

On a scale from 1 to 10, where 1 is the time you felt the worst and 10 the time you felt the best regarding your marriage, where do you position yourself?

At the beginning of therapy: 0 (Ana); 4 (Pedro)

At the end of therapy: 6 (Ana); 9 (Pedro)

At the follow-up (after 6 months): 5 (Ana); 9 (Pedro)

FURTHER THOUGHTS

While several authors have reflected on and written about the application of positive psychology to therapy (Joseph & Linley, 2004, 2005, 2006; Ruini & Fava, 2004; Seligman, 2002b; Seligman & Peterson, 2003), this application is, nevertheless, a new perspective for therapy. It needs to be evaluated through empirically validated studies, as any good science must do. However, the future of positive psychology and its impact in therapy cannot be formatted in rigid, prescriptive interventions. The space for creativity and art, the space to feel, explore, and connect, might be lost if we impose too much science, too much structure, too much technique. We should not base our sole direction on moving to a predetermined and prearranged outcome, through a programmed technology.

Innovation might guide us to new questions, not only to new answers.

Putting It into Practice

1. Ask questions as your main form of communication.

As language in general and questioning in particular is the most powerful tool to promote positive transformation, inquire in a positive, hopeful, strengths- and future-oriented manner as the structural net of your therapeutic interventions. Because questioning is the grammar closest to the recognition, development, and use of strengths, appreciative, circular, and reflexive questioning promotes individual and couples growth.

2. Emphasize the development of strengths or gifts.

Look for the positives and strengths in the individual, couple, and family relationships rather than getting caught up in the couple's negative narratives. Pedro and Ana had been able to keep their relationship going for three years. How had they done that? What helped provide the cement and functionality in the relationship for that period?

3. Consider the Strengths and Fulfilled Dreams Genogram.

This tool actively invites clients to acknowledge, discuss, and own the values and character strengths they see in their families and themselves. Using this in the first session enabled Ana and Pedro to leave with a focus that had shifted from their initial negative narratives to an awareness of strengths in themselves and their families.

4. Explore the past, present, and future of the relationship.

When couples like Pedro and Ana present for therapy, these three temporal dimensions are frequently dominated by negativity. Observing this, the therapist used Pedro and Ana's past experiences, present narratives, and future expectations to identify and amplify strengths and to balance or rebalance negative and positive emotions. What would be more helpful for the couple to be thinking and saying about their past, present, or future? Picturing themselves together in the envisioned future is a way for couples to focus on solutions and positive outcomes.

5. Use deep and surface strategies.

Help your clients find hope and optimism while still listening empathically to the stories they tell. With Pedro and Ana, we sought to do this by having them explore their *goals* for the relationship, the *pathways* by which to get there, and the *agency* to motivate them along the way.

6. Direct attention toward pleasure, engagement, and meaning.

Finding pleasure and enjoyment in life, discovering what engages us with deep, focused attention, and having a meaning or purpose for life and our relationships can be seen as the three core pillars of both individual and relational well-being. We sought to direct Ana and Pedro's attention toward these by using the type of questions described in the text and in the Appendix.

APPENDIX

The Strengths and Dreams Fulfilled Genogram Interview: Questions Based on and Adapted from the Values in Action Classification

1. Appreciation of Beauty and Excellence

- Who in your couple/family of origin appreciates beauty the most?
- Did you learn from your partner or a relative to visit museums, art galleries, stop to watch a sunrise/sunset, or listen to a bird singing?
- How do you as a couple let beauty enter into your lives?

2. Gratitude

- In the genogram we drew, to whom are you most grateful?

(Continued)

(Continued)

- In what ways are you differently grateful to your family of origin and to your spouse?
3. Hope
 - Who generated most hope in both your two families of origin?
 - Who did/does generate more hope in your relationship?
 - How is that usually done?
 - Who developed more intensely the aptitude to confront pessimism?
 - Who is the one who helps the other the most to confront his/her pessimism?
 4. Humor
 - Who cultivates and exercises most the quality of making the other laugh?
 - When and how?
 - Who was the person honoring humor the most in your families of origin?
 5. Spirituality
 - In what way does each one of you become conscious of his/her life purpose?
 - How does each one of you help the other to become a person with a deep sense of the meaning of life?
 6. Creativity
 - Who in your family likes to become involved in creative tasks?
 - Who most enjoys finding new uses for common objects?
 - In what ways do you, as a couple, show creativity?
 7. Curiosity
 - Who most enjoys discovering/experimenting/finding out about new and different things?
 - How is curiosity important in your relational life?
 8. Love of Learning
 - How does each of you help the other to cultivate learning and wisdom?
 - When did you most enjoy learning something new together?
 9. Open-Mindedness
 - How does each of you help the other to expand his/her horizons?
 10. Perspective
 - How and when are both of you able to transcend your own positions and attitudes?
 11. Authenticity
 - Do you see any family resemblance between your commitment to your own values and anyone else related to you?
 - Who else in your family wanted to be true and genuine?
 - When in your time together do you feel the need to be authentic?
 - How does the other help you in your expression of authenticity?
 12. Bravery
 - Besides you, who else would do things as needed in spite of the fear he/she felt?
 - How did bravery help your relationship to be mutually satisfying?

- In your life as a couple, in what circumstances did you fight closely together against challenges?
- 13. Persistence
 - How do each of you help the other to be a goal-oriented person?
- 14. Zest
 - In what way do you help the other to become “bigger than life”?
 - What do both of you do to put excitement and enthusiasm in your life as a couple?
- 15. Kindness
 - Did you have a role model for kindness in your family?
 - How do you emulate him/her in your relationship?
- 16. Love
 - How does/did your love relationship help in each person’s autonomy and personal growth?
 - When did you feel more loved by the other?
- 17. Social Intelligence
 - How does each one of you help the other to be conscious of his/her social life skills?
- 18. Fairness
 - With whom did you learn to be fair?
 - How did he/she teach you that sense of justice?
 - How do the two of you exercise fairness in your relationship?
- 19. Leadership
 - Who shows more leadership skills?
 - How do those skills help your relationship?
- 20. Teamwork
 - How does each of you help the other to be a good team member?
 - How do you accomplish tasks together?
- 21. Forgiveness
 - From whom in your family did you learn to appreciate the value of forgiveness?
 - Can you remember a situation where you and your spouse displayed forgiveness?
- 22. Modesty
 - How does helping the other to show self-restraint positively impact your relationship?
 - How does modesty help both of you not to get a fixed and rigid personal identity?
- 23. Prudence
 - How does each one of you show that you have developed the ability to reflect before speaking or acting?
- 24. Self-regulation
 - How does each one of you help the other to exercise self-control?

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CHAPTER 3

What Is Right with Him?

Ericksonian Positive Psychotherapy in a Case of Sexual Abuse

Betty Alice Erickson

MEET THE CONTRIBUTOR

Betty Alice Erickson, MS, has been keynote and plenary speaker, as well as faculty, at various international hypnosis and Ericksonian congresses and conferences throughout the world for the past 20 years. She coedited the volume *Milton H. Erickson, M.D.: An American Healer* and coauthored *Hope & Resiliency*. She has written numerous book chapters and articles that have been translated into several languages and her book, *New Lessons in Hypnosis*, is published in Russian.

A clinical consultant for the American Society of Clinical Hypnosis, she

served as a demonstration subject in hypnosis for her father, Milton Erickson, and for many of his students for over three decades. Awarded the First Franco Granone Prize, she has a private practice in Dallas, Texas. Erickson's brief, solution-focused and positive psychological orientations are manifest in her work and teaching. Her main interests focus on the healing components of psychology and therapy as well as expanding the specific techniques of psychotherapy.

Joe, a young man in his early 30s, was referred by his physician for hypnotherapy regarding a problem of erectile dysfunction. Even just one sentence into his case and we can see how the therapist's orientation can make a big difference to the direction and outcome of therapy. Did I join the language of the referral and see Joe as a problem of erectile dysfunction, or did I wonder about his ability to function? Did I look at what was wrong with him, or did I ask myself what was right with him? Of course, both aspects were a part of Joe, and both needed to be heard and acknowledged, but which one I attended to would make a big difference to (a) how I as the therapist saw therapy unfolding, (b) how Joe experienced it, and (c) what the outcome would be.

Positive psychology—the notion that psychology should be based on wellness rather than on pathology, should focus on helping people live productive lives, and should base its efforts on people’s own resources and strengths—can be firmly tied to the work of the late Milton H. Erickson, M.D. Although Erickson, a psychiatrist, is probably best known for his scientific research in hypnosis, his methods of psychotherapy based on beliefs in positive wellness have gained enormous acceptance. They formed the basis of my work with Joe.

ERICKSONIAN POSITIVE PSYCHOTHERAPY

Erickson believed, understood, and taught that normal behavior existed on a wide continuum. Most people want to live a happy productive life and do their best to achieve that (B. A. Erickson & Keeney, 2006). People find joy as they deal with the multiple problems that being alive entails and when they work to find solutions and independence through their own choices. Erickson’s work celebrated those premises and utilized them at every point. He also was wise enough to understand that steps toward independence and productivity were moves on the person’s own timetable and accepted that clients are the ones who create and find their own happiness.

Perhaps a flaw in Erickson’s protocol, although most see it as an asset, was his atheoretical stance. He believed that because humans are far too diverse and unique, and life circumstances so varied, no theory can encompass all the distinctions and differences of people. Even defining what is considered “normal” is difficult. “I think we all should know that every individual is unique,” said Erickson. “There are no duplicates. In the three and one-half million years that man has lived on the earth, I think I am quite safe in saying there are no duplicate fingerprints, no duplicate individuals” (Zeig, 1980, p.104). This led him to advocate that therapists “individualize your therapy to meet the needs of the individual patient” (Zeig, 1980, p.113). Such an individually oriented approach to therapy along with Erickson’s lack of a global theory makes it difficult for his work to be encapsulated and taught easily.

Erickson’s psychotherapy cannot be discussed without discussing his work with therapeutic hypnosis. Not only was he a leader in formal trance work, but he also used naturalistic or conversational trances that occur in the context of ordinary, day-to-day interactions. These have the same psychological and physical characteristics as formal hypnotic trances (such as expectancy, selective attention, dissociation, responsiveness to suggestions, relaxation, and sensory shifts), but the inward focus is produced through a seemingly normal conversation. With this altered state, new information and different perspectives can be given and heard on deeper levels, bypassing a person’s ordinary defenses (Erickson, 1959/2008). The words and, more important, the meta-message are heard by the unconscious.

Conversational trances can be fleeting or lengthy, but, just as in formal trances, forgotten strengths and resources can be accessed. Hypnosis is like a dream that feels real, enabling our mind and our self to create a different reality (Erickson, 1958/2008, 1966/2008). Changes occurring as a result of these trances are more likely to happen when the hypnotherapist trusts the client’s own processes toward good health (B. A. Erickson & Keeney, 2006; Erickson, 1966/2008; Erickson & Rossi, 1981/2009).

Using Dysfunction as a Positive Therapeutic Resource

Not all of Erickson's therapeutic work relied on hypnosis. One of the most famous of his cases illustrates the straightforward but highly creative use of a dysfunction as a positive resource. It also illustrates how Erickson as a therapist was less interested in the common clinical question *What is wrong with this client?* and more interested in questions such as *What is right with this client? What are his or her strengths? What abilities or resources does this person have?* Contrary to the way many other therapists were viewing pathology at the time, Erickson seemed to ask himself these questions: Even if the pathology is predominant, can this be used as a strength? If this is something a client is doing well, can it not be used as a resource for change?

Long before the advent of effective psychotropic medication, Erickson worked in a psychiatric hospital where there was a long-term patient who believed he was Jesus Christ. The man spent most of his days sitting on a bench waving his hands as he "blessed" the people walking by. Erickson spent quite some time sitting next to the man, saying nothing, just being with him. Finally, Erickson began a conversation with the man and remarked, "I understand you have experience as a carpenter."

This put the man in a bind to which he had to agree. If he was Jesus, of course, he had that experience of being a carpenter. If he did not have that experience, then he could not have been Jesus and his delusion had to change. Erickson pointed out how the motions with his hands, as he "blessed" people, were remarkably similar to the movements made when a carpenter sands wood. Erickson gave him sandpaper and pieces of wood, and the man began sanding wood (Gordon & Myers-Anderson, 1981; Haley, 1973; Short, Erickson, & Klein, 2005). These were the man's first steps toward a more positive and productive life.

Over a period of time, and carefully coached by Erickson, the man developed wood-working skills. Then Erickson encouraged him to construct shelves and bookcases for his ward. As he produced better and better quality work, doctors and nurses began requesting bookcases and paying him for his efforts. The man's days became filled with productive and rewarding work.

He still had a severe mental illness, but he had become more than just another patient in the hospital. He was useful and added value to the world. He had earned the respect of those around him and, in doing so, earned self-respect. His life was significantly improved because Erickson had paused to ask himself that important question: What is right with this man?

Using Skills as a Positive Therapeutic Resource

Another famous case is the depressed woman whom Erickson visited at the request of her nephew. Her only social connection was attending church on Sundays. Erickson introduced himself, and as they were walking through her home, he noticed a few African violets blooming on her sun porch: again showing his orientation to what was right, what resources or strengths this person had. At that time, modern hybrid plants had not yet hit the market, and African violets were notoriously difficult to grow. Erickson was rightfully impressed. As he admired her abilities, the woman showed animation for the first time. Erickson suggested that she give one to every family with a new baby at her church. She did not even have to tell them who sent it. Let people wonder. Eventually, he suggested, she might want to give violets for the families who had a funeral service at her church. And of course, weddings are happy occasions and should also be included.

Erickson saw the sequencing here as important. Giving a present to a new baby was an easy and pleasurable task, funerals were respectful, and weddings were another happy event. This sequencing was also a metaphor for the therapy and associated positive, compassionate experiences with her activities.

This was long before research began to confirm how giving to others, being altruistic, and showing compassion can benefit not only the recipient of such acts of kindness but also the giver (Otake, Shimai, Tanaka-Matsumi, Otsui, & Fredrickson, 2006; Schwartz, Chapter 13, this volume).

The woman began doing just that. Caring for so many violets occupied her time productively. She had a purpose. Eventually, of course, human nature being what it is, people figured out who was sending the beautiful flowers. She became a beloved fixture of the church and enjoyed as much social life as she wanted. When she died many years later, the newspaper announced the death of the “Violet Lady”; her funeral was attended by hundreds of people (Zeig, 1980).

This case was typical of Erickson’s focus on what was good in the mental health of a person. The woman was justifiably proud of her ability to grow such a difficult plant. Erickson showed genuine, interested admiration. Then he suggested sharing her talents, giving the plants for celebrations and even as comfort at funerals. Her anonymity was an important component of this. No one could “intrude” into her depression. However, as she attended church faithfully, she would be able to see and hear how appreciated her gift was.

People tend to continue and expand behaviors that are rewarding. Erickson recognized that ultimately people would discover who was giving the violets. By the time they figured it out, the woman would be happy to be discovered.

One of Erickson’s favorite metaphors was the snowball effect: If you roll a snowball down a hill, you don’t know where it will end up, what it will pick up, or what it will incorporate on the way down. All you really know is that the snowball will be different when it gets to the bottom. The African Violet lady is a perfect example.

Using Individuality Positively to Promote Future Well-Being

Erickson also used the positive aspects of people as ways of promoting future health and happiness. My youngest child was adopted as an infant. Her father and I and her two brothers, who were almost her age, are all blond, with fair skin and blue eyes. Kimberly is Vietnamese and clearly very different from the rest of her adoptive family. Those type differences often are not seen as positive—and certainly they were not in the mid-1960s.

When Kimberly was about three years of age, Erickson, as her grandfather, had a discussion with her. Without ever mentioning the obvious differences in her coloring from her brothers and parents, they decided she was a Gingerbread Girl: brown-skinned, eyes that were black like raisins, and her whole self sweet and spicy just like gingerbread. Erickson had a box of gingerbread cookies on hand, and Kimberly, as the Gingerbread Girl, got to hand out the cookies to her brothers. On the next visit to her grandfather, he had a Gingerbread Girl doll for her and, once again, special gingerbread cookies for her to distribute to her brothers. This practice continued until the end of his life—he always had some form of a gingerbread treat for Kimberly.

Every little girl wants to have a position of power over her older brothers, and handing out cookies was a perfect situation. She was in charge of the cookies *only* because she was a Gingerbread Girl. Her brown skin and black eyes became an asset her brothers had to

acknowledge as they held out their hands for cookies. Each part of this was positive. She had influence based on her differences, and, on a deeper level, gingerbread is sweet and spicy, which meant she had to use her authority in a nice way. Her grandfather firmly believed in her importance and in the positive value of her differences and demonstrated that in ways that were significant to her. Best of all, her older brothers recognized those differences as having great benefits.

Kimberly showed unequivocally how important this was when she started kindergarten and had a Hispanic teacher. On the first day, she said in a very satisfied way, “Mama, my teacher is a gingerbread lady. I told her I was a gingerbread girl, and she put her arm next to mine. We looked and we’re the same color—gingerbread.”

This acceptance and valuing of her and her differences also had lasting impacts on her brothers and her relationship with them. Years later people would look at the tow-headed boys with their dark-skinned sister and rudely ask, “Is she adopted?” Her brothers would look puzzled and respond, sometimes in the same moment, “No, *we’re* adopted!” Kimberly would sometimes decide to argue with the boys about who was or was not adopted, much to the confusion of the questioner. The dynamics of what could have been a hurtful query were changed with the children holding appropriate power over their situation—again as a result of asking that simple question, What is right with this person?

CASE EXAMPLE BUILT ON ERICKSON’S POSITIVE PSYCHOLOGY

How can we apply that orientation and approach in therapy? Joe, who was referred for hypnotherapy regarding a problem of erectile dysfunction, offers a good example. Joe chose to seek therapy, he said, because he was beginning to choose partners he really did not want to be with. “They’re the type I don’t really like,” he announced. “They drink too much or don’t have a good job. It’s like I’m with them so when I fail, I have a reason. But that doesn’t make sense.”

In addition, Joe didn’t like his job anymore, but he just could not pull himself together to go look for a new one. He had never had trouble looking for or getting a job before, and he felt everything was somehow related. “It is almost as though my life is slowly falling apart, like it’s making me get help to figure it out.”

I listened very carefully. I believe that clients tell us as clearly as they are able exactly what is going on with them. His words—“so when I fail, I have a reason” and that his life was “slowly falling apart . . . making me get help to figure it out”—were very clear messages about four things that were right with this man.

1. He had a good understanding that life was not going the way he wanted it to go, especially in his sexual behavior and relationships.
2. He was motivated to seek assistance and find a resolution.
3. He clearly communicated that the path he needed to follow was one of “figuring it out,” of using his reason and cognitive processes of understanding.
4. He was letting me know that reason and figuring things out were processes he had probably used, and used successfully, in the past as a means of problem solving.

In these ways, he expressed the core ingredients of what Snyder (1994, 2002) described as the important therapeutic variable of hope. Joe showed that he had defined goals he wanted to achieve in therapy, he had the resources and pathways by which to achieve them,

and he possessed the motivation or agency to move in those directions. (See Cheavens & Gum, Chapter 5, this volume.) My next question became: How can I help him utilize what is right to make things even better?

Joe's history was simple. He seemed to have had a normal childhood. His still-married parents appeared to have given him and his sister a good upbringing. He felt loved and said everyone seemed to enjoy life within the family. Alcohol was not a problem, Dad was employed in middle management, and Mom was a stay-at-home housewife until the children were in high school. Both Joe and his younger sister did well in school and played sports, which the family attended. After college, Joe struck out on his own, and his sister married.

His sexual history was more tangled. His first sexual experience occurred just days after his 15th birthday, when a male youth counselor crawled into his sleeping bag at a church retreat and fondled Joe until climax. He did not tell anyone at the time because he had not wanted to cause a "commotion." He never told anyone later because it did not seem that important. I was the first person he mentioned the incident to, and the only reason he told me was because he wanted to figure out what was wrong with his life.

THE THERAPEUTIC GOALS

Joe's goals were both simple and profound. First, he wanted to have normal lasting relationships and, second, he wanted to reach good futures in both his career and personal life. I was in wholehearted agreement. Unfortunately, I know it is almost an axiom that abuse victims feel some sort of responsibility for their abuse, and their guilt and shame can make life difficult for them.

My aim therefore included helping Joe see himself as victimized rather than as a victim or a participant. Why would a therapist holding a positive orientation to therapy want a client to see himself as victimized—a position that is usually associated with powerlessness and helplessness? I had three reasons.

1. I wanted Joe to see specifically that he had been badly and inappropriately treated rather than globally see himself as a victim.
2. As long as he felt any responsibility for the adult counselor's crawling into his sleeping bag, he could not assign blame or even responsibility to the proper person. Part of that goal was recognizing that the counselor perpetrated a legal and a moral wrong on him.
3. If Joe insisted on keeping any part of the responsibility for what had happened to him, I wanted him to be able to acknowledge that he had paid enough.

Perhaps more important were the goals I did *not* have. I did not think it important that Joe relive his abuse or even admit that the long-ago abuse was not forgotten and was probably causing him pain today. I believed Joe's words "get help to figure it out" indicated exactly what he was trying to do. My premise was that when he figured out he was not to blame, he would no longer set up self-punishment and thus would be free to build the more desired sexual responses.

Often the first positive step occurs when clients are allowed the dignity of defining their own problem. Merely assigning words and definitions subtly changes the structure of the relationship with problems. Joe had no hesitation or embarrassment telling me exactly what

his problem was, how he failed in completing sexual acts. My first intervention was to attempt to distance or externalize the failure from him.

“You mean your *erection* failed?” I asked while at the same time implying it was not he who had failed.

He agreed. It was the erection that failed. But then he pointed out that he was attached to the erection. We both laughed.

At that moment, “failure” was redefined in a much more limited sphere, and the kind laughter we shared removed some of the burden from Joe. Some of the intensity of the negative emotionality was removed. Erickson valued, incorporated, and encouraged the use of humor in therapy, believing that our clients have enough serious problems without offering them serious therapy as well. Erickson said: “In teaching, in therapy, you are careful to bring in humor, because patients bring in enough grief” (Zeig, 1980, p. 71) and “It’s never too late to have a happy childhood” (Hicks-Lankton, 2007, p. 152). As Joe asked to learn self-hypnosis and, as part of my goal as a therapist is to meet any productive goal of the client, I agreed to teach him. He was an excellent subject and practiced faithfully.

Joe told me the church counselor claimed both of them had enjoyed the encounter, but Joe was pretty sure he hadn’t. He said that he “couldn’t argue” he had reached climax, and he didn’t remember telling the man to stop. This puzzled him because he thought he had and was pretty sure he hadn’t enjoyed the act. But he couldn’t argue with the fact that he did reach a climax.

My response was calculated to surprise Joe. Creating a break in a person’s usual, patterned thinking is one way for that person to reexamine what had happened and to bypass the defenses built over the years. Through a challenge to Joe’s thinking, he could revisit his abuse from another perspective. Further, there could be no resistance because I wasn’t suggesting any change. I was merely making a remark that opened a door to that different point of view.

When Joe said that he could not argue that he had reached climax, I responded that I personally was glad he had physically responded. He looked at me, stunned. As he waited for some sort of explanation, I continued in an intense, hypnotically paced voice. “This way, Joe, you know you’re wired correctly. You got stimulated, you responded.”

There was a long silence as he thought, rearranging his previous awareness. Then he grinned. “You’re right. But I still wish it hadn’t happened.” We both agreed on that.

Again, thinking in terms of what was right with Joe helped my orientation as a therapist and, consequently, his perspective as the client. While there had been something invasive, unsolicited, and deeply distressing about the situation, he also seemed to acknowledge that there had been something intrinsically pleasurable or satisfying, at least on a physical level. This was good news; hence, my validation that he was hard-wired correctly. Our bodies are designed to respond sexually. Part of our sexual and relationship maturity is about learning to make choices regarding to whom we respond and under what circumstances. What was right here was first that Joe could respond to sexual stimulation, get an erection, maintain an erection, and attain a climax. If it was possible for the mechanics of his sexual responsiveness to function well in the past, it was also possible for them to do so again in the future. The second aspect of what was right is that Joe could make choices. In reviewing the past, he was making a choice that he would prefer things to have been different. In this way, as tough and as undesirable as the experience had been, it provided a useful learning experience. In addition, Joe had been making choices about his most recent partners. As he readily

acknowledged, they were not always the best choices. However, he was engaged in a process of refining his decision-making, and this implied that he could find ways to do that in a more desirable manner.

As Joe accepted this different perspective about his response, he could consider that there might be other ways in which he could interpret what had happened to him.

“I want to use hypnosis to go back and remember what really happened,” he said.

Re-remembering memories, especially of emotionally charged events, is problematic at best. Not only do subjects tend to please the therapist with responses they think might be wanted, but memory does not function like a videotape. While this can be true of any regressive type of therapeutic endeavor, it has been studied and noted in particular with hypnosis. The bottom line is that any recall of such past events can be highly inaccurate, and we have no way of judging the accuracy without external, collaborative evidence (Yapko, 1994).

My assessment was that Joe was a basically healthy young man who would not create a situation that would harm him. Consequently, I offered him two options. “Would you like to do that here with me?” I asked, offering the safety of my presence in my office, “or would you prefer to do it on your own, at home, while you practice your self-hypnosis?”

He did not hesitate. “I want to do it on my own.”

The next week he entered the office and announced triumphantly, “I did it! I remembered that night, and you know what, I did say ‘Stop.’ I said it three times. He just didn’t pay attention. I didn’t want anyone to know what was happening, so I just let it go on. But I did say, ‘Stop!’”

I smiled happily back at him. He clearly felt vindicated and stronger believing he had told the man to stop. I have no idea if what Joe remembered was true. It did not really matter. What he remembered was true to him, and this truth was helpful. This truth helped him to heal as he no longer had to believe that he had willingly participated in his own abuse.

LIVING FOR TODAY AND TOMORROW

For the next few sessions, Joe directed conversation more toward his life in the future: what he wanted in such areas as his job and his “shopping list” for a romance. I saw this as a healthy sign and was reminded of a comment of Erickson’s: “Your patient has to live in accord with today. So you orient your therapy to the patient living today and tomorrow, and hopefully next week and next year” (Zeig, 1980, pp. 268–269). Just as Erickson had taken the positive aspects of my youngest child, Kimberly the Gingerbread Girl, as ways of promoting her future happiness, so I wanted Joe to look forward, to live in the joy of the present and with expectations of a hopeful future. The abuse he had suffered in his past unfortunately would not change. However, the way he perceived himself as a result of that event and ways he now moved forward from it were changeable.

Throughout I kept these questions in my mind: What is right about this person? What are the strengths and resources he possesses? Not only does looking for the positives help my frame of reference as a therapist, but it also sets a role example that may lead clients to ask the same questions about themselves. In the process, I learned that Joe had been a Boy Scout, and this led us into a discussion of Boy Scout values.

This was an easy sequel into the next step. I said that I had once been to a meeting where a woman had talked about five moral and ethical values that are recognized in virtually every

culture. We joked about how boring lectures on ethics can be. But this was different, I told him. “In fact, it was one of the most fascinating talks I’ve ever listened to.”

The stage was set. My comment had drawn his close attention. So I asked him to guess what the five values were. He could guess only four.

“Hardly anyone gets them all,” I said, “probably because we all know them without knowing we know them. They are: Truth, Justice (which has nothing to do with truth), Compassion, Respect, and Accountability.”

Joe sat in silence for a moment as he thought. “Everyone should have those values,” he said. Then, with the first bit of anger I had seen in Joe, he added that his molestation had violated those values. He went through the list, talking about how they had been broken. But, he said regretfully about his abuser, “He’s gotten away with it. There was no justice in this.”

There was nothing I could say. He was right. Platitudes of how the man had to live with his wrongdoing or how Joe had triumphed over his abuse would have been patronizing and dismissive.

In a wonderful stroke of incredible serendipity, Joe returned the next session even more elated. In our state, there is a web site listing convicted sexual offenders. Joe had gone on the site and found the name of the man who had molested him. “Somebody told!” Joe said. “Somebody told and he got arrested and convicted. There *is* justice!”

Joe talked enthusiastically the whole session. No wonder his abuse impacted him so. All five of the moral values were violated. How lucky he was that someone had told and the abuser had been tried and convicted. He spent the whole session explaining to me how the abuse had affected him. Now he knew it was not about him, although it felt like it was. He was not to blame. My job that hour was simply to listen and validate his newfound feelings.

At the end of the session, he said that he felt different. He felt capable of continuing on himself. Nonetheless, I asked him to come back after a few weeks for a “well-baby check.” This was a deliberate phrase I used both to convey that we would be checking on his wellness rather than his problems and to set an expectation that nothing was likely to be wrong.

THE OUTCOME

When I saw Joe almost a month later, he had a new job and was dating someone he liked. “I don’t have any problems,” he said, blushing. “I don’t think I need to come back.” We said good-bye, each confident that if he did need to come back, he would.

This case is not ordinary. Joe was eager to put his life back on track and fearless in confronting what needed to be dealt with. His job, and mine, was made a great deal easier by using premises of positive psychology. If, instead of trusting him and working from a perspective of his positive good health, I had decided to “work through” his sexual abuse and insist he had been molested, I believe our course would have been much different. He would have suffered unnecessarily during his quest to re-achieve contentment, better mental health, and better sexual performance.

In our sessions, Joe asked, “Why didn’t I protest more? I was 15. I should have.”

There are any number of answers to that question. I chose one I have used with many others in similar situations of abuse. “In essence, you didn’t because you were a kid.” Joe shook his head, rejecting my explanation. He knew better. He *should* have stopped the man.

Accepting that he should have stopped the man, I said, “In a perfect world, it never would have happened but, if it had, you would have been able to stop it. However, it’s not a

perfect world because it did happen and you didn't stop it." He paused, trying to sort out what I'd said. Such confusion can create a focus of concentration and search for meaning. The client is briefly engaged or entranced in much the same way as if entering hypnosis and is thus open to suggestion (Erickson, 1960/2008). Then I firmly announced, "Not fair, Joe! Absolutely not fair judging that barely 15-year-old youngster, faced with a situation he'd never really thought about. At night, lights out, and suddenly a man who should have been trustworthy, who worked for your church, touches you when you said stop. Not fair judging what that shocked youngster did or didn't do in a bygone world of 20 years ago!"

Joe stopped and thought. Then he selected one of the various objections I'd offered. "It was different 20 years ago, wasn't it? I'd never thought about being abused. Now they have programs on television and in school about how to say no, where people shouldn't touch you, stuff like that." He thought more and then finished. "I guess I really didn't know what to do. It was a different world back then."

Joe gave me reaffirmation that people want to do the right thing for themselves. Relying on his strengths to "figure it out" gave Joe a new sense of competency and control. In these ways, he provides a clear picture of how using the positive assets all clients possess enabled him to increase his own positive and productive life. Working with the resources our clients bring to the table, rather than the difficulties or pathology, offers clients ways for focusing on strength and on that all-important question: What is right with this person?

Putting It into Practice

1. Adopt a what-is-right orientation.

This orientation looks to function more than dysfunction, outcome more than problems or pathology, and strengths more than weaknesses. It guides the path of the therapist and, in turn, the therapeutic path of the client. Looking more toward what was right than what was wrong influenced the therapeutic direction in the case of Joe, the way he experienced the process, and the outcomes he was to achieve. Ask yourself, What is right about this person? Follow that by asking, How can we utilize what is right toward the achievement of the therapeutic goals?

2. Encourage your clients to explore what is right about them.

By taking a what-is-right orientation, you begin to model it for your clients, in turn helping them shift their attention more toward their strengths and resources that might be engaged in the healing process. Just as you might ask yourself *What is right?* encourage your clients to ask themselves the same question. By seeing what he had done that was right in the situation of abuse as a 15-year-old, Joe could value himself as someone who was victimized rather than someone who was a victim. Seeing his own resources empowered him within a month to find a new job and a more desirable partner.

3. Use humor and playfulness.

Sharing laughter, humor, and playfulness with Joe helped remove some of the burden about discussing a difficult topic and diminished the intensity of the associated negative emotions. Using humor and playfulness can enhance

the learning process while at the same time make therapy more enjoyable for both client and therapist. In introducing these qualities, you again model appropriate and desirable skills for building more positive ways of being.

4. Orient therapy to today and tomorrow.

As Erickson said, our clients' futures lie ahead of them. As they will be living their lives for today, tomorrow, next week, and next year, it is logical that this is where therapy needs to be directed. Shifting his perspective about the past, Joe spontaneously began to look ahead, directing our conversations more toward what he wanted in his job and in a romance. Ask your clients about their goals and where they see their lives heading. Look for the skills and strengths they have to move in these directions. Help them find ways to utilize these skills for their future well-being.

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CHAPTER 4

The Why, Not the What

The Positive Power of Intrinsic Motivations in Client Goal Setting and Pursuit

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MEET THE CONTRIBUTOR

Helen Street, PhD, is associate professor in behavioral science at the University of Western Australia. She completed her thesis on depression at the University of Sheffield in the United Kingdom before moving to Australia to take up a position as a lecturer in psychology in 1998. After spending a year in Queensland, she settled in Western Australia, where she became a senior lecturer. Her interest in goal-setting and mental health has resulted in the publication of many internationally peer-reviewed papers and a coauthored book

with George Burns (with a foreword by His Holiness, the Dalai Lama). Helen is a registered psychologist, Western Australian Health Department research consultant, and cofounder of Wise Solutions, a service developed to assess and promote mental health in adults and children. She runs seminars for Wise Solutions on workplace mental health, incorporating a focus on motivation and healthy goal setting. She lives happily in Perth with her partner, Neil Porter, and their three gorgeous girls, Lucia, Molly, and Tess.

How many cares one loses when one decides not to be something but to be someone.

—COCO CHANEL

* I would like to thank Sean Murray, PhD, director of Curtin University Counseling Service in Western Australia, for sharing his therapeutic experiences so enthusiastically, intelligently, and candidly.

Dave, a 31-year-old, full-time PhD student, presented to the university counseling service for procrastination issues specifically related to his studies. He wasted no time in telling Sean, his therapist, about the difficulty he was having finding any enthusiasm or energy for his work.

“I have been battling to complete my PhD,” he said with obvious frustration in his voice. “I’m stuck in the middle of the whole process and close to giving up completely. I can’t help but feel so much pressure from the high expectations of everyone around me. My girlfriend, my family, my friends, and my colleagues all used to believe I could do exceptionally well as an academic but have become increasingly impatient about my lack of progress. I desperately need help to get back on track.”

The approach to Dave’s presenting problem was novel and perhaps needs some explanation. It is an example of how theory, research, and clinical practice have combined for the benefit of the client in therapy. I (Helen Street) am an academic psychologist employed by the University of Western Australia, and Sean Murray is a therapist and the director of counseling at Curtin University. My work exploring the links between motivations controlling goal pursuit and well-being have found therapeutic application in the work of Sean and his team with a variety of clinical cases. This chapter is a record of our conversations about Dave’s case.

IMPORTANT LIFE GOALS AND INTRINSIC MOTIVATIONAL THERAPY

The approach taken with Dave stemmed from a growing literature concerned with the importance of the identification and development of intrinsic motivations underlying goal setting and pursuit. However, before I embark on Dave’s therapeutic journey, I need to make one vital distinction, the distinction between an “intrinsic motivations approach to important life goals” and “therapeutic goal setting.” Nearly all therapists set therapeutic goals (Elliot & Church, 2002; Tjeltveit, 2006). These may be goals arrived at by the client, by the therapist, and/or by the client and therapist together. The goals of therapy help both client and therapist to decide on the best therapeutic interventions to pursue and in turn help guide the therapeutic process. It is to be expected that therapeutic goals will overlap with the client’s own important life goals. However, the client’s important life goals are not necessarily the same thing as therapeutic goals. The client’s important life goals (Burns & Street, 2003; Street, 1999, 2001, 2002; Street, O’Connor, & Robinson 2007)—also called personal strivings (Emmons, 1999), personal projects (Little, 2007), and current concerns (Klinger, 1977)—are representative of his or her most important aims and objectives in life as a whole.

An intrinsic motivation focus on goal setting is about exploring the motivations controlling important life goals. It is about helping clients set and pursue their important life goals from a positive foundation of intrinsic motivations concerned with personal and social development. Intrinsic motivations help individuals experience a sense of ownership over their life’s path and develop a nurturing environment, ongoing personal development, and a path to self-actualization.

THE CASE OF DAVE

Dave began his therapy with an exploration of his personal experience of procrastination, describing his biggest concern as being one of avoidance. It seemed that Dave would do anything other than what he was “supposed” to do—work on his PhD.

“I seem to be able to do any other tasks related to my life at the university rather than pursue the one task I really need to pursue, that is, my study,” he told the therapist. “I am always getting caught up with personal chores, anything other than my PhD. I find myself avoiding my work like the plague.”

Even when Dave did make time to focus on his work, he ended up doing very little. He would spend a lot of time preparing to “get going,” cleaning his desk, sitting in front of the computer, making sure that his articles were there, possibly reading them, and even if he had read them before, reading them again. He would do all the preparation he could possibly think to do and at the same time make absolutely no progress.

When asked to describe his feelings in relation to his problem, Dave told the therapist that he felt both embarrassed and highly stressed. “If I am honest,” he said, “I have to admit that I have been studying for a very long time.” Dave was in his fourth year and should have finished his studies by now, but he was not even halfway. So he felt embarrassed. He kept creating new stories for his supervisors, describing why he was delaying. There was always an excuse. At the same time he was feeling very incompetent and starting to doubt his abilities, doubt his intelligence. He had begun to describe himself as “just lazy” and “just useless,” labels all too frequently connected to increasing feelings of self-doubt.

“I feel that I am not motivated and I want you to motivate me, to complete the PhD,” he stated. He had hoped that his therapist could give him a single, simple technique—a magical motivational cure—that would somehow dissolve his procrastination and make him, once again, keen to study.

From a more traditional approach, Dave’s story could easily result in a therapist classifying him as having a chronic procrastination problem or, given his level of motivation and application, as being depressed. This, in turn, could lead to therapeutic efforts to eliminate the procrastination or treat the depression, possibly with medication. It would also be easy to wonder if Dave was pursuing the best goal he could and even to suggest, in light of his behavior, that doing a PhD was perhaps not in his best interests.

What is different about this goal-setting approach, and what puts it in the realm of positive psychotherapy, is what came to light during the early therapy sessions with Dave: His problem was not the *what* but the *why*. It was not *what* he had chosen as his goal (his PhD) that ultimately proved to be the problem but rather *why*—the reasons controlling his choice of this important pursuit.

THE *WHAT* VERSUS THE *WHY*

The importance of our personal life goals can certainly not be underestimated. Not only do they play a vital role in both our day-to-day and long-term well-being (Burns & Street, 2003; Street, 2002), they have been found to be pivotal in predicting our ability to find meaning and purpose in life, our drive to self-actualization and even our longevity (Burns & Street, 2003). Early pioneers of personal goal research concentrated on the specifics of the goals themselves. They were quick to find relationships between goal content and well-being, finding that individuals giving preference to intrinsic goals such as personal development and intimacy enjoy a greater degree of well-being than those who prefer extrinsic goals such as money, career achievement, and image (Kasser & Ryan, 1993, 1996). Thus came the often-cited finding suggesting that, above and beyond the need “to finance our survival,” money cannot buy happiness (Kasser & Ryan, 1993, 1996).

Today we know that it is not so much that extrinsic goals are unfulfilling but rather that a preference for extrinsic goals above and beyond intrinsic ones can be limiting (Kasser & Ryan, 2001). Someone who focuses attention on extrinsic goals above all else is more likely to be missing out on the rewards that intrinsic goals bring, by their very nature—rewards such as a sense of belonging, personal growth, connections with others, and emotional safety and security, or rewards that are intrinsically tied with the key facets of a nurturing environment so vital for lifelong development (Street, 2004).

Yet it is far too simplistic to believe that if we all pursue personal development and close relationships as a priority, we have conquered the link between our goals and our well-being. As with every psychological construct, there is always more to see when you look at what is driving the construct rather than the construct in itself. And so it is with goal setting. We have found that the motivations controlling goal setting and pursuit can be far more powerful than the goal setting and pursuit per se (e.g., Srivastava, Locke, & Bartol, 2001; Street, 2001, 2002). Intrinsic goals are valuable not just because of the intrinsic rewards that they promote but, moreover, because they are the goals most frequently controlled by intrinsic motivations. In contrast, extrinsic goals are often set and pursued under pressure from others (perceived or real), out of social insecurity and a desire to pursue social norms irrespective of their inherent meaningfulness (e.g., Sheldon, Ryan, Deci, & Kasser, 2004). Thus, it is not so much that “money won’t buy happiness” or even that a focus on self and important others will increase our well-being; rather, we have come to find that a focus on intrinsic motivations controlling goal pursuit can enhance well-being and positive behavior, irrespective of goal choice.

A therapeutic focus on the motivations controlling goal setting, rather than the goal setting itself, can help clients to discover, and frequently rediscover, intrinsic motivations. Intrinsic motivations ultimately foster a nurturing environment of personal belonging, emotional safety, and connections with others. Intrinsic motivations also encourage creativity and act as a guide towards self-actualization.

Once an intrinsic goal-setting focus has been established, clients can more easily and effectively turn their attention to focusing on pursuing goals in a way that promotes a sense of ownership, perceived success, and ongoing mental health. For example, an intrinsic motivational focus encourages goal framing in terms of approach rather than avoidance. The intrinsically motivated individual is aiming *toward* intrinsic rewards rather than *avoiding* extrinsic failure. Research has identified strong relationships between mental health and an approach focus on goals (Elliot & Church, 2002; Stoeber, Stoll, Pescheck, & Otto, 2008). Individuals who aim to gain something, such as increased confidence, are not only able to experience greater success, they also have significantly greater well-being than those who are trying to avoid something, such as social anxiety. Similarly, an intrinsic motivational focus encourages individuals to concentrate on process rather than outcome (Burns & Street, 2003; Street, 2004). A focus on the process of heading toward a goal is a focus on the day-to-day living associated with goal pursuit. In contrast, a focus on an outcome that has not yet been obtained can lead to a neglect of the ongoing process of daily decisions and actions.

UNDERSTANDING THE PROBLEM

Given this, I needed to explore the psychological assessment of Dave and the therapist’s choice of intervention. The therapist could easily have decided to focus on Dave’s choice of

goal or the many expressed reasons behind this choice. I asked how the process of developing an appropriate and personal therapeutic journey came about.

The therapist described how Dave's understanding of his problem unfolded within the safety of the therapy session. "Once we started to talk, Dave became more and more aware that there were more underlying issues here, issues that were more than just about procrastination. There was the question of ownership of the PhD, the question of why he was doing it, what the current drive was, what the initial motivation driving his choice to begin a PhD was." The therapist expanded: "We looked at some of Dave's external sources of stress in terms of how he perceived the consequences of his not doing well. What did potential failure, or even potential mediocrity, mean to him? What did it mean to the people he was in contact with?" As Dave began to answer these fundamental questions, it became clear that he strongly believed that others judged him on the basis of his ability to achieve academic success. Consequently, he now feared that others perceived him as a failure and a disappointment. In fact, Dave went on to describe his parents' expectations of him as being very low. "It is as if they already believe I have failed," he stated. Dave appeared to be on a lifelong journey to prove his parents wrong. He had excelled in school, in his undergraduate studies, and now he had taken on a PhD in a continued bid to seek parental approval that remained unforthcoming.

To compound the problem, the PhD project had been conceived by a supervisor, not by Dave himself. This further led Dave to believe that it was not really his, that there was no intrinsic connection to the project. Hence, it was hardly surprising that, once under way, Dave did not feel the project was something he was motivated or even able to pursue.

Dave was struggling with a goal that was largely controlled by extrinsic motivations: The need for parental approval and the pressure of his supervisor were particularly salient. However, pressure from his long-term girlfriend to finish his studies and marry was also on Dave's mind, as was a perceived pressure from others in the university. The pressure had become unbearable for Dave, and he now resided in a fearful limbo, an inactive state where he was caught between a fear of failure and the imagined disappointment of others but also a fear of success and a belief in the continuation of unmanageable pressures throughout an increasingly challenging career.

HOLDING ON TO THE GOAL

The therapist had certainly challenged the rationale of Dave's continued pursuit of his studies. "That was one of the first things I asked," the therapist told me. "However, Dave believed that there were too many consequences he had to face if he didn't continue, even though he knew some of these consequences were irrational." The biggest anticipated consequence was that Dave thought he would let himself down. As Dave himself said, "If I start something, I want to finish it."

So it was that even though Dave was not enjoying pursuing his goal, the consequences of letting it go, in terms of others' disapproval and his negative self-judgments, led him to believe that giving up was not an option. Dave's own cost-benefit analysis about his PhD offers a timely reminder about the mixture of costs and benefits associated with any decision-making process. All too often, clients can get caught up in trying to make a "right" decision with regard to an important goal domain, when the reality is that any choice contains both

positive and negative consequences. It is perhaps more effective to think of choices in terms of their impact on continued personal development rather than in terms of good versus bad (Yapko, 2007). With Dave determined to maintain his goal choice, the therapist turned his attention to the motivations controlling Dave's ongoing goal pursuit.

BUILDING INTRINSIC MOTIVATION

Despite Dave's insistence that he continue with his studies, the external pressures that he perceived to be present were preventing him from making any progress. Thus, he was caught in a distressing and stressful state of dissonance, his thoughts and behaviors in conflict with each other. After the first two sessions, both therapist and client spent the next eight weeks gradually refocusing Dave's attention on intrinsic motivations. This gradual shift ultimately led to the unearthing of a dormant but powerful internal drive in Dave.

"When I got a sense that Dave did indeed have internal motivations to finish his studies, I got a sense of his very real desire to complete the project that he had wholeheartedly begun four years previously," the therapist said happily. "I could also see that this goal really meant something to his sense of self-worth and self-development."

Through the therapy sessions, it had become increasingly apparent that the external factors were very concrete for Dave and thus had been easy to quantify, identify, and focus on. His girlfriend wanted him to finish and start a family, the scholarship had its requirements, the lecturers wanted him to finish and work as an academic, and so on. Dave had become an expert in understanding his extrinsic motivations because it was these that he so often communicated to others and also to himself. It was a timely reminder of the power of language to set priorities both internally and externally.

To begin the process of rediscovering Dave's intrinsic motivations, subsequent therapy sessions focused on two priorities: the process of achieving ownership of the PhD and a strategy for goal pursuit. Dave needed to discover that a sense of goal ownership arises from a recognition and acceptance of intrinsic motivation concerned with self. He needed to develop the belief that the process of the goal pursuit was something that was an integral part of his self-development.

The therapist began to challenge Dave's perception of success and the meaning of success when he asked his client, "What could be good for you in terms of achieving this PhD? How could doing the PhD be beneficial for *you* rather than for your lecturer, your girlfriend, or your parents?"

At first, Dave had trouble answering questions such as these, but over time he began to see more and more positives in terms of his own journey in life and in his study. During the course of therapy, the therapist helped Dave break the PhD up into all its components in terms of personal satisfaction, personal development, and increased connections. As collaborators, both therapist and client used a whiteboard to list these components and addressed each task with such questions as: "What could be stimulating, rewarding about this part of the process?"

As he went through this detailed process, Dave realized that he had originally been motivated by a belief that the PhD was indeed a personal challenge. Moreover, he had originally seen it as an exploration into an area that he had begun to know well, an adventure for himself. However, as time passed, he had become disillusioned. In reality, the topic was foreign to him and he had not felt a connection. Now Dave was learning that the unfamiliarity of the topic made the PhD a different kind of challenge. In fact, his lack of knowledge in the area was a challenge in itself.

Dave was particularly taken by a metaphor the therapist used to illustrate his point. “If we had a video game and you knew exactly what was going to happen in this game and you played it, how long would you enjoy the game?” the therapist asked.

“Not very long, because I would get bored” came Dave’s reply.

“So,” the therapist suggested, “now imagine that the game has a novel component ensuring that you will not know what is going to happen next. How would you see the game now, what would you do?”

“I would just play the game. I would just work it,” Dave replied. In answering the metaphorical question, he began to find the answer to his own questions concerning his intrinsic motivations toward his study. He could try to explore all this knowledge that he did not know about and try to discover it.

Over the next few weeks, Dave explored all the component areas that he had very little knowledge about and started to develop goals that he wanted to achieve in each area. Rather than see the PhD as something he had to finish, he began to see it as an ongoing process resulting in an accumulation of stimulating experiences and increased wisdom. He broke the work on his literature research up into challenges, into each thing that he wanted to discover, into little compartments, and applied himself to it more intensively.

By making more specific concrete goals and also learning about the elements of goal pursuit, Dave was motivated with a desire to satisfy his own inquisitive needs and to have ownership over the project, his project. This shift in thinking also resulted in him increasingly focusing on the process of studying rather than on the outcome of “just having to get this done.”

DEVELOPING A FOCUS ON INTRINSIC REWARDS

Another important aim of therapy was to encourage Dave to focus on the intrinsic rewards he could realize once he had completed his goal. Dave was frequently challenged by his therapist with questions such as, “What do you think will be the biggest value for you personally in terms of completing your PhD?”

Dave said, “The most important thing will be that I have learned a lot of things about theory that I did not have any previous knowledge about.”

This perceived outcome then became an intrinsic motivation in itself. Dave could see his goal as something that would benefit him in a lasting and personal way. He perceived it as something that would develop his intellect and his academic experience. Moreover, he began to see his anticipated rewards as greater goals, above and beyond the completion of his studies. He realized that the goal was in the process of the study, in the knowledge he could gain, and all that that meant. It was not in the number of pages he could write each day or the number of papers he needed to review. He examined each part of the “process” of study and tried to define it in terms of his greater goal of self-development and personal wisdom.

As Dave was an athletic person, he found insight with the use of another therapeutic metaphor, this time involving sport. “If you want to run a marathon, you have to achieve a number of things to reach that goal,” the therapist suggested. “You have to access resources. It is good, for example, to know what kind of shoes you need, why they are good, how they help you. You need to know what sort of clothing is appropriate and engage in the act of buying it. What kind of diet will you need? This information may not seem relevant to running a marathon to most people, but when you are involved in planning for a marathon,

it becomes a crucial part of that process. Discovering all that is, in itself, a learning process. You need to do the same for your study. You have the desire to have more knowledge about this area that you have very little knowledge of. What are the resources you need to access this knowledge?”

All this time Dave had known *what* he had to do but had lost sight of *why* he was doing it. He had never thought of his PhD in terms of *why* he was doing each task. He just thought of it as a mechanical predetermined process. The consequences of such a superficial and mechanical approach to such an important life goal had resulted in a lack of connection to the goal in any personal terms. When questions such as What are the purposes of these literature searches at the library? Why do you spend the time there? came up in therapy, Dave had to think about the reasons behind the process, not just the mechanics of how to get there.

STARTING FROM THE BEGINNING, RECLAIMING OWNERSHIP

When Dave sat down for the beginning of his next session, he was asked to further increase and explore his motivations by revisiting his studies from the very beginning. “I want you to go back and imagine you are starting again, literally starting from scratch again,” the therapist challenged. “Only this time, ask yourself: How would I do this again? How would I start doing this whole process, and why? What is important about each small step? What does it mean to the goal of the PhD but moreover to my personal and professional development? The goals for the PhD may be the same, but how can I achieve those greater goals of self-development and self-actualization?”

For the first time, Dave reassessed his important life goal as something that he wanted to achieve for himself. He started to discuss new ideas, things that would move outside of the perimeters of what was expected of him. Finally, the PhD had become something he owned, something that meant something to him. Moreover, he started to assess his progress in terms of what he had learned and how he had developed rather than by how near the end seemed.

A final significant point in the therapeutic process was reached when Dave mentioned that he was having difficulty understanding a lot of the statistics he was using. “I don’t really know what the computer software is doing or the reasons behind my choice of particular statistical tests,” he stated. Certainly difficulties such as these are not uncommon. Many students do not fully understand the workings of the statistical software they use; however, they are satisfied that the computer programs work accurately and accept the results. Dave was different. He was bothered that he did not know exactly what the statistics were doing to the data, exactly how the math worked. So the therapist suggested that he take a course in statistics specifically aimed at his subject area. Initially, Dave was extremely resistant to the idea. “I can’t do that,” he said. “It’s only going to take me even further away from the task of getting this PhD written up.” However, after some discussion, Dave reluctantly agreed to take a weeklong course that was offered by the university.

When Dave arrived at his next therapy session following completion of the course, he was animated and full of enthusiasm. “The course was fantastic,” he announced. “It was so very useful. I have actually learned a new skill. I have taken in a whole lot of knowledge that will possibly serve me for the rest of my professional life.” And so it was that Dave began to realize the importance of paying attention to his personal growth. Finally, he was viewing

the PhD in a different light. Rather than it being an end in itself, he saw it as an opportunity to learn for today, tomorrow, and possibly the rest of his life.

PROCESS OVER OUTCOME

By the time Dave ended his 10 sessions of therapy, he was experiencing a new enthusiasm for his studies. Not only was he making progress again and feeling motivated, but he was also embracing the PhD with a new sense of creativity and purpose. He had approached his supervisor with new ideas that were met with delight and encouragement. He read around his subject area, branching out if he found something of particular interest. He had broken up his work into manageable goals and was writing steadily, and well. He was gaining new insight into his studies and also into himself.

Some four years have lapsed since Dave sought assistance from the university counseling service. You may be curious as to whether he successfully completed his PhD or not. While most case studies traditionally have a follow-up, this case study does not. Dave was not followed up, and he has not been in touch since his therapy ended. We do not have the *what*, the ultimate conclusion or extrinsic goal for Dave's PhD. However, this not knowing provides a fitting outcome for this particular story. It emphasizes the importance of the process (the *why*) over and above the outcome (the *what*) and the fact that in many senses, the outcome of goal pursuit often does not matter at all. Curious as one may be about it, it is certainly not needed to complete this chapter. Whatever the final outcome of Dave's degree, we can feel a sense of success in knowing that he left therapy with renewed enthusiasm, a strong sense of ownership over an important life goal, and a real awareness of the importance of lifelong intrinsic motivations.

Putting It into Practice

The processes that were helpful for Dave may also be relevant for clients seeking to attain any important life goal, whether that is an avoidance goal (I want to lose weight, stop smoking, be less depressed, etc.) or an approach goal (I want to achieve a degree, have a good relationship, be happier, etc.).

1. Avoid counseling on the "apparent."

Given the conflict Dave initially presented with, it would have been easy and, in some ways, seemingly logical to advise that he give up his PhD and thus reduce the conflict. However, this might have done him a disservice and not allowed him to acquire some essential goal-setting skills that will, it is hoped, accompany him through life. Moreover, it may have left him feeling that he had failed in some important way and had not only let others down but had ultimately disappointed himself.

2. Help the client focus more on intrinsic goals.

While Dave was focused on the extrinsic goal of attaining a PhD, and all the expectations accompanying that goal, he was less aware of the intrinsic goals that are so vital for our lifelong well-being. Ask your clients not just *what* they want to achieve but *why* they want to do so; often this will open up opportunities to explore more intrinsic goals.

3. Help build intrinsic motivation.

Ask questions such as these: What could be good for you in terms of achieving this goal? How could doing this be beneficial for you? Such questions help focus on and build the intrinsic motivations in the client's goals pursuit.

4. Break the goals down to the components.

Breaking goals down into their specific component parts and writing them up on the whiteboard helped Dave reduce a daunting objective to easily attainable components and also allowed him to examine the intrinsic motivations and rewards for each step. This might be facilitated with questions such as: What could be stimulating or rewarding about this part of the process?

5. Develop a focus on intrinsic rewards.

Asking Dave "What do you think will be the biggest value for you personally in terms of completing your PhD?" drew his attention to his greater goals and his personal intrinsic rewards.

6. Help clients claim or reclaim ownership of their goals.

Simply put, if we own our goals, they are easier to attain than if we feel they are set by others' expectations. Ownership may be helped with such questions as: Imagine you are starting again from scratch. How will you do it this time, and why? What is important about each small step? What does it mean to your goal but moreover to your personal and professional development?

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CHAPTER 5

From Here to Where You Want to Be

Building the Bridges with Hope Therapy in a Case of Major Depression

Jennifer S. Cheavens and Amber M. Gum

MEET THE CONTRIBUTORS

Jennifer S. Cheavens, PhD, completed her doctoral degree in clinical psychology at the University of Kansas in 2002. During her time there, she trained under the tutelage of Dr. C. R. Snyder, the academician behind hope theory. She also became a huge college basketball fan. Since leaving Kansas, Jennifer completed a predoctoral internship and postdoctoral fellowship at Duke University Medical Center. She remained at Duke as an assistant clinical professor until the fall of 2007, when she joined the faculty of the Psychology Department at the Ohio State University. There, Jennifer conducts research on constructs that facilitate psychological treatments (e.g., hope, forgiveness) and complicated psychological treatments (e.g., personality disorders, judgmental thinking). She teaches a positive psychology course at The Ohio State University.

Amber M. Gum, PhD, completed her doctoral degree in clinical psychology from the University of Kansas in 2002. A life-changing experience occurred while there, when she completed a traineeship with older adults in a nursing home. Many of these elders were inspiring, maintaining hope despite daunting obstacles, while others suffered from hopelessness and depression. Based on these observations, Amber sought Dr. Rick Snyder's mentorship to apply hope theory to work with older adults. After leaving the University of Kansas, Amber completed a psychology internship at the Palo Alto Department of Veteran's Affairs and a postdoctoral fellowship at University of California, San Francisco. Both focused on psychotherapy with older adults. Since 2004, she has been an assistant professor in the Department of
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improve services and increase the availability of evidence-based goal-focused psychotherapies for depressed elders.

Mike had responded to a flyer he had seen stapled to a telephone pole: “Having trouble reaching your goals?” and “Feeling down?” Mike silently answered yes to both of these questions and tore off the slip of paper with the name of the study and the phone number. When he arrived for his initial assessment, he looked like any other young man that you might see in a midwestern U.S. city. He had a worn baseball cap pulled down over his eyes and was dressed in baggy jeans and a sweatshirt. He was in his early 20s and working a job that paid the bills but gave him little else in his life.

Feeling lonely, isolated, and incapable of making connections to others in his life, he said, “I just don’t seem to fit in with other people of my age and feel I have given up on trying to be around other people in any meaningful way.” Then he added, “I’ve never had a serious relationship with a woman and am becoming convinced that this type of relationship is not possible for me.” During this conversation about romantic relationships with women, he avoided eye contact with me and silently pointed to the acne scars on his face.

Mike looked and spoke like someone who had given up on a future that held any hope or meaning. Keyes and Lopez (2002) proposed a typology whereby individuals who are high on a scale of mental illness (in Mike’s case, a major depressive disorder [MDD] diagnosis) and low on a scale of mental health or emotional well-being can be described as floundering. This description may best capture Mike. At the time he presented for treatment, he could not find meaning in his own life pursuits or in society more generally, did not have relationships that he considered warm and trusting, and did not accept or like himself.

Was it possible for someone like Mike to increase his level of hope? Could hope make a difference in how he was currently experiencing his life? And, if so, how could he employ hope therapy to improve his lot in more helpful and hopeful ways?

THE BACKGROUND OF HOPE THERAPY

In 1989, Rick Snyder proposed his theory of hope upon which this chapter and the corresponding treatment is based. Prior to this instantiation of hope theory, however, there were myriad examples throughout mythology, literature, and anecdotal stories of the role that hope plays in psychological health and the psychotherapy process. The *nature* of the role of hope in these psychological processes has been a long-debated topic. For example, one of the original stories of hope was the infamous Greek myth of Pandora’s Box. According to the recounting of this tale, hope was the only attribute that did not escape the jar sent by the gods to punish humanity. Some authors have argued that the myth of Pandora portrays hope as the greatest evil meant to harm humanity with prolonged

torment (e.g., Nietzsche, 1878/1986). Other authors, however, have argued that the myth portrays hope as the “one good little sprite” left to soothe humanity (e.g., Menninger, 1959, p. 483).

In the late 20th century, theorists began to link hope to the goal pursuits in which people engaged (e.g., Frank, 1975; Menninger, 1959) as well as the experience of meaning in such pursuits and struggles (e.g., Frankl, 1946/1992). Here, hope has a target: the goals that a person desires to obtain—goals that give meaning to a person’s life. Thus, in the academic literature, one conceptualization of hope became the link between where a person is in the present moment and where she or he wants to be in the hoped-for future. Building on this conceptualization of hope, Snyder (1994, 2002) defined hope as a type of thinking that incorporates (a) the belief that one can generate ways to reach a desired goal (pathways) and (b) the belief that one can generate and maintain the necessary motivation and energy to reach a desired goal (agency). As such, according to the theory, individuals with high hope are able to successfully build a bridge from where they are to where they want to be (i.e., achieve personally meaningful goals), because they are equipped with a belief in their own abilities to maintain goal pursuits. These high-hope beliefs are theorized to lead to behaviors that are directed at actively striving toward goals as well as generating many ways to navigate the obstacles to those desired goals. In fact, research has supported this contention: Several empirical investigations demonstrate that individuals with high hope are successful in many various domains, such as academics, athletics, and both physical and psychological health (for a recent review, see Rand & Cheavens, 2009).

THE NEED FOR HOPE-BASED TREATMENT

Thus, theory and research both bear out the contention that hope is beneficial for individuals, at least using the definition of hope provided to us by Snyder (1994, 2002). There are many people, however, who are not high in this type of hopeful thinking. Such individuals might have difficulty defining exactly what they want in their futures (poorly defined goals), thinking of ways to reach their goals (low pathways), and/or believing that they will be able to move forward toward their goals (low agency). For just about any struggle that a client is facing, the inability to achieve desired goals is likely to be involved.

Take, for example, the almost ubiquitous goal of developing and maintaining an intimate relationship with another person. There are at least three potential ways in which low hope could contribute to the inability to reach this goal.

1. Low-hope persons may not be able to clearly articulate what they are looking for in a partner. In this way, individuals with poorly defined goals will have difficulty moving forward in finding a satisfying intimate relationship because there will not be a clear indication of progress toward the ultimate goal. If you do not know where you are going, it is extremely difficult to know whether you are headed in the right direction.
2. Low-hope persons may be able to define their goal but be unable to think of viable routes to reach this goal. For example, they may know exactly what they are looking for in a partner but have no ideas about ways to meet such a person or how to move a relationship from a casual acquaintance to increased intimacy.

- This type of presentation would be indicative of someone with low pathways thinking.
3. Low-hope individuals might be able to define their goal of developing an intimate relationship and subsequently might be able to generate several potential pathways to doing so (e.g., asking friends to set them up, using online dating services, asking a casual acquaintance out on a date). These individuals, however, might not be able to muster any belief in their motivation to use these pathways. For example, although they can develop the plan to ask a single coworker out on a date, they do not think they would be able to do that because it would be too embarrassing or the co-worker is likely to decline the offer, which would be intolerable.

It is not difficult to imagine that for any goal, a deficit, or perceived deficit, in any of these three areas would hamper a person's ability to move toward a desired future state.

As you might imagine, based on these examples, low hope is associated with increased depressive symptoms and negative thoughts (Snyder et al., 1996, 1997). This is a consistent finding across a number of populations, including college students, clients in psychiatric treatment, and medically ill individuals (Cheavens, Feldman, Gum, Michael, & Snyder, 2006; Snyder et al., 1997; Stanton, Danoff-Burg, & Huggins, 2002). According to hope theory, negative emotions result from disruptions in goal pursuits, and past experiences in goal pursuits (successes or failures) influence the emotional tone and cognitions with which current and future goals are approached (Snyder, 2002). The theory states that individuals with several goal-failure experiences are likely to approach new goal situations with negative emotions, passive problem-solving stances, and low self-confidence. It is for these individuals that hope therapy was initially developed.

DEVELOPING A HOPE-BASED TREATMENT

Based on this theoretical account of hope and the accompanying empirical findings, we began working with the idea that there might be some way to teach low-hope individuals to increase their hope and help them to garner some of the rewards available to high-hope individuals (e.g., higher self-confidence, fewer depressive and anxiety symptoms, better relationships with others). At the time, the hope research being conducted was primarily a measure of the benefits that were evident in the lives of individuals with high hope. Thus, these research efforts were informing the age-old question stemming from the "gifts" in the jar opened by Pandora. Based on years of scientific research, it appeared that hope, at least as defined by Snyder and colleagues, was a *good* thing to have. From these findings, however, stemmed a second fundamental question: Can we teach people with low hope to think and act in ways that will garner them the same bounties as their high-hope counterparts?

To answer this, a group of clinical researchers at the University of Kansas (including both authors of this chapter) put their heads together. How would one go about increasing hopeful thought? Could a therapist help a client to become more hopeful? As a starting point, we turned to McDermott and Snyder's book, *Making Hope Happen* (1999), written for lay readers as a manual to increase hopeful thoughts and help individuals move toward their goals. We translated the manual's lessons of hope (e.g., goal setting, problem solving, encouraging self-talk, motivation) into an 8-week group protocol. In a small pilot study

($N = 32$ who completed the groups), we tested our newly developed manual and found that it was possible to increase hopeful thoughts and, in turn, decrease the symptoms of depression and anxiety (Cheavens et al., 2006). Through our work in developing the manual for this hope-group treatment and in conducting the first pilot study, we were able to meet several wonderful people who increased hope in their own lives. Mike, who responded to the flyer on the telephone pole, was one.

THE ASSESSMENT

Mike participated in a Structured Clinical Interview for the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* Axis I Disorder (First, Spitzer, Gibbon & Williams, 1995) with me (JC) to determine whether he met criteria for any psychological disorders. He also completed a written assessment battery that included questionnaires to assess symptoms of depression and anxiety as well as measures of meaning, or purpose in life, and self-esteem, including the Hope Scale (Snyder et al., 1996).

In the context of the pilot study, we wanted to include measures that allowed us to demonstrate three things.

1. Our central question was whether we could impact someone's level of hopeful thinking with a time-limited group intervention.
2. We wanted to demonstrate that changes in hope corresponded to changes in symptoms of psychopathology. That is, we felt that it was important to show that becoming more hopeful was linked to becoming less depressed and anxious.
3. In some ways most important to us, we measured indices of flourishing or positive psychological functioning.

Many treatments work wonders in decreasing symptoms of depression and anxiety, and we were not interested in re-creating the wheel with this hope intervention. Thus, we wanted to know whether we could help people (a) find more purpose in their lives and (b) feel more confident about who they were as individuals.

Based on this interview, Mike met criteria for a current episode of major depressive disorder (MDD), and this was his third, recurrent episode. From his responses to the questionnaires, Mike was classified as low hope (low on both the pathways and agency subscales); he had elevated depressive and anxious symptoms; and his self-report indicated a significant lack of purpose in life as well as extremely low self-esteem.

DEVELOPING GOALS FOR THERAPY

Mike was randomized to the experimental treatment condition in the research protocol, and we moved forward with setting goals for the therapy. We aimed to use the lessons of hope to move each individual closer to his or her personally defined goals. All clients, including Mike, were encouraged and prompted to define therapeutic goals for themselves in the first group meeting.

At this meeting, as the coleaders of the group, we (JC, AG) asked each client to talk with the group about what they wanted in their lives that they were not yet able to achieve. Mike was somewhat hesitant about sharing his therapeutic goals with the group. He continued to avoid eye contact and mumbled something about meeting more people. With some gentle encouragement by us and other group members, by the end of the first two-hour group session, he was able to articulate three goals related to interpersonal relationships: (a) he wanted to be able to talk with people more freely, (b) he would like to go on a date, and (c) he would like to be able to speak with people at work without questioning and berating himself before and afterward. In our eyes, this commitment to interpersonal goals in a roomful of strangers was the first step in moving toward hope. We commented as such to Mike and the group, and praised him for this important accomplishment.

Not all clients are able to articulate such specific goals by the end of the first session. Some identified general goals, such as “I want to be less depressed” or “I would like more joy in my life.” Over the following weeks, we assisted these clients to more concretely define their goals in terms of specific behavioral approach outcomes, asking questions such as “If you had more joy in your life, what would that look like? How would I know you were more joyful?” Given that this treatment is closely aligned with traditional cognitive-behavior treatment (CBT) interventions, most therapists will be familiar with this type of successive approximation in goal setting.

CLIENT RESOURCES

As it was clear from the outset that the positive psychology construct we would be targeting in treatment was hope, there was little work to do in terms of how to match Mike’s strengths with the construct to be woven into treatment. It is our belief that increasing hope can be beneficial to almost all clients who present for psychological treatment, given that pursuing goals is universal to humans. Helping clients to either tap into or generate agentic energy toward goal pursuits and viable pathways toward valued goals is a component of most empirically supported treatments. In this hope-based treatment, these types of strategies are explicitly made the focus of treatment, and the targets of treatment are changed from symptoms to strengths.

Despite Mike’s presentation during the assessment and initial group session, there were several strengths that were apparent just beneath the surface. For one, Mike was willing to believe in his treatment team and the therapy that we were offering him. Thus, although at the time he had very little belief in himself and in others in his immediate environment, he had not given up on everybody and everything. This was evident in the way he engaged in homework assignments, responded to gentle pushes from us and other group members, and shyly smiled when given praise. This ability to hold onto trust, hope, and faith that things might be able to be better at some point seemed to be a real strength. Similarly, Mike was incredibly hardworking and conscientious. Even though his mood was extremely low (including his self-reported energy and motivation), he continued to go to work and do the best job that he could do. We quickly saw that this transferred to the work we asked him to do in therapy. Thus, although he had given up on goals related to pleasure and self-fulfillment, he maintained a level of committed behavior that was admirable. We believed that if we could transfer that strength and related skills from his “should” activities to his “want to” activities, we might be able to make some real progress with Mike in a short time span.

We consistently encouraged his efforts by pointing out the relations between these skills and his goals. For example, at one point in group, Mike was reporting on a task he had accomplished at work, and I (AG) said to him, “That sounds really hard. I know that if you can get that done, you will be able to ask someone to join you for coffee!”

HOPE-BASED THERAPY AS OPPOSED TO OTHER TREATMENTS

It should be stated from the outset that we felt quite confident that Mike would likely have responded to some form of traditional treatment for MDD, including but not limited to options such as CBT, problem-solving therapy, and/or psychopharmacological management. He was, however, already taking medications, and this course of treatment alone had not yet alleviated his symptoms or bolstered his mental health. He had an extremely negative internal self-dialogue that likely would have responded well to a cognitive intervention focused on the symptoms related to this type of self-talk. An intervention that included thought records, an explanation of how thoughts are tied to feelings and behaviors, and behavioral activation would likely have reduced his depressive symptoms significantly. Thus, we are not making the argument that a hope intervention would be the only, or even the primary, manner in which to work with a client such as Mike.

We believe that hope therapy is one potentially viable option for two reasons.

1. Most important, moving the focus of treatment from deficits (of which Mike was acutely aware) to strengths may be enough of a paradigm shift for some clients that it “wakes them up” to the potential for new learning.

One way to test this potential paradigm shift is to try to explain to colleagues that you would like to embark on a mission to increase mental health in individuals with no diagnosable mental disorders—“languishers” according to Keyes and Lopez’s (2002) typology. Your colleagues are likely to struggle as they try to imagine what such an intervention would look like without attempting to *reduce* some sort of symptom or pathology.

2. We believed that Mike and others would benefit from participating in a group with other individuals, both with and without diagnoses from the *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (American Psychiatric Association, 1994), as they worked toward their own goals.

In this group context, all participants are able to utilize their own strengths to help others move forward and also are provided the opportunity to develop new or underutilized strengths through modeling and interactions with others. In this vein, one woman in Mike’s group was struggling with finding meaning in her life after she had lost a tremendous amount of weight. She had started her weight-loss journey with the belief that when she reached her “perfect” size, everything else would be “perfect” too. Thus, she was struggling with how to set new goals that would imbue her life with a sense of purpose or, alternatively, how to approach the already present goals with a purposeful stance. Mike, who had no trouble setting goals but had extreme difficulty moving toward these goals, was able to assist this woman by asking questions that pointed her to where she wanted to go. In turn, she was able to help him apply his determination to the goals he wanted to approach, using her weight loss as an example of going forward in the

face of what seemed impossible. For both of them, helping someone else brought forth already present strengths, and working with someone who possessed complementary strengths helped in learning new skills.

THERAPY TARGETS

In terms of hope theory, Mike presented with extremely low agency and low pathways. At the beginning of therapy, he did not believe that he could meet goals he set for himself and experienced a lack of energy when thinking about his goals. Based on his overall low hope score, we considered that Mike's individualized work in the therapy group would need to focus on increasing his energy and motivation in goal-pursuit situations and on problem-solving skills and creativity/curiosity—particularly because he felt so hopeless about more obvious routes to his goals. Being able to develop new and unique routes to these important life goals might move Mike forward by circumventing his “I know that won't work” attitude toward previously attempted routes.

Most of Mike's goals were interpersonal in nature. Somewhat surprisingly, he was convinced that he was “not good” with people and indicated that he had a hard time developing relationships and friendships. I say “surprisingly” because everyone involved in the study, from the undergraduate research assistants, to the therapists, to the other group members, uniformly reported liking Mike. He had an endearing quality about him that seemed to make other people feel good in his presence. Thus, we wanted to build on his interpersonal skills, help him acknowledge these skills without being dismissive of them, and utilize these skills to move toward his interpersonal goals. By the time the group concluded, Mike wanted to be able to approach potential friends and dating partners with confidence.

INTERVENTION

For Mike, and all the other clients in the group, we used the treatment protocol described by Cheavens et al. (2006). This treatment was designed as an eight-week group therapy protocol with each of the sessions lasting two hours. The group was closed, meaning that once the group started, no new members were admitted. Mike's group had seven members, and group size for the other groups ranged from four to eight participants. Over the course of the eight weeks, the group covered skills related to goal setting (e.g., defining subscales, stating goals in approach terms, building success experiences into goal pursuits), pathways building (e.g., generating routes to a goal, recognizing potential goal obstacles, enhancing effectiveness of primary pathways), and generating agency (e.g., self-empowering statements, self-care exercises such as sleep and nutrition lessons, garnering energy from the group).

After the first meeting, each subsequent session began with an individualized recounting of the homework assignment from the previous group meeting. This was followed by the introduction of a new skill related to hope, and each group concluded with every member developing a personalized homework assignment that synthesized the skill lesson with his or her own goal(s). Thus, although we utilized a structured protocol, the individualized goal setting and homework made the protocol flexible enough to apply to all the group members.

Notably, the groups were diverse in terms of age, race/ethnicity, and personal challenges, ranging from young adults like Mike, to middle-age individuals seeking more meaningful careers and family relationships, to older adults dealing with caregiving and other aging issues.

In the first weeks of the group, each member was asked to choose something that was an important goal to him or her *and* in which progress could be demonstrated over the course of eight weeks. We told group members that the skills we would be teaching and/or refining over the course of the group would be helpful for larger goals as well. However, for the purpose of the group, we wanted all members to have the opportunity to see the skills in action and experience some degree of desired change. For example, Mike had the goal of meeting new people, making friends, and developing a relationship that would eventually result in marriage and a family. We encouraged him to set his group goal of going on dates and initiating meetings with friends over the life of the group, with the expectation that the skills learned to accomplish these goals would generalize to the larger goal of getting married and having a family and close friends in his life.

During the homework development section of the group meeting, we encouraged group members to troubleshoot potential problem areas in completing the homework for the coming week. For example, Mike decided that, in order to increase his ability to pursue goals energetically, he would notice one positive thing about himself or his behavior each day and incorporate that observation into his self-talk. Everyone agreed that this was a fantastic homework assignment, but before sending Mike off to complete this task, we helped him to anticipate and troubleshoot potential obstacles.

I said, “Mike, I think that sounds really great. I would love to see you do that this week. Can you think of anything that might get in the way or make it hard for you to get that done?”

Mike thought for a minute and responded, “No, I think I’ll be able to do that.”

I smiled in encouragement at his commitment to completing the homework assignment and continued with the line of questioning. “I agree. I think you will be able to do it. I wonder, though, if there might be things that make noticing all the good things about yourself harder when you are at home or at work.”

Mike thought for a minute and then answered, “Well, I might not be able to come up with different things I like about myself every day.”

A group member chimed in, “Do they have to be *new* things every day?”

In response to this, I looked quizzically at Mike. “That’s a good question. I don’t know. Mike, do you think they need to be new things each day?”

In this way, individualized homework assignments were generated and then refined until potential obstacles had been identified, and participants, with our help and the help of their fellow group members, had thought of ways to get around such obstacles, should they arise.

One of the group activities that proved to be most useful for the group members and most inspiring for us as the group leaders was the goal-mapping project. Members were asked to generate some form of written or otherwise tangible representation of the process of going from where they were currently located to where they wanted to be in eight weeks. We raised this project with the participants at approximately the second week of the group, and we asked them to bring the project in at one of the last two group meetings. Thus, this project was cumulative in that it incorporated every lesson and skill covered in the group.

At the last group meeting, Mike brought in a large piece of poster board. At the top, there was a photograph of Mike sitting alone and looking sad. The writing on the poster board said, "I am here." At the bottom of the poster board, there were two pictures, both cut from a magazine. One was a picture of a very attractive young woman and the other was a picture of a group of young men and women sitting outside on a patio in the sun. Mike had taken photographs of himself smiling and appearing confident and pasted those pictures next to the attractive young woman and the group of young people having fun. The caption said: "Goal—to get here." There were several arrows connecting the picture at the top of the poster board to the pictures at the bottom. Each arrow represented a pathway or route from where Mike was beginning to where he wanted to end up. One arrow said: "Invite coworker to coffee" and another said: "Register for social networking Web sites." Some arrows had blockades drawn through them with caveats such as "Thought—No one will look at my web profile." Next to each of these obstacles were ways to move through and continue on the path to the goal. Mike had taken each of the lessons we had provided about hope and created a hope wall hanging. Each of the other group members presented their goals in creative and wonderful ways that went beyond any of our wildest expectations.

OUTCOME

At the end of the eight weeks of therapy, Mike had made significant progress. He had asked a coworker to go have a cup of coffee or watch a sporting event after work on several occasions. He felt much better about his ability to initiate friendships with others and was hopeful that several of these relationships would continue to deepen into close friendships. In terms of dating, he had joined an Internet social networking site and had been exchanging information with two women by the time the group ended. He had also joined one organization that matched his interests in the hope that participation in such events might be an entrée into meeting people with similar interests. By the end of the group, Mike's hope, self-esteem, and purpose in life scores had increased while his depressive and anxiety symptom scores had decreased. His self-esteem and purpose in life scores were still lower than we would have liked at the end of the group, and it is possible that, with a longer treatment protocol or an adjunctive individual intervention, change in these areas would have been more dramatic. Nonetheless, as with all other group members, Mike had developed specific pathways and agency strategies to continue pursuing his goals after the group ended. He was making significant progress, which was fueling his agency to continue pursuing his goals.

We followed up with Mike three months after he completed treatment. He had maintained the gains made in therapy. He was continuing to use the skills that he had learned in the group to move toward his goals, and his social interactions had been steadily increasing since the group ended. He reported having friends for the first time that he could remember. While he still had trouble approaching women, he was thinking about seeking some sort of adjunctive treatment to address his continued anxiety in this area. We interpreted this as a sign of hope: Mike was able to identify his anxiety as an obstacle to his goal and had generated ways to deal with this obstacle through additional treatment. He was willing to use this pathway without getting mired down in his former "why bother" or "it will never work" thoughts.

LESSONS LEARNED

After our experience with this hope-based group intervention, we consider that hope therapy has application for a range of human struggles and that individuals with low hope can learn effective strategies to increase their hopeful thinking, goal-pursuit behavior, meaning, and self-esteem while reducing symptoms of distress. With assistance, individuals can identify meaningful goals, sources of energy and motivation, and ways to overcome obstacles and work toward their goals. An essential prerequisite for clients is the willingness to consider what their goals are and how these goals are related to mental health. Some clients will require more intensive intervention to plant even the tiniest seed of hope. With others, however, some goals may be unattainable (e.g., bringing back a loved one who has died). We think it is important to acknowledge and validate these experiences of loss and recognize that some obstacles are, indeed, insurmountable. That being said, we also consider that the vast majority of people will be able to generate some meaningful and attainable goals that are likely to increase purpose, social connectedness, and other such indices of mental health, particularly if these constructs are addressed within a therapeutic relationship. Within a group context, individuals are able to help each other pursue goals and increase their hope, even when they are dealing with vastly different goals. As Mike illustrated with his poster, we are all trying to move from “I am here” to “This is where I want to be,” and thus we can all help each other identify where we want to be and build the bridges to get there.

Putting It into Practice

1. Develop goals for therapy.

If having goals helps build hope, then a primary therapeutic task is assisting clients to explore the goals they want from therapy and in life. Ask them questions such as: If this is where you are now, where do you want to be in the future? What do you want in your life that you haven't been able to achieve yet?

2. Encourage specific goal development.

Not all clients are readily able to articulate their goals initially, and some are able to identify general goals but have difficulty in being specific. The more specific goals are, the more immediate and more achievable they become. If a client's goal is global, such as “I want to be happy,” invite exploration of the specifics with questions such as: If you had more happiness in your life, what would that look like? What would you be doing, thinking or feeling that you are not doing now? How would you or others know that you were happier?

3. Find your client's resources.

Look for the resources your client has that might be mobilized in the building of hope. For Mike, there were strengths such as his belief in the therapy being offered and his conscientious, hardworking attitude. What

(Continued)

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strengths and resources can you observe in your client? How might these be utilized in attaining the therapeutic goal?

4. Assist the development of pathways.

Mike was able to generate ways and means to reaching his goals (a) through his own thinking stimulated in the process of hope therapy, (b) from observing others in the group, and (c) by creating a poster board (goal map) that represented both his current and desired positions as well as the routes to move from one to the other. Brainstorming ideas with clients, inviting them to explore possibilities, setting homework tasks, and offering suggestions are some alternatives.

5. Help build agency.

One of the core questions of effective therapy is how can we help clients generate and maintain the necessary motivation and energy to reach a desired goal. Mike showed that by breaking the goals down from larger goals, such as getting married, into bite-size bits, such as having a coffee with a coworker or joining an Internet social networking site, brought their own intrinsic rewards and motivations.

6. Consider working with groups.

We found that group members assisted each other in two ways:

- a. Helping someone else brought forth already present strengths in the helper.
- b. Receiving assistance from someone who complemented the recipient's strengths promoted the learning of new skills.

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CHAPTER 6

You Want Me to Fix It?

Using Evidence-Based Interventions to Instill Hope in Parents and Children

Robert Weis

MEET THE CONTRIBUTOR

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“I feel I am out of options,” said Mrs. Werth, exasperated by her grandson’s aggression at school and disruptive behavior at home. Andrew was born with mild fetal alcohol syndrome (FAS), caused by his mother’s alcohol consumption during gestation. As a single mother, she attempted to care for Andrew for the first few years of his life, but eventually abdicated responsibility to Andrew’s grandmother. Now 15 years old, he was a large boy, standing 5’ 7” and weighing 150 lbs. Officially, he was an eighth-grade student, but his intellectual functioning was about that of a 10-year-old child.

Andrew had been suspended twice in the previous month for fighting. His classmates teased him because he struggled academically and because he had facial anomalies characteristic of FAS. In class, he behaved in a clownish and disrespectful manner. At home, he was defiant toward his grandmother. He refused to do his homework, to perform chores, or to clean up after himself. Arguments were common.

“I don’t know what to do,” his grandmother explained. “If Andrew gets into trouble again, they’re going to send him to an alternative school. At home, I’ve given up. I used to be able to get him to do what I wanted by spanking or yelling, but that doesn’t work anymore. Parenting is for young people—not people thinking about retiring. I’ve raised two kids. I can’t handle any more.”

During therapy, Andrew was not interested in talking about family, school, or friends—all problem areas in his life. In order to build rapport, we spent most of our time drawing with colored pencils and talking about his hobby of motorcycles. At the third session, Andrew arrived carrying a small toolbox.

“Your pencil sharpener’s busted. You want me to fix it?” he asked.

As Andrew carefully disassembled my broken electronic pencil sharpener, he talked about how he and his neighbor were building their own motorbike in his neighbor’s garage, how they planned on racing it someday, and how he would like to be a professional motocross racer or, at least, a mechanic after he finished school.

“The only problem is,” Andrew added, “I’ll probably not graduate. You know, if it wasn’t for my mom’s drinking, I wouldn’t have all of the problems I’m having right now. I wouldn’t be so dumb and the kids wouldn’t bother me so much. I wish she could have loved me more than the booze.”

HOPE THEORY AND PSYCHOTHERAPY

Hope theory is based on the assumption that people’s actions are goal directed (Snyder, 1994; Snyder, Rand, & Sigmon, 2002). Hopeful people set clear, objective goals that have sufficient value to justify their time and energy. Goal attainment is dependent on two types of cognitions: agency thinking and pathways thinking. *Agentic cognition* refers to people’s perceived motivational capacity to take steps to achieve their goals. Agentic thought motivates people to persevere despite obstacles and is evident in self-statements such as “I can do this” and “I am not going to be stopped.” *Pathways thought* refers to people’s perceived ability to generate plausible routes to accomplish their goals. Pathways thinking is evident in self-statements such as “I can find a way to get this done.”

Hope depends on both agency and pathways thinking (Edwards, Rand, Lopez, & Snyder, 2002). Agentic thought, without pathways thought, occurs when a person is motivated but cannot identify ways to reach his or her goals. Pathways thought, without agentic thought, can be seen in the person who can identify many routes toward goals but does not believe he or she can begin or sustain the journey toward goal accomplishment. Fortunately, agency and pathways thinking are additive and iterative constructs, in that identifying the routes toward goals can increase a person’s motivation to work toward them. Similarly, cognitions that motivate people to take action can also prompt them to find viable ways toward their objectives. Willfulness (agency) and wayfulness (pathways) are correlated constructs.

Snyder's (1994) general model for hope has been applied to psychotherapy (Cheavens, Feldman, Woodward, & Snyder, 2006; Cheavens & Gum, Chapter 5, this volume; Lopez, Floyd, Ulven, & Snyder, 2000; Snyder, Feldman, Taylor, Schroeder, & Adams, 2000). From this perspective, people seek therapy when they repeatedly encounter barriers to their goals that they cannot circumvent or overcome. These barriers engender negative emotions, such as anxiety, depression, or anger, which are often the proximal determinants of their decision to seek help. The therapist's job is to increase hope by helping clients (a) set clear, objective goals; (b) increase agency; and (c) increase pathways thinking. Snyder has argued that hope is a common factor in psychotherapy (Snyder & Taylor, 2000), especially as clients are often demoralized when entering therapy. However, their decision to seek help indicates at least some motivation to change (Snyder, Parenteau, Shorey, Kahle, & Berg, 2002). Therapists can build on this kernel of agentic cognition by capitalizing on their clients' positive expectations for therapy as well as their own perceived influence over clients. Agency thinking is also fostered by the therapeutic alliance that is built on acceptance, positive regard, and empathy. Pathways thinking is fostered initially by providing clients with a convincing rationale for the method of treatment followed by concrete steps designed to improve their functioning. According to Snyder (2000), "[P]sychotherapies 'work' precisely because they enable people to identify goals that represent solutions to their problems, they specify particular routes for reaching those goals (pathways thinking), and they motivate clients to use those routes so as to implement change (agency thinking)" (pp. 257–258).

General support for Snyder's assertion that hope is central to the therapeutic process comes from meta-analyses of adult psychotherapy outcome studies (Snyder & Taylor, 2000). In general, adults participating in psychotherapy placebo control groups show moderate improvement over adults who receive no treatment whatsoever. Snyder and colleagues interpret this placebo effect as evidence for the efficacy of agency thinking, because clients improve without the implementation of specific therapeutic interventions. Furthermore, adults who participate in specific interventions (e.g., cognitive-behavioral or interpersonal therapy) show moderate improvement beyond those who participate in placebo control groups. Snyder and colleagues interpret the apparent benefit of specific interventions to increased pathways thinking, as clients learn ways to alleviate suffering and reach desired outcomes.

More recently, Weis and Ash (2009) demonstrated a similar relationship between parent and adolescent hopefulness in therapy and adolescents' subsequent therapy outcomes. Adolescents referred to outpatient treatment, and their parents, rated adolescents' behavior problems, adolescents' adaptive behavior, and their own subjective experiences of hope at intake and at three-month follow-up. Therapists also rated adolescents' behavior problems and adaptive behavior at intake and follow-up. Adolescents who reported increased hopefulness during treatment showed significantly fewer behavior problems and greater adaptive behavior at follow-up than adolescents who reported stable or decreased hope. Similarly, adolescents' outcomes were significantly associated with parents' change in hope during treatment.

The application of hope theory to psychotherapy has led to the development of specific strategies to increase hope in community and clinical settings (McDermott & Snyder, 1999, 2000; Snyder, 1994, 2000; Snyder, McDermott, Cook, & Rapoff, 1997). Unfortunately, the very few published studies investigating the efficacy of hope-based interventions for children

and parents do not offer clear, supportive evidence for using such approaches (Buchanan, 2008; McNeal et al., 2006). Several unpublished studies report more beneficial outcomes for hope therapy with youths, but the evidence is still not conclusive (see Pedrotti, Edwards, & Lopez, 2008).

Given the current lack of an adequate research base to support the use of hope therapy as a primary means of intervention for parents and children, readers may well ask: Then why use it? Clearly, hope theory and the interventions based on it hold promise for therapists interested in systematically increasing hope in their clients. Hope theory may best be incorporated into clinical practice with evidence-based treatments that address the elements of hope described in Snyder's (1994) model. Indeed, several evidence-based therapies appear to address goal setting, agentic thinking, and pathways thinking in parents and children (Silverman & Hinshaw, 2008). Rather than using hope *therapy* as a first-line treatment, therapists may wish to use hope *theory* as an explanatory model for therapeutic change to guide their interventions.

HOPE AND EVIDENCE-BASED INTERVENTIONS FOR YOUTH

Hope theory is more difficult to apply to children and adolescents than to adults for three reasons.

1. Most youth do not have clear goals for therapy, and many do not even recognize that they have a problem that merits intervention.
2. Children and adolescents often have very low motivation to change their behavior. While Snyder (1994) interprets adults' decision to seek help as a first sign of agency thought, few youth refer themselves to therapy, and many are outwardly resistant toward the therapeutic process.
3. Children and adolescents have limitations placed on their pathways thinking not experienced by adults. Whereas adults can generate a wide range of pathways to reach their goals (e.g., take a more satisfying job, leave an abusive relationship), children's options are often more limited. A child cannot always decide to quit math class to focus on his strengths in English or to live at a friend's house to avoid her father's substance abuse.

Nevertheless, hope theory can provide a useful framework for helping clinic-referred youth, as it seeks to build the very things they are often low on: goals, motivation, and pathways. Andrew's comments in therapy indicated that he had very low hope in several life domains: school, friends, and family. As suspected, he earned a very low score on the Children's Hope Scale. Furthermore, teacher-report ratings on the Behavior Assessment System for Children-2 (BASC-2) indicated significant problems with oppositional and aggressive behavior at school as well as low academic achievement. A self-report version of the BASC-2 revealed that he also experienced clinically elevated symptoms of depression. In some areas, however, he displayed relatively high levels of hope and had already shown his ability to engage these processes when offering to fix my pencil sharpener. In that situation, as well as when working with motorcycles, he had a clear, objective goal, high motivation or agency, and was thinking strategic pathways to accomplish his goals.

Identifying Meaningful Goals

Hope-based interventions have two components in common.

1. The therapist presents the basic tenets of hope theory, including a description of hope as a cognitive construct related to goal pursuit, a description of agency and pathways thinking, and a discussion of barriers and the negative emotions they can elicit.
2. The therapist helps the client identify meaningful goals. This can be accomplished by encouraging clients to reflect on satisfaction in various life domains, such as school, work, and relationships. For example, when a client complains, “I don’t want to be lonely,” the therapist can help reframe this dissatisfaction into a clear goal to target, such as “I want to make one new friend at school.”

With Andrew, my first objectives were to help him set a therapeutic goal for changing his behavior at school. Like many adolescents, he was reluctant to participate in therapy. He saw himself as a victim and not as someone capable of taking action to improve his situation. Prochaska and DiClemente (1982) would place Andrew in the “precontemplation” stage of therapy: He simply was not ready to change. Using the principles of motivational interviewing (Miller & Rollnick, 2002) to increase his readiness to change, I first tried to build trust by empathizing with his dissatisfaction with school. Andrew was angry toward his classmates and his mother and embarrassed by his low grades and appearance. He wanted his classmates and teachers to leave him alone, and he wished he could spend his day working on motorcycles. I also attempted to develop a discrepancy between his current problem behavior at school and his desire to work with motorcycles in the future.

“I don’t know as much about motor vehicles as you do,” I admitted. “What kind of schooling do you need in order to become a mechanic?”

Andrew replied, “I’m not sure. I know they use a lot of computers, so I guess they have to be pretty smart.”

“Do you think they need to finish high school?” I asked.

“Probably,” he responded. “They probably have to take car classes and stuff like that.”

“So if you want to work with cars someday, you’ll need to go to high school. But you can’t go to high school if you keep getting into trouble in eighth grade,” I suggested.

“I guess that’s right,” Andrew admitted.

“So we need to find a way for you to avoid fights and get through eighth grade so you can make it to high school. Then you can start taking some classes you really enjoy, like automotives and maybe mechanical drawing.”

“That’s right,” he concluded.

Increasing Pathways Thinking

To improve pathways thinking, therapists might employ three steps:

1. Break down complex goals into more manageable subgoals. A subgoal for “making a friend at school,” for example, might be to initiate one conversation with a fellow student over lunch.

2. Encourage the client to mentally rehearse the steps needed to accomplish each subgoal. During imagery, the client might anticipate possible barriers and identify ways to overcome them.
3. Help the client acquire the skills necessary to achieve subgoals. For example, a lonely client might benefit from assertiveness or social skills training before attempting to strike up a lunchtime conversation.

Increasing pathways thinking with Andrew was my next objective. Now that he had a personally relevant goal, he needed ways to work toward it. Unfortunately, he seemed to lack the social problem-solving skills necessary to reach his goal. When teased by peers, he did not have a strategy for negotiating interpersonal problems. Instead of generating alternative, adaptive ways of responding to peers, he was able to identify and select only one course of action: aggression.

Considerable evidence suggests that social problem-solving skills training (PSST) is efficacious in reducing aggression and promoting prosocial interactions among youth (Weis, 2008). From the perspective of hope theory, PSST teaches children and adolescents pathways thinking by helping them systematically interpret interpersonal problems, generate a list of possible solutions, select and implement the best solution, and evaluate the outcome. I taught Andrew to use these problem-solving steps through a combination of modeling, role playing, and in vivo practice.

Increasing Agency

After the client identifies a personally relevant goal and finds pathways or means to get there, the therapist attempts to foster the client's agency. One technique to improve agentic thought is to help clients identify self-statements that rob them of their capacity to strive toward their goals. Self-statements such as "I'm just no good at small talk" or "I'll say something stupid" might dissuade someone from initiating a conversation at lunch. Instead, the therapist encourages the client to reframe these thoughts into more realistic self-statements, such as "It might be a little uncomfortable, but I can do it" or "I might stumble over my words a bit, but I'll do fine." A related technique to improve agency thinking is to help clients recall times in the past when they successfully confronted barriers to their goals.

A final component of therapy involved fostering Andrew's agency thinking. I was concerned that he might learn valuable social problem-solving skills in therapy, but be too reluctant to apply those skills at school. In particular, I was concerned about his tendency to attribute negative events to internal, stable, and global causes. For example, he believed that he struggled at school and was teased by peers because he was "dumb" and consequently "no good at anything." These attributions can contribute to feelings of depression and interfere with adolescents' capacity to take action to improve their functioning. In other words, they can strangle agency thinking (Prinstein, Cheah, & Guyer, 2005; Stevens & Prinstein, 2005).

To increase Andrew's agency thinking, I relied chiefly on portions of the Penn Resiliency Program curriculum, a cognitive-behavioral intervention for youth (Seligman, 1995; Shatte, Seligman, Gillham, & Reivich, 2005). At the heart of the program is the notion that children's beliefs mediate the relationship between antecedent events and social-emotional consequences; stated another way, events do not cause us to feel and act in certain ways, our

thoughts do. Often children have little control over adverse events, but they can be taught new ways of thinking to influence their actions and emotions.

The complete curriculum consists of many sessions, but I focused chiefly on helping Andrew recognize distorted thoughts that predisposed him to feeling depressed, angry, and hopeless. Then I tried to show him ways to think differently about adverse situations so that he might be less likely to fight and more likely to use his social problem-solving skills. To accomplish these tasks, I relied on three activities, spread out across several sessions.

1. *Cartoons*. This first activity allows children to understand the relationship among thoughts, feelings, and actions. I gave Andrew several cartoons, each divided into three frames (e.g., beginning, middle, end). The thoughts of the character in the middle frame were absent, so I asked Andrew to insert a thought for the character that would fit the antecedent event and consequence of each story. Then I encouraged him to generate alternative thoughts for the character that might elicit a different behavioral or emotional consequence.
2. *The Detective Game*. In this activity, I read stories to Andrew about two detectives, Sherlock Holmes and Merlock Worms. Holmes is a good detective because he considers all of the evidence and identifies many suspects to solve a crime whereas Worms is a bad detective because he ignores important clues and tries to pin blame on the first person he sees. The game is designed to teach children to think about alternative possibilities for adverse events rather than to immediately blame themselves or their shortcomings.
3. *Examination of adverse events*. To help Andrew identify automatic thoughts in his daily life that contributed to his negative feelings and interfered with successful problem solving, I asked, “What adverse things have happened during the previous week?”

“The teacher asked me to do a math problem on the board in front of class and I didn’t know how to do it,” he recalled. “I screwed it up and the other kids laughed at me.”

“Okay. Imagine you are standing at the board and the kids are laughing at you. What’s going through your mind?” I asked.

“I feel hot all over—mad,” he replied.

“That’s how you’re feeling,” I said. “What are you thinking?”

“Like I’m dumb. Like I’m no good at anything.”

“Okay. Let’s see whether that’s true. Let’s be a good detective. Is there any evidence that you’re not dumb? Are there any things you are good at?”

After pausing for a while, Andrew said, “I am good at cooking breakfast.”

“And you fixed my pencil sharpener,” I added. “I have a PhD and I couldn’t do that.”

“Yeah. I know more about fixing things than you.”

“So maybe you had problems with that particular math exercise, or maybe you were hungry or having a bad day, but you’re certainly not dumb. There are some things you can do well—maybe even better than most people.”

In this instance, I was trying to help Andrew attribute the negative experience at the blackboard to external, unstable, and specific causes (e.g., difficulty with the specific math problem, having a bad day) rather than to internal, stable, and global causes (e.g., low

intelligence, incompetence). The goal of these cognitive interventions is not to encourage youth to put a positive spin on adverse events but rather to help them think more realistically instead of pessimistically or catastrophically. Kendall (2006) calls this “the power of nonnegative thinking.”

Several evaluation studies indicate that the Penn Resiliency Program is efficacious in preventing or reducing depressive symptoms in older children and adolescents. Furthermore, the intervention appears to reduce the frequency of children’s negative automatic thoughts and may be associated with fewer emotional problems in youth with disruptive behavior disorders, such as Andrew (David-Ferdon & Kaslow, 2008; Gillham, Brunwasser, & Freres, 2008).

HOPE AND EVIDENCE-BASED INTERVENTIONS FOR PARENTS

Like many caregivers, Mrs. Werth saw the focus of treatment to be her grandchild, Andrew, rather than herself. However, caregivers’ capacity to help children overcome psychological disorders often depends on their own socioemotional well-being (Conley, Caldwell, Flynn, Dupre, & Rudolph, 2004). With this in mind, I administered three self-report measures to Mrs. Werth to obtain an estimate of her current functioning: the Hope Scale, the Beck Depression Inventory, and the Parenting Stress Index. Results of these norm-referenced measures indicated that she was experiencing very low hope regarding her ability to manage her grandson’s behavior, moderately high levels of depression, and considerable stress in her role as caregiver.

Identifying Meaningful Goals

Using hope theory to guide my intervention, my first objective was to help Mrs. Werth identify a clear, meaningful goal for therapy. She was distressed about so many aspects of Andrew’s behavior, and her own state of mind with respect to her caregiving role, that she did not know exactly what she expected from therapy. To help her set a clear, objective goal, I asked her to generate a list of Andrew’s disruptive behaviors at home. Then I asked her to rank-order the list from least to most disruptive.

Mrs. Werth concluded, “It really upsets me when Andrew refuses to listen. I’ll ask him to do something, but he ignores me until I yell.”

Wanting to help Mrs. Werth reframe this behavior problem into something positive and measurable, I responded, “Tell me the last time that Andrew didn’t listen to you.”

“Yesterday, I asked him to turn off the PlayStation and come to dinner. I had to ask him 20 times and threaten to take away his video games before he came to the table.”

“So you’d like Andrew to come to dinner when you call him without having to yell or threaten?” I asked.

“Yes,” she replied. “It seems like a small thing, but it would really make me feel good, like I had some control over him.”

Increasing Pathway Thinking

Mrs. Werth agreed to meet with me individually each week to learn some specific techniques (pathways) to improve Andrew’s compliance at home. Fortunately, there are several

evidence-based interventions available for the parents of disruptive youths (see Eyberg, Nelson, & Boggs, 2008). During the course of these parent management training programs, parents learn new skills to manage their adolescents' noncompliant behavior (e.g., turn off the PlayStation immediately after his refusal to come to dinner), set clear and consistent rules at home, and improve the quality of family communication.

Increasing Agency

The final component of my intervention targeted Mrs. Werth's low agency thinking. Although she would learn new ways to manage Andrew's behavior, she seemed to lack the resolve to try these skills at home. As attrition in parent management training programs is common among caregivers experiencing psychosocial stress, I encouraged her to attend a local support group for grandparents caring for grandchildren for three reasons.

1. I wanted to normalize some of the hardships she was experiencing in caring for Andrew as a single, working grandparent.
2. I wanted her to expand her social support network so that she felt less isolated and more invigorated by social contact.
3. I wanted her to develop some friendships through her participation in the group so that she would be able to ask others for help (Smith & Drew, 2004).

Considerable research supports the notion that perceived social support promotes more positive parent-child interactions and reduces parenting stress (Heath, 2004). From the perspective of hope theory, social support can give parents the willpower to adhere to parent management training programs despite the obstacles of children's defiant behavior, psychosocial stressors, and daily hassles. Indeed, some newly developed group interventions for the caregivers of oppositional youths specifically target parents' socioemotional functioning in order to increase the benefits of treatment (Hutchings & Webster-Stratton, 2004). I hoped that Mrs. Werth could experience similar benefits from her participation in the group.

CLINICAL OUTCOMES AND CONCLUSIONS

After 20 sessions of therapy, Andrew was still oppositional but the frequency and intensity of arguments were greatly reduced. Indeed, normative data from the parent version of the BASC-2 indicated a decrease in Andrew's externalizing behavior problems to within normal limits. Mrs. Werth reported having greater confidence in her ability to manage his behaviors at home, and having gained considerable benefit from participating in the grandparent support group. There was a marked reduction in her self-reported depressed mood and parenting stress.

Andrew refrained from fighting at school and graduated in the spring. His teacher reported a 2 standard deviation reduction in aggression, but borderline-significant problems with oppositional behavior and poor study skills. However, Andrew's mood greatly improved, as evidenced by self-report data from the BASC-2. He was excited about attending high school the following autumn, where he would be able to take courses more suited to his interests. Andrew and his grandmother discussed the possibility of his participating in a job skills training program through school, which would allow him to work part time in local businesses.

Therapy with Andrew and his grandmother deepened my appreciation for hope theory as an explanatory framework for the psychotherapy process. Although I do not think the research base supports using hope therapy as a primary intervention for parents and children at this time, I am more confident that goal setting, agency thinking, and pathways cognitions are important targets for therapeutic interventions. I would urge clinicians to be creative in identifying and employing evidence-based interventions to promote these components of hope in the children and families they serve.

Finally, I would like to suggest a modification to hope theory borne out of clinical experience and consistent with the empirical evidence on the role of hope in psychotherapy. Snyder and colleagues posit that hope is an important component of psychotherapeutic change in that “psychotherapies ‘work’ by increasing hope” (Snyder et al., 2002, p. 258). However, it is also possible that increased hope may be a by-product of successful therapy. Symptom reduction and improvements in functioning may elicit hopeful cognitions as clients realize that they are overcoming obstacles and making progress toward their goals. Evidence-based interventions may be particularly useful in bringing about this improvement in clients. Whether we view hope as a primary target of therapy or as a benefit of the change process, we are nevertheless trying to instill in clients like Andrew a sense that they can find direction, meaning, and purpose in their lives.

Putting It into Practice

Adopt a Hopeful Explanatory Model

Rather than seeing hope as a *therapy* for first-line treatment, it may be better to adopt an approach that uses hope *theory* as an explanatory model for therapeutic change to guide your interventions. In this way, it can inform and enhance the application of evidence-based therapies.

POSSIBLE INTERVENTIONS FOR YOUTH

While hope theory is more difficult to apply to children and adolescents than to adults for several reasons, it can still provide a useful framework for helping youth set goals, increase their motivation to change, and find viable pathways to reach their objectives.

1. Identifying meaningful goals.

The principles of motivational interviewing were used with Andrew to increase his readiness to change and help identify his meaningful goals. To accomplish this, encourage your client to reflect on his or her satisfaction in various life domains, such as school, work, and relationships, and reinforce even small steps toward goal pursuit.

2. Increasing pathway thinking.

Pathways to a client’s goal can be found by breaking down complex goals into subgoals, mentally rehearsing the steps needed to accomplish each

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subgoal, anticipating possible barriers, identifying ways to overcome them, and acquiring the skills necessary to achieve those subgoals. With Andrew, I used problem-solving skills training. Look for what evidence-based approaches offer the skills and pathways relevant for your client.

3. Increasing agency.

Use cognitive-behavioral interventions to help children change maladaptive thoughts and increase energy toward goal attainment. To increase Andrew's agency thinking, portions of the Penn Resiliency Program curriculum were used, including cartoons, a detective game, and critical thinking about adverse events.

POSSIBLE INTERVENTIONS FOR ADULTS

It is not uncommon for caregivers, parents, or grandparents, like Mrs. Werth, to experience very low levels of hope regarding their ability to manage a child's behavior, feelings of depression, and considerable stress.

1. Identifying meaningful goals

Use principles of behavioral assessment to establish clear, operationally defined goals, or conduct a functional analysis of the problems. Mrs. Werth was asked to generate a list of Andrew's disruptive behaviors at home, rank-order the list from least to most disruptive, and target specific, desired goals.

2. Increasing pathway thinking.

There are several evidence-based interventions available for the parents of disruptive youth to learn specific techniques or pathways to improve behavior at home. Teach parents the effective, practical skills for managing their child's behavior.

3. Increasing agency.

Besides using cognitive interventions to help parents identify and change depressogenic cognitions, increasing parental support can help overcome low agency thinking. Mrs. Werth was encouraged to attend a local support group for grandparents caring for grandchildren.

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CHAPTER 7

Putting the Lid on the Divorce Monster

Creating Hope-Filled Narratives with Storybook Therapy

Joy Nel

MEET THE CONTRIBUTOR

Joy Nel is an educational psychologist from Johannesburg, South Africa. She is currently studying for her doctorate in utilizing stories and metaphors in trauma with children. She is involved in the training of fellow psychologists in narrative ideas, focusing on the utilization of stories in guiding children to cope with issues such as divorce, bullying, trauma, and abuse.

Joy received her training in Ericksonian psychotherapy from the Milton H. Erickson Institute of South Africa (MEISA). She has presented her work

at international congresses for psychologists in Germany and South Africa and is involved in the MEISA activities in South Africa. When not reauthoring hope-filled stories with young clients, Joy enjoys traveling her country and other parts of Africa. It is during these travels that she spends time witnessing, photographing, and listening to stories of hope and resilience from all over the continent. To find solace and peace she loves to trek through South Africa's National Parks or the Bushveld.

A knock on the door announced her arrival at my school office. Upon opening the door, I was greeted with “Hi, my teacher said you’re the new lady at school that can help me put the lid on my problems.” Her green eyes glanced over me. “I wrote you a note. They said we have to do that . . . did you get it? I sure hope we can sort this out. I’m sick of having this problem,” she said as she brushed past me and walked into the therapy room. Determined. Resolute.

This is the story about Monique and her unwavering resilience in fighting the monster of her parents' divorce. An 11-year-old sixth-grade student, she made her acquaintance with divorce at the age of 4. At that point, divorce had no real meaning for her, but she was greatly confused when her father moved back into the home two years later.

Monique had one older and one younger sister. Her mother decided it was best to raise her daughters with the idea that their father was just a "visiting uncle," thinking this would cause them less confusion. In fact, the opposite happened for Monique. When he moved back again, Monique could not call him "Daddy" even though she was sure he was her father. Adding to the confusion, her mother asked Monique to protect her younger sister from the truth—and she did. They continued living together under this pretense for three years, until her father moved out again. However, he came back to visit the children and their mother often. Even more confusingly, now that he no longer lived with them, they were allowed to call him "Daddy," and their mother gave Monique and her older sister the task of informing her younger sister that he was their father and she should call him "Daddy."

The picture became even more confusing when, six months later, her parents resumed living together again until her father moved out for the third time about a year later. Her mother, along with the three girls, shifted to her parents' home—a three-bedroom dwelling that now housed Monique's grandparents, mother, Monique, her two sisters, an aunt, and two uncles. According to her mother, Monique used to be the "clown" in the house, always "joking the bad things away." Since the divorce, she had become quiet and no longer displayed her emotions. She did not want to do her schoolwork, slept most of the time, and isolated herself from the rest of the family. She also suffered constant stress ulcers in her mouth.

HOPE-FILLED STORYBOOK THERAPY

I refer to my therapeutic work with young clients, in which we utilize narratives and metaphors, as storybook therapy (Nel, 2007). The aim of storybook therapy is the writing, editing, and publicizing of the client's own narrative of hope in the face of adversity. Narratives of hope are within us and around us. The word *narrative* refers to the emphasis that is placed on the stories of people's lives and the differences that can be made through particular tellings and retellings of these stories (Morgan, 2000). Shank (1995) said, "In the end all we have are stories and methods of finding and using those stories" (p.16). As therapists, we are afforded a unique opportunity when we take time to listen, share, tell, and write stories with our clients for it is in these stories that our clients find themselves and their strengths and opportunities to live out and confirm the importance of their own lives. The writing up of a client's life story can be a journey of experiencing life and hope as well as a profound way of helping our clients step more fully into their preferred way of being (White, 1995). During this process, clients are the owners of their stories and lives while the therapist takes on the role of scribe. The writing up of a hopeful story with a client is thus a positive and creative process.

HAVING A HOPE-FILLED FRAMEWORK

Perhaps it is most fitting to start the explanation of my theoretical framework of hope with a personal account. My interest in therapeutic stories was sparked by my parents, who, true to

the Afrikaans culture and tradition, shared stories over the dinner table about Anglo-Boer War heroes who lived, loved, and fought with hope. As a young child, I spent time with our African gardener, Kleinboy, who called me Nomalanga (Little Sun). He filled my mind with fascinating stories of the Zulu-speaking people and how they witness and live hope in their lives. In his wise voice, he said, “Nomalanga, you hear these stories and you give them wings when you tell them. One day they will make you a warrior of hope and peace.” As a therapist, I am now privileged to guide young people to give their own stories wings and become messengers of hope and peace in their own lives.

The importance of hope to humankind is recorded back in the Greek myth of Pandora’s Box (Cheavens & Gum, Chapter 5, this volume; Kershaw, 1990; Thatcher & McQueen, 1971). Some writers conclude from the story that hope was unleashed from Pandora’s Box and bestowed on humankind to fight the tormenting plagues and as a means of overcoming hurt and pain. I prefer to think that hope is an omnipresent gift that enables us to live hopeful lives. It is with this belief that I go about discovering and writing stories of hope together with my clients. It is with a notion of hope that I help search for resilience, action, and movement in my clients when uncovering and reauthoring their life stories. The search for and creation of movement in our clients, more than the movement away from suffering and pain, is a movement toward lives lived in contentment and joy (Duckworth, Steen, & Seligman, 2005). Constructive, positive approaches to therapy such as Ericksonian psychotherapy and narrative therapy afford us as therapists the opportunity to participate in and co-construct movement with our clients (Epston & White, 1992; White, 1995). The utilization of narratives and metaphors in therapy assists my clients to bring meaning into their lives and build knowledge of who and what they are (Burns, 2001, 2005, 2007; Hoyt, 1997; Kotzé & Kotzé, 2001; Kotzé, Myburg, & Roux, 2002; Nel, 2007; White, 1995). It is how clients construct, deconstruct, and live this knowledge that leads to emancipation from problems and the enjoyment of a happy, hope-filled life (Hoyt, 1997; Mills, 1997; Morgan, 2000; White, 1995, 2003). Hope seems to be so important in both life and therapy that some researchers and writers describe it as the most crucial ingredient in, or determinant of, therapeutic outcome (Frank, 1968, 1975; Hubble & Miller, 2004; Snyder, 1989, 1994, 2000, 2002). As a narrative therapist, I am continuously searching for those moments in a person’s life that tell about ability, competence, and hope (Morgan, 2000; Nel, 2007; White, 1995, 2003; White & Epston, 1990). My view and belief in people being competent and resilient is what, in turn, gives me a hopeful outlook on life and places me in the privileged position of doing hope-filled and hopeful work with my clients.

EXAMINING AND DECONSTRUCTING PROBLEM STORIES

Finding the Client’s Resources and Strengths

At the start of our first therapy conversation, I gave Monique a customary tour of the practice. I do this with all my young clients, as it helps orientate them toward therapy and gives them an idea of all the materials, toys, and media they can use to help them in therapy. Monique decided that since she loved doing art, we should conduct our sessions in the art room.

I asked her, “Would you like to paint me a picture of how your life is right now with all the sad stuff of divorce in your life?”

She covered a sheet of paper with black paint and made yellow splashes on it. “It’s really bad and sad,” she explained. “Some days are a bit okay, but it’s just bad.”

I replied, “From your painting, I can see that it really is bad for you. I wonder how you manage, in all this blackness and sadness, to have some days that are a bit okay?” My comment was designed to (1) acknowledge her sad feelings and (2) draw her attention to the glimmer of hope she expressed and how she was capable of attaining it.

Confidence shot from Monique’s lively green eyes as she said, “Well, that’s easy! I think of bright colors, and I make a plan to make the day okay. I am good at making plans and always have a plan A and a plan B for something.” She explained how her younger sister was scared of monsters and how she would sit with her some evenings, making plans about how not to be so scared of them.

“I guess that you also have a monster in your life at the moment, trying to make your life black and sad?” I replied, steering her toward externalizing the problems that she was facing. By helping clients externalize problems and see them as separate from themselves, we “allow for explorations of the relationship *between* the person and the problem” (Morgan, 2000, p. 28).

“Yes,” she said. “It’s like a monster—the divorce monster.”

I suggested that we take some time to examine the work and ways of the divorce monster in order to see what plans she could make to get it out of her life.

Excitedly she explained, “I can’t wait to be happy again and put the lid on the divorce monster.” I made a mental note of the fact that she had several times now used the metaphor of putting a lid on the monster.

I considered it necessary during my first conversation with Monique to get a good idea of what her perception and experience of divorce was like. I believed that this would assist me in grasping her concerns and experience of the problem and that it would guide us in our dealings with the problem. Moreover, I thought it would help me find moments where the problem was *not* active in her life. As a therapist working from a positive psychology foundation and a hopeful disposition, I believe these moments are there and constantly aim at making them stronger in my clients’ lives.

To this end, I asked Monique to draw me a picture of the divorce monster. With evidence of the glaring monster on paper, I said, “I’m so happy that you have the ability to make good plans. I’m sure that you and I can make a plan to put the lid on this monster.” We decided that we would spend the next session researching the divorce monster in order to find ways of doing just that.

As Monique got up to leave the art room, she picked up the picture of divorce monster, tore it up, opened the rubbish bin, and threw the torn pieces away. Triumphant she said, “See, I’m already putting the lid on him.”

Externalizing and Deconstructing Problem Stories of the Divorce Monster and His Buddies

In our second session, Monique came in, walked over to the painting of “blackness” she had made in our first session, and said, “We ought to put some more yellow splashes on as there have been more okay and happy days since I saw you. I think it’s because of my plan of throwing the divorce monster in your bin.”

Monique was already externalizing the concept of divorce as a monster and could thus view it from a more detached perspective. Wanting to validate her movement in this positive direction, I asked how we could go about increasing those happy days even more.

“I think we just have to kill him completely,” she replied.

In this and the third session, our conversations thus focused on deconstructing the divorce monster and how “he was trying to steal [her] happiness.” We discovered there were a number of factors that empowered the divorce monster. Two allies were part of the divorce monster’s gang and used “tricks and lies” to make Monique’s life “difficult and bad.” In order to get a good description of these problem monsters, I asked her to draw a picture of each. The heartache monster and anger monster were externalized through her artwork.

During our fourth, fifth, and sixth conversations, we investigated the tricks and lies of the heartache monster and anger monster on Monique’s life. Asking clarifying questions throughout the discovery, externalization, and deconstruction of each problem opens up opportunities in the conversations to identify moments when she had stood up to these problems. These moments—also known as sparkling moments (Epston & White, 1992)—are the times of strength and competency in our clients that we as therapists need to ratify and strengthen for them. In doing so, we help them develop richer and more helpful descriptions of themselves. It is these richer descriptions that assist our clients to build and live out more positive and hopeful life stories. We strengthened these sparkling moments throughout our sessions by noting all the positive, empowering times and adding them into Monique’s story.

During our ninth conversation, we celebrated the monsters’ demise and her achievement by giving her a certificate. This narrative practice aims at “commemorating significant events and turning points” as well as “celebrating the new story” (Morgan, 2000, p. 90).

Confronting Old Discourses or “Silly Monster Lies”

Problems can survive and create havoc in our lives only when they are supported and strengthened by particular ideas, beliefs, and practices from our broader society. These ideas, beliefs, and practices, can be defined as discourses (Hare-Mustin, 1994; Morgan, 2000). The divorce monster had survived and grown stronger in Monique’s life due to the beliefs (discourses) society holds regarding a family that has been influenced by divorce.

Throughout our sixth, seventh, and eighth conversations, Monique expressed that the “divorce monster was made bigger through anger and heartache” because they were “telling her things about herself and divorce that she must believe.” We made a list on the chalkboard of all the things that these monsters were telling her about herself and divorce. Discourses from the list were erased from the chalkboard only when she was able to stand up against those beliefs. Throughout our conversations, we referred to and unpacked the various discourses that were strengthening divorce in her life. She felt that anger had convinced her that “her friends were laughing at her behind her back” and “saying that she was silly” because her “dad and mom are divorced.” These ideas that the anger monster brought to mind, and that Monique later stated were not true, were strengthened by some of the children in the school who were teasing her about “her mom and dad being divorced and being poor.” The discourse of capitalism—also situated within the school context—implied that one is worthy only when one has sufficient money. These assumptions, supported by society and herself, led Monique to believe that she could be happy again only if her mom and dad got remarried.

During our conversations, we sought to deconstruct the assumption that families are happy and good only if their parents are together and have sufficient money. Having me invite her to question and challenge these assumptions seemed extremely helpful for her, especially when she stated in our penultimate session, “I don’t believe the silly monster lies anymore.”

CREATING THE PREFERRED STORY

Putting the Lid on the Divorce Monster

Monique’s opening metaphor that she wanted to put the lid on the divorce monster allowed me to (1) join forces with her against the problem and (2) start working toward authoring the alternative, preferred story. Our conversations thus focused on highlighting a number of actions that Monique could take as well as characteristics that she possessed. They were aimed at enabling and empowering her to work against the problem monsters. We utilized her experiences to deal with each problem that plagued her and to progressively reauthor her old problem-saturated story.

Monique’s statement in our first conversation that she is very good at making plans was utilized in the building of her alternative story by drawing on her plan-making expertise to devise various strategies to stop the heartache monster and the anger monster from strengthening the divorce monster and stealing her happiness. These plans of action were written down on poster board that she took home and hung on her bedroom wall. She then tried out the plan during the week, monitored its effectiveness, and gave me feedback in our following session. The plans that did not work for her were replaced by a new plan of action. In the language of hope theory, she was finding and testing out potential pathways toward her goal of being free of the monsters. Through these plans, Monique was reclaiming her sleep, energy, and happiness from the monster problems.

She explained, “Happiness is like the color green, inside of me. Everywhere I see green I will be reminded of my happiness. There is a lot of green around me, like the trees, grass, and football field. Green will remind me that I have killed the divorce monster and am now happy.”

Holding on to a Rainbow of Colors

In reviewing what Monique had rediscovered about herself, and aware of the association she had already made with colors such as black, yellow, and green, I asked if we could assign a color to each aspect of her discoveries. She described these colors as being just like a rainbow. Given this rainbow image, I told her the biblical story in which Noah saw the rainbow that God had promised him after 40 days and 40 nights of rain. Monique commented that her own rainbow of colors meant she would never be alone as God was always at her side. As this promise represented hope for Monique, I suggested that we should find a way for her to hold onto her colors of hope.

She said, “I want these colors with me all the time, especially when I am at school.”

As Monique loved dressing up and wearing jewelry, she decided that she would like to make a bead necklace to wear all the time. I bought the necessary beads and accessories and had them ready for our next session. During that session we sat together making two necklaces, one for her and one for me.

As a hope-filled therapist, I believe that hope needs to be shared with as many people as possible. I always suggest to my clients in therapy that they should celebrate and share their newfound or rekindled hope. The celebration of hopeful or preferred stories is a narrative practice based on White's (2003) claim that celebrations contribute to the progress of the client. I therefore asked Monique whether she would like to celebrate by sharing her story of hope with significant people in her life. This prospect excited her. We spent some time during our necklace making session discussing and planning this celebration. Monique felt it was important that she share her hope with her loved ones. She asked whether she could make a necklace for each of the people attending her celebration. She felt this might assist them in finding their own hope and happiness and "conquer the problems they have." White (2000) explains that celebrations of hope are "retellings in which the stories of people's lives become joined around shared themes, purposes, values and, at times, commitments" (p. 8). Not only was this a chance of doing hope (Weingarten, 2000), but it was also a time to celebrate with Monique her story of determination and hope.

VALIDATING THE NEW HOPE-FILLED NARRATIVE

Writing, Designing, and Editing the New Story

Back in our second session, I asked Monique whether she would like to write up the story of how she put the lid on the divorce monster and suggested both she and I keep notes of our conversations and her drawings, as a reminder of her determination and happiness. She was excited about this idea.

I said, "I like your idea of putting the lid on the divorce monster. Would you want that to be the title of your story, or would you choose another title?"

Monique said, "I want to call it 'The Divorce Monster.' It's shorter." And so the story of 'The Divorce Monster' began.

The writing up of the hopeful story in therapy usually starts as soon as the alternative story or counterplot emerges. However, Monique preferred to write her story on completion of our conversations, so we arranged to meet for three additional sessions for the writing, editing, and creating of her book. I gave her time to peruse the variety of books created by other children: poster books, matchbox books, pop-up books, computer books, pocket books, talking books, and so on. True to her creative style of thinking and artistic talent, she decided to make a "tin book." She suggested that we write her story on precut circles (the size of a tin), bind them together, place the story in a small circular tin, and decorate the lid. Then she smiled and said, "See, that way I can really put the lid on him."

We chose the characters that would be part of her story, as well as what information she wanted to include about herself in the story. Finally, we wrote up the story on the computer with me typing what Monique dictated. Monique's hopeful story, which I have translated from her native Afrikaans, is presented next.

The Divorce Monster

This is my story of how I killed the Divorce monster.
I put the lid on him! YIPPEE!!!

I am very good at making plans. I can make clever plans to kill the Divorce monster when he brings Heartache and Anger into my life again. I can tell you about my plans.

Here is my story:

Five years ago the Divorce monster came into my life, but he hid himself away for a long time. At the time I did not know much about him. Mom and Dad separated a year ago. Only then did I see his ugliness and tricks. It was only then that I saw what the Divorce monster could really do. Many things happened that made the Divorce monster so strong. These things are:

We had to leave my home.

We had to go and live with Grandpa and Grandma.

We didn't have any money.

We had to go to a new school.

The Divorce monster brought Heartache and Anger into my life. They worked together and tried to take joy away from me.

Heartache said to me:

"You must always have heartache!"

"Cry all the time!"

"Don't look happy!"

"Wake up every night and cry!"

"Let your tummy ache!"

"Let me give you heartache all the time!"

"Your father does not care about you!"

"A person can only be happy when her mom and dad live together!"

"Don't do your work, think about me all the time!"

Heartache was so big that I couldn't sleep at night. He kept whispering those things in my ears all the time. I became very tired and had blue circles under my eyes.

Even though Heartache was so big, I knew all the time that I was much stronger than him. I killed Heartache. I thought out a plan of action against Heartache. We wrote it out and I pasted it onto the wall next to my bed.

My plan was: When Heartache wakes me up at night, saying "You must wake up and be sad," I am going to say "You must leave me alone and die! I am going to show you what a happy person looks like." Then I drew a happy person. I also used some songs to help me kill Heartache.

My plan worked very well. Heartache started visiting me less and less. I carried out my plan so well that Joy (my psychologist) gave me a certificate. I keep it in my Grandma's book in which she keeps all her important things.

So I chose not to listen to Heartache any longer. I chose to be happy instead. Happy is in me like the color green.

When I see green, or when I think about green, I know that: I am happy and I want to remain that way; I have got good friends; I am a good friend; I am a good sister.

Anger also came to visit me and tried to make things bad for me. He was always there when Mom said something ugly to Dad on the telephone.

(Continued)

(Continued)

Anger said to me:

“Things are never going to come right again,”

“Always ask why it is your mom and dad that got divorced.”

“Fight with everybody, you will feel better!”

“Ignore people, especially your family.”

“Be nasty to people when they are kind to you.”

“Swear at people!”

“Don’t sit with your friends, they are not good enough for you!”

“Don’t listen to your sisters when they want to talk to you.”

Anger was especially there in the mornings as I woke up. He was at school, too, and told me not to sit with my friends. Some children brought Anger along with them when they teased me about my mom and dad’s divorce.

I realized that Anger was not around when I was doing nice things and visiting people. I then started to play with my friends again and spoke to them about nice things. I also decided to listen to my sisters again and to talk about nice things to them. Anger did not worry me so much anymore and I said to him, “I am not going to listen to your lies. I am stronger than you!”

Sometimes he returns again to tell me lies. Then I just repeat these words and he disappears again.

I am now a very happy girl with lots of people that love me and who help me to keep the bad things away. YES!!

I have learned many things about myself while putting the lid on the Divorce monster:

I choose happiness!

I am friendly!

I am artistic!

I have got lots of guts!

I am special!

I also learned lots of things about the Divorce monster’s lies. I don’t believe his lies anymore. I know now that:

A person is not only happy when your mom and dad are married.

I can still love both of them just as much.

Sometimes divorce is better for families.

It is not the children’s fault when mom and dad divorce.

I can be proud of both of them.

A person’s life is still good after divorce.

This is my story, I am very proud of coming so far in changing my life and living a happy, healthy, and hopeful life! If you are reading this or listening to this, remember that hope is always there!

Celebrating and Sharing the Hope-Filled Message: Hope Begets Hope

In her seventh session, Monique said something that seemed indicative of her progress: “I wish that other children can also learn about getting rid of problems and having more hope for life.” Wanting to validate how her attention had shifted from her own problems to being interested in the well-being of others, I suggested we arrange a celebration party to which she could invite people with whom she would like to share her wish. We drew up a name list and designed invitations to the celebration. She decided that she would like to make a rainbow necklace for each person attending as she felt this gesture toward her friends, sisters, mother, and grandparents would indicate to them that “they are not alone and that they must believe in themselves.”

During the celebration on our ninth session, Monique explained to her gathered family and friends how she felt now that she had destroyed the problems that divorce brought to her life. “I feel really, really happy again,” she said, “and know that I can feel like that forever.”

Then she read her story, “The Divorce Monster,” to them and handed each person their necklace of happiness and hope. We asked the group at the celebration to write Monique a brief note on what they had learned from her about reclaiming hope and happiness from problems. These notes served as a confirmation of the problem-solving skills and personal knowledge she had gained. She took them home and pasted them on her wall as a reminder.

Monique’s party was more than a celebration of her defeat of the monsters that had plagued her. It created an opportunity for her to once again reexperience hope by sharing her hope-filled learnings with friends and family.

“How did you feel reading your story to your friends and family?” I asked her.

“It was good. I think they can now feel happier because they know that they can kill any problem that tries to steal their happiness.” Then she added thoughtfully, “My hope is bigger and Mom’s hope is bigger now, too.”

TOUCHING HOPE

Four weeks after completing therapy with Monique, I invited her to a follow-up session. In the interim, she had been to visit her father for the first time in a year. At first she had been scared about the visit and was concerned that the divorce monster might come back, but she reported happily that had not been the case and that she felt “happier than ever before.”

She said, “I know my talks with you have helped because I laugh a lot these days. I have hope and can be excited about every new day. I am happy to go to school and laugh a lot with my sisters and friends. Hope means I am strong, no matter what happens in life.” Then, removing her school tie, unbuttoning the top of her blouse, and feeling her necklace, Monique said with a smile, “My necklace is a reminder of my hope. I think it’s so cool to be able to touch my hope.”

I, in turn, hope that Monique’s story illustrates the benefits of listening to a client’s metaphor and combining narrative therapy, positive psychology, and hope theory in working with a young client not only to cope with a current problem but also to build skills for the future. As such, I believe it underscores Snyder, McDermott, Cook, and Rapoff’s (1997) statement that our hope-filled stories “provide a means of navigating the future—they are prospective. We are on a pilgrimage from the past to the future, and our hope laden personal tales help us to chart this journey” (p. 18). As a hope-filled therapist, I

believe that the “storying” of positive ideas with clients is prospective as it helps make their future seem possible.

Putting It into Practice

1. Have a hope-filled framework of therapy.

If you hold realistic hope for your client, your client’s abilities, and the outcome of therapy, it is more likely your client will benefit from the therapeutic experience. In having a hope-filled framework, you are:

 - a. Setting a positive expectation for your client.
 - b. Being goal or outcome directed.
 - c. Role-modeling the value of hope.
2. Examine and deconstruct the client’s problem stories.
 - a. Helping Monique discover and accept her own strengths empowered her to tackle the problem stories she had been telling herself. What are your client’s resources and strengths? How can you assist them in that discovery?
 - b. Stepping back from a problem, externalizing it, seeing it as something outside of us rather than as something wrong with us personally may put us in a better place to deal with it. Monique did that with her externalizing images of the divorce, heartache, and angry monsters. Invite your clients to form their own externalizing images. When you talk about that problem, what image comes to mind? If you saw it as something outside of you, what would it look like?
 - c. It is easy for all of us to start to believe the thoughts we have in our head and to treat them as if they are real. These discourses may be reinforced by beliefs and concepts in our society or culture. Help your client challenge those that are not helpful or realistic. Is that true? Is it helpful to think in that way? What might be more beneficial thoughts you could create?
3. Create a preferred, more hope-filled story.

Monique did this with her empowering story about putting the lid on the divorce monster—a story that acknowledged her problems; recognized her personal strengths; found effective cognitive strategies to modify her old, unhelpful discourses; and provided her with skills for the future. Ask your clients: What is your preferred outcome to this story? How will you be thinking, feeling, and behaving when you are there? And what steps do you need to take to get there?
4. Validate the new hope-filled narrative.

For Monique this was writing, designing, and editing her own story-book. For other clients it may be in writing, drawing, telling, or simply starting to live out the new story. As they do so, how might they celebrate and share the new hope-filled message?

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CHAPTER 8

Development through Disability

The Unfolding and Sharing of Psychological Resources

Antonella Delle Fave

MEET THE CONTRIBUTOR

Antonella Delle Fave, MD, is professor of psychology, specializing in clinical psychology, at the Faculty of Medicine, University of Milano, Italy. Her interest in psychological resources and optimal functioning dates back to her college years. Together with her research team, she collected the largest cross-cultural data bank on psychological selection and optimal experience. She has supervised intervention projects and international cooperation programs in the domains of health and education.

After organizing the Second European Positive Psychology Conference in Italy (2004), she became president of the European Network of Positive Psychology (2006–2008) and president of the International Positive Psychology Association (2010–2011). She is author of 1 book and 120 articles and chapters, and editor of 10 books and 2 special journal issues. With her husband, Fausto Massimini, she shares their research work, love for classical music, and interest in Asian cultures.

Dipendra, sitting on a bench in his little shop in the Himalayan country of Nepal, is carving leaves and flowers on a wooden frame. He looks deeply concentrated and absorbed while working. Beautifully carved panels are hanging from the ceiling or leaning against the walls. Outside in the narrow street, children are going to school and the sun shines in the bright winter sky.

Some people visit the shop during the afternoon: a couple of friends or a customer asking for a decorated door. Dipendra exchanges conversation without moving from his sitting position. At a more careful observation, something is peculiar in his posture at work: Besides

using his hands for carving, he has put his left leg on the left side of the frame, to keep it steady. Nearby, a pair of crutches lies on the floor.

In a completely different situation, Giulia sits at her computer desk in an office building in her hometown in Italy. Her attention is rapidly passing from one task to the other: phone calls, people entering her office with the most diverse questions, e-mails and open files lying on the table. About 5 P.M. she switches off the computer, gathers some papers, and exits the building. A minibus waiting outside will drive her home. She gets assistance to enter the back of the vehicle in her wheelchair. Giulia lives with her mother, whose own unstable health conditions require that she also receive practical help. The apartment is equipped with technological aids that allow Giulia to accomplish most daily tasks on her own.

This chapter investigates the psychological well-being of these two persons with motor disabilities. Permanent motor impairments have a dramatic impact on individuals and their families. From the person's point of view, in the short run, they cause a decrease in autonomy and interaction with the environment. The ensuing difficulties can lead to progressive isolation and restriction of daily activities and interests. From the psychological point of view, in the medium-long-term period the person can develop loss of motivation, fatigue, and depression.

In chronic disease research, subjective well-being and perceived quality of life are quite recent issues, and they have rarely been explored in cross-cultural perspective. My goal is to analyze the life stories of two people with disabilities who live in different countries. I attempt to identify their psychological strengths and resources and to draw some suggestions for intervention. From the theoretical point of view, I propose an approach focused on positive psychology and optimal experiences. It relies on a wide range of previous studies that clearly highlighted the paramount relevance of identifying positive components in life events and daily experiences in order to attain a successful adaptation at the psychological and social levels in conditions of disability (Delle Fave & Massimini, 2004).

HEALTH IN THE BIOPSYCHOSOCIAL PERSPECTIVE

The health conditions of human beings have biological, cultural, and psychological dimensions. At the biological level, the ecosystem and the genetic features of the population influence the kind of diseases people are exposed to. As for culture, each community develops traditions and beliefs concerning the body and its functions, the causes and treatment of diseases, and the impact of physical and mental impairments on the person's functioning potential. At the psychological level, each individual develops a personal evaluation of well-being and health, according to criteria such as values, beliefs, goal hierarchy, personality, and idiosyncratic style of interaction with the environmental opportunities (Delle Fave, 2006). The limitations of looking at disease and disability from a purely biomedical approach were first highlighted by Engel (1977), who claimed the need for a biopsychosocial model, centered on the patient as a person with a cultural background and a subjective experience of health, disease, and quality of life.

People with physical disabilities often are considered a disadvantaged group. However, this cannot be related to their biological impairments only. It also depends on the cultural

attitude toward such limitations (Delle Fave & Massimini, 2005) as people are only disadvantaged in an environment in which their condition brings about disadvantageous consequences (Ingstad, 1999).

Many people with disabilities perceive themselves as ordinary persons coping with extraordinary circumstances (Saravanan, Manigandam, Macaden, Tharion, & Bhattacharji, 2001). Supporting them in the process of adjustment to disease, and to its consequences, is a demanding task. Health professionals are becoming increasingly aware of the necessity to improve patients' long-term quality of life through the promotion of their autonomy and well-being, but also of their responsibility and active adherence to treatments and to healthy lifestyles. Nevertheless, the strictly biomedical approach still prevails in most countries and health services.

In developing countries, healthcare and disease prevention are officially proclaimed as goals to be pursued, but in practice they are far from being achieved. Again, cultural, political, and economic reasons contribute to this situation. In the last two decades, the attempts to promote health in spite of resource restrictions gave rise to intervention projects based on decentralization, low costs, and involvement of local communities (Atkinson, Rolim Medeiros, Lima Oliveira, & Dias de Almeida, 2000). These community-based rehabilitation (CBR) programs provide medical treatment and psychosocial support to people with chronic disease and disabilities. The involvement of family members in physiotherapy training partly compensates for the shortage of health professionals. Disabled people are offered vocational training and job opportunities. Advocacy campaigns to prevent discrimination and to promote disease prevention are organized in the communities. CBR projects represent, therefore, a prominent tool for health promotion: They are strongly connected to the local culture, they enhance awareness and participation of the families in the rehabilitation process, and they contribute to community empowerment (Lombardi & Delle Fave, 2002).

Health and Positive Psychology

As several studies have shown, it is crucial to assess well-being from the subjective perspective and not just the physical, taking into account factors such as the individual's evaluation of his or her social relationships, work opportunities, physical conditions, goals, and achievements (Diener, 2000; Marmot & Wilkinson, 1999; Veenhoven, 2002). The investigation of subjective well-being allows researchers to detect psychological resources, strengths, and potentials that effectively contribute to health besides physical conditions or bank accounts. Moreover, an approach focusing on resources and abilities instead of weaknesses and deficits can provide useful information for designing interventions aimed at promoting development and well-being in any domain of society.

These are precisely the goals positive psychology pursues in its applications to the health domain. Some of the constructs developed within this framework seem especially useful for health-related intervention. Self-efficacy, sense of coherence, self-determination, resilience, optimism, hope, and the ability to find meaning in one's circumstances can represent powerful tools to support individuals and caregivers in the adjustment to disease.

These constructs belong to a specific approach within positive psychology: the eudaemonic perspective. This approach stems from Aristotle's concept of eudaemonia as the fulfillment of one's true nature, which includes both self-actualization and commitment to socially shared goals (Ryan & Deci, 2001). According to this perspective, well-being derives

from the cultivation of personal resources and strengths but also from the pursuit of collective values, leading individuals to actively contribute to the well-being of their community. The eudaemonic perspective identified well-being with engagement and commitment rather than with positive emotions and pleasure. Therefore, it is particularly suited to support well-being among people who have to cope daily with extraordinary circumstances while pursuing personal growth and social integration.

DISABILITY AS A RESOURCE: TWO EXAMPLES

Context: Nepal and Italy

Nepal is an Asian country undergoing quick changes at the political, economic, and cultural level. It has over 23 million inhabitants, 45 percent of them younger than 20. In 1998, according to the Nepal Human Development Report, people with disabilities represented 10 percent of the population. In spite of legal provisions, only 15.3 percent of them benefit from health facilities, over 70 percent have no education, and 76.6 percent fully depend on their families. Several nongovernmental organizations (NGOs) provide rehabilitation services, but they are located primarily in big towns, while the greatest part of the population lives in rural areas. In Nepal, the first CBR project was launched in 1986 in Bhaktapur, a city in the Kathmandu Valley. The project started with 11 children and now serves over 1,000 people (Save the Children Norway—Community Based Rehabilitation, 2000).

In Italy, a recent study (Istituto Nazionale di Statistica, 2005) reported that people with disabilities account for 12 percent of the population. Like all the other citizens, they have free access to health services. Among them, 14.2 percent (mostly people above the age of 60 and with severe mental disabilities) have no education. As a consequence of national policies aiming at maximizing the social integration of citizens with disabilities, 92.8 percent of the school-aged people attend regular classes along with students without disabilities. About 60 percent of the adults are working or worked before retirement in private or public organizations. As in most European countries, Italian policy makers are paying increasing attention to the psychological and social components of disability. In 1981, the European Parliament stressed the need to promote the economic, social, and vocational integration of disabled people. In 2000, the Lisbon and the Nice European Councils emphasized the necessity to offer “appropriate solutions reflecting disabled people’s own perspective and experience.” Within a five-year community action program to combat discrimination, 2003 was declared the European Year of Disabled Citizens. Italy has demonstrated a growing effort to remove architectural barriers and to guarantee the accessibility of private and public places to all citizens. More attention is also being paid to the implementation of job and educational opportunities available to people with disabilities (Delle Fave & Massimini, 2005).

The Participants: Dipendra and Giulia

Dipendra, whom we met at the beginning of this chapter, is 20 years old. He lives in a small town in Nepal, together with his mother, two younger siblings, and the family of his older married brother. His father, a woodcarver, died five years earlier, after having taught Dipendra the basics of his art. When Dipendra was 6 months old, he contracted poliomyelitis, and his legs

became floppy and flaccid. His parents could not afford medical treatment. They already had three children, and in the next few years two more siblings were born. Dipendra spent his first seven years of life sitting inside the house, without going to school, without playing with other children besides his siblings, and with no idea of what his future would be.

In the meantime, a local CBR project was started, and Dipendra's parents were invited to send their child for free surgery and physiotherapy treatment. This had an enormous impact on Dipendra's life: His physical condition dramatically improved, his upper limb muscles became stronger, and he learned to skillfully move around on crutches. He completed primary school, and his father started him off on woodcarving. It seemed a very good investment for the future of a boy who could not walk and stand. By virtue of Dipendra's outstanding accomplishments in carving, after his father's death, the CBR organization proposed he attend a vocational training course. Dipendra could thus complete his apprenticeship and start his own business.

Giulia is a 43-year-old lawyer in an Italian city. She works for a nonprofit association providing legal consultancy to people with spinal cord injuries. Thanks to her professional competence, in the last 17 years she has brought to the attention of policy makers the needs and resources of people with motor disabilities, thus contributing to the implementation of services and provisions. She is also chief editor of the association's quarterly journal, which represents an effective instrument for networking and advocacy.

Giulia was the victim of a road accident at the age of 16, when she was a successful high school student actively involved in scout activities. She sustained a severe spinal cord injury and became quadriplegic. Rehabilitation in specialized centers in Italy and Germany allowed her to partially recover the functionality of her right hand and arm. Thanks to these positive outcomes, today she can write, eat, shake hands, cook food, and move around with the aid of a wheelchair.

After a study interruption due to rehabilitation, Giulia graduated from the law faculty. Her family and friends supported her in facing her difficulties and barriers.

The Research Questions: Optimal Experiences and Psychological Selection

Studies on disability often focus on pathology and psychological distress. In contrast, my research team aimed at investigating the positive side of life history and daily experiences. We assumed that a constructive perception of one's own physical, psychological, and social conditions, coupled with environmental facilitating factors, can help people with disabilities to cope successfully with life challenges and pursue meaningful goals. To investigate these issues, we used qualitative research instruments based on open-ended questions, thus allowing people to provide their own subjective outlook.

The first instrument was the Flow Questionnaire (Delle Fave & Massimini, 2004), designed to investigate the activities and situations people associate with optimal experience, or *flow* (Csikszentmihalyi, 1975). This positive and rewarding state of consciousness is characterized by the perception of high environmental challenges, matched with adequately high personal skills. Concentration, engagement, enjoyment, control of the situation, and intrinsic motivation are other components of the flow experience. Cross-cultural studies with thousands of participants have shown its universal recurrence and psychological features (Massimini & Delle Fave, 2000).

The second instrument was the Life Theme Questionnaire (Csikszentmihalyi & Beattie, 1979), which allowed us to investigate the participants' evaluation of their own life history in terms of past influences, present challenges and accomplishments, and future goals.

We hypothesized that psychological well-being and social integration do not depend on physical conditions alone. Rather, physical constraints can help people discover opportunities. They can foster personal growth and enhance strengths and resources (Delle Fave & Massimini, 2003). We also expected to find for each person a relationship between the activities associated with optimal experiences and the features of his or her life history. Several studies suggested that optimal experience represents a psychological compass orienting *psychological selection*.

Psychological selection is a lifelong process that leads individuals to preferentially cultivate specific activities and values over time while discarding others. In turn, this selection guides meaning making—a process by which people ceaselessly review their past, attribute meanings to life events, and build their future expectations (Csikszentmihalyi & Massimini, 1985).

The Answers: Eudaimonic Lives

Dipendra associated optimal experience with woodcarving. He also provided some details on the onset and unfolding of this optimal experience for him. “It is a situation of deep concentration,” he said. “I feel happy immediately when I start carving. Enjoyment grows gradually as the work progresses and the results are satisfying. But if the difficulties are too high, as happens with complex and highly detailed carvings, this feeling stops.”

When I asked, “What things do you like to do most?” Dipendra again answered, “Woodcarving.” As for the most enjoyable activities in his life, he reported, “To carve stone statues of Hindu deities.”

“What are your most positive life influences?” I asked.

“My job and having learned to play drums,” he replied. “My job is especially important, because through it I can earn money and I can do other things.”

He also identified negative influences, stating “Due to physical constraints, I cannot carry heavy loads and I cannot walk. However, physiotherapy exercises and the support of CBR brought about many improvements. I learned a job that does not require me to carry weights and I learned to walk with crutches.”

Concerning his present accomplishments and future goals, Dipendra said, “The most satisfying accomplishment till now is my present situation, what I could achieve through regular physiotherapy exercises, school education, and vocational training. My happiest memory is when I started walking with crutches after the treatment. My goal for the future is to become a good woodcarver and to teach this job to other people.”

Finally, when I asked Dipendra to describe himself, he said, “I am a nice boy. I do not want to hurt other people. However, sometimes I get angry when children disturb me with silly comments on the way I walk.”

Giulia associated optimal experience with several activities. “My job,” she said, “because I like it very much; reading the newspaper; watching a movie; attending conferences on spirituality and religious topics.” She continued, providing additional details on the onset and unfolding of optimal experience at work. “It can happen when I am talking on the phone with someone who needs help . . . or when I am working at the journal, searching for new ideas for an article or reading new interesting information. I feel satisfied with myself and happy to

transmit my experience, and to get inner enrichment. This feeling starts spontaneously and goes on by itself because I like my work. It is a source of complete satisfaction and self-actualization.”

“What have been the most positive influences in your life, Giulia?”

“To grow up in a beautiful and healthy family, to join a scout group at the age of eight and to find very good friends through it. These influences represented the foundations of my life, they taught me basic values that are still valid for me today.

“I cannot identify any negative influences,” continued Giulia. “I would rather speak about painful events which severely tried me, but I learned to overcome them by myself. They made me a better person. I became stronger. These events were the road accident, the death of my father, the death of a dear life companion, the death of an intimate friend, and the health problems of my mother. These events caused much sorrow and grief. They let me question my own behavior and raised doubts about myself. I lost my inner balance. When my mother was sick I also had to face practical difficulties in daily life management, but all that was not completely negative, if we can manage to turn it into a positive—as I did. I became stronger, and my personality improved. I looked for help in religious faith.”

When asked about her accomplishments and goals, she answered, “My most satisfying accomplishment till now is having lived my life intensely, moment by moment, getting the best from every experience. This is important because the time we have been given is sacred, and it must be used well. To pursue this result you have to give meaning to your life, and I found it through faith.

“My future goals are to improve myself as a person and to attain an effective management of practical daily activities. The first goal is the most important one, because a good relationship with yourself is the starting point for everything else. My work is connected with these goals, because it puts me to the test as concerns my skills in accomplishing tasks and in interacting with people. I am always watchful and careful. At the end of a task I check what I have done and I try to do better.”

Finally, when asked to describe herself, she said, “I am a strong and, at the same time, sweet person, ceaselessly aiming at self-improvement.”

The Environment: Opportunities and Constraints

Giulia and Dipendra live in very different environments that, since childhood, provided them with different opportunities for action and development.

Giulia was born in a big city of a postindustrial western country. Free health services and mandatory vaccinations allowed her to grow into a healthy girl. After the road accident, she got the best medical and rehabilitation treatments available in Europe. She was raised in a middle-class family, both her parents had stable jobs, and they could provide their two children with a good standard of living, college education, and the opportunity of cultivating their favorite sports and hobbies. In spite of physical limitations, today Giulia runs a basically autonomous life thanks to up-to-date technological aids and the accessibility of most places. In the social context, she can rely on a supportive family and lifelong friendships.

Dipendra was born in a little town of a very poor country. In Nepal, health services are limited and expensive. Free vaccinations against polio were begun only in the late 1990s, but many children are still not getting immunized. When Dipendra was born, poliomyelitis was one of the predominant causes of disability among Nepalese children. When he contracted the illness, his father’s income was not sufficient to provide him with adequate medical

treatment. Moreover, his parents had to care for four other children. All of them received primary school education, the maximum their parents could afford. Dipendra's future prospects were quite discouraging, but the start of a CBR project dramatically changed them. After seven years of hopeless passivity, he received medical assistance, education, and vocational training. A new life had started for him.

While very beautiful, Dipendra's hometown is an ancient city, scattered with architectural barriers for people with motor disabilities who have to be very creative in order to cope with the daily challenge of moving around. In 12th-century streets and buildings, even simple technological aids such as wheelchairs (if they were available) would be basically useless.

The Persons: Psychological Resources and Adjustment Strategies

Giulia shows three psychological resources that have been investigated by positive psychology.

1. She is resilient in that she was able to undergo a successful development in spite of adverse "extenuating conditions" (Masten & Reed, 2002).
2. She has strong self-efficacy beliefs, considering herself capable to actively control her level of functioning in dealing with environmental demands (Bandura, 1997). Self-efficacy positively affects motivational and decisional processes in the short run while, at the same time, influencing future goals. It fosters goal commitment, perseverance, attribution of successes and failures to predominantly internal causes, and the perception of environmental demands as challenges rather than as threats.
3. Giulia reports that she is deeply religious. Faith and religion provide an answer to the human need for giving a sense to daily circumstances, allowing individuals to transcend their own limited self toward a wider vision of reality (Sperry & Shafranske, 2005). Consistent with previous findings on the relationship between well-being and religious beliefs (Koenig, McCullough, & Larson, 2001), in faith Giulia finds hope, support, goals, and life meanings.

These resources have allowed Giulia to pursue and achieve complex goals: a university degree, the engagement in a socially relevant profession, and the cultivation of lifelong friendships. The association of her daily work with optimal experience confirms the consistency between her long-term commitments and her everyday choices and its positive outcomes at the experiential level. Such resources also have enabled Giulia to state that her accident, rather than being a negative life influence, made her stronger through inner growth and endurance.

Unlike Giulia, Dipendra faced disability early in his childhood. He had to become precociously aware of the limitations imposed by his physical and environmental conditions. In spite of his young age, he shows a good degree of realism and objectivity in describing his situation and life expectations. At the same time, he looks optimistic about his future: He is committed to improving his job skills and to start a woodcarving training course for others. According to Taylor and Gollwitzer (1995), optimism represents an important resource, in that it supports efforts toward goal achievement. However, only positive levels of realism and optimism combined together can be adaptive in any

situation, thus helping the individual to correctly perceive risks, constraints, and problems (Schwarzer, 1994).

In Dipendra's story, woodcarving emerges as the prominent interest and source of well-being in everyday life as well as in the future. Previous findings have shown that optimal activities play a prominent role in disabled people's chances of integration in the active life, in that their cultivation contributes to maximize residual sensorimotor skills and implementation of vicarious abilities. The enjoyment, high challenges, and intrinsic motivation reported in doing such activities foster their preferential replication and the achievement of higher levels of complexity in behavior through the progressive increase of related skills and the acquisition of new information. This is particularly true of work activities, especially those requiring complex competencies, such as handicrafts. Dipendra's association of optimal experience with an activity that represents a source of income, of social integration, and of psychological well-being is a substantial prerequisite for his pursuit of a successful life.

SUGGESTIONS AND WARNINGS FROM POSITIVE PSYCHOLOGY

Giulia and Dipendra come from vastly different cultures, live in very different environments, have suffered different disabilities, and received different levels of community and medical support. Nevertheless, they share something important: Both have reached a successful adaptation that highlights how psychological resources play a primary role in the promotion of well-being and social integration. Moreover, their stories emphasize the necessity to consider quality of life as a subjective concept when working with people facing the challenge of disability. Far from being related to health only, well-being involves domains and activities that are not necessarily dependent on bodily conditions alone.

That being the case, what can we learn from how Dipendra and Giulia developed through their disabilities that might help other disabled people enjoy more optimal experiences and a life of well-being? Their stories highlight the dynamic interplay between individuals and the environment. Two persons in the same health conditions can have different levels of functioning. It depends on variables that differ from physical factors alone but that are nevertheless connected with health: psychological features, family and social support, material and economic resources, educational background, cultural representations, and social policies (Üstün et al., 2001). It is thus incumbent on psychotherapists and, indeed, on all health workers to be aware of *all* of these factors and to take them into account in their therapeutic approaches.

A Warning to Consider in Therapy

At this point let me offer a warning. The spreading trust in the astonishing powers of the "psychologically positive" entails two main risks:

1. The adoption of a simplified approach to the complexity of human behavior that dichotomizes the positive and the negative aspects of experience, instead of considering their natural mixture throughout most daily situations

2. An excess of trust in the applicability of positive constructs to intervention models, as if they were a panacea for any problem (Delle Fave, Bassi, & Massimini, 2008)

However, keeping these risks in mind, the promotion of resource maximization and development is of paramount importance in fostering well-being. Moreover, the eudaemonic approach helps us focus on meaning making and goal pursuit in a perspective of sharing and community empowerment. This is important in a discipline such as psychology, which is focused on interventions involving persons, individual issues, and proximal social environment. The eudaemonic perspective invites us to dare to search for higher meaning and broader visions and to support our clients to look for them as well.

It is therefore mandatory for psychologists to develop models of individual optimal functioning that encompass biological and cultural components. These models should focus not only on deficits and pathologies but also on psychological resources, perceived sources of positive and rewarding experiences, and long-term goal setting and meaning making. In evaluating the resources available in the social context, attention should be paid not only to the family but also to the community. It is hard to imagine any clearer or more inspiring examples of the application of these principles than those offered by Dipendra and Giulia. They show the means by which a person can learn to successfully adapt to a major disability. They show it is possible not to see oneself as a disabled person but to accept oneself as a person *with* a disability *and* with abilities to live a meaningful and fulfilling life.

Putting It into Practice

1. Inquire about the client's psychological resources.

The questions put to Dipendra and Giulia helped them identify a number of psychological resources for creating a quality of life experience after a severely disabling problem. Might similar questions assist your clients? What are the strengths, resources, and abilities they have or have exercised in the past? How might they be assisted to employ their psychological resources to deal with current challenges?

2. Ask about sources of positive and rewarding experiences.

For Dipendra, one positive experience was obviously his carving, while for Giulia, it was helping someone on the phone or working on the journal. What are your clients' optimal experiences? What activities provide them with challenges that promote concentration, engagement, enjoyment, control of the situation, and intrinsic motivation? How can they increase these activities to enhance their experiences of well-being?

3. Explore the client's long-term goal setting.

Dipendra's goal was to become a teacher of his trade whereas Giulia's was one of self-improvement. Where are your individual clients heading?

(Continued)

(Continued)

What are their long-term goals? How might you help them set those goals and plan the steps for their implementation?

4. Assist clients to make meaning of their experience.

Giulia saw that her physical disability had (a) made her a better, stronger person; (b) improved her personality; and (c) enhanced her religious faith. Ask your clients to search for their own meaning through questions such as: What have you learned from your experience? In what ways has this benefited you? As unfortunate as this may have been, what positive things can you glean from it?

5. Explore the support networks among family and friends.

Dipendra's learned woodcarving from his father and many essential life and coping skills from his family. Growing up in a beautiful family, plus having good friends in the scouting movement, were the foundations of Giulia's life and values. What supportive family and friend networks does your client have? If already present, how can the client utilize them? If absent, how can you help the client build them?

6. Help the client maximize resources in the community and social context.

The local CBR project provided Dipendra with free surgery, physiotherapy, and vocational training that enabled him to complete an apprenticeship and begin his own business—and enhance both his physical and his subjective well-being. What resources exist in your client's community that might be of assistance? Our clients' lives exist beyond our consulting room. It is important for us to be acquainted with the facilities in their environment.

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CHAPTER 9

From Vulnerability to Skillfulness

Leisure and Positive Intervention in Therapy with Adolescents

Teresa Freire

MEET THE CONTRIBUTOR

Teresa Freire did her PhD in social psychology and has been a university lecturer for the past 20 years. She is currently professor of psychology in the Institute of Education and Psychology, University of Minho, Portugal. Her main academic interests have been related to social and developmental psychology and more recently to positive psychology. She is particularly interested in the study of the person-environment interaction, how contexts can shape life trajectories and individual development, and psychological interventions such as psychotherapy for individuals and groups.

She also coordinates community projects both inside and outside of the university. Leisure is one of her main contexts for studying all aspects of human well-being and positive psychology. The concept of optimal experience forms a conceptual and methodological contribution to the study of leisure experience and positive development. Her own leisure pursuits include reading, writing, thinking about life, sports, being with family and friends, walking with her husband, and educating their children (two boys and one girl) as future citizens of the world.

I remember the first time I came to these sessions of psychology. I remember because that day I cried a lot, with fear! I cried because I spoke, for the first time, about my problems. I told which problems they were and how they tormented me along the years . . . and I cried because, by saying them aloud and to a person I didn't know, I faced them and I thought for the first time: They are problems but they can be resolved.

THE ADOLESCENT I WANT TO SHARE WITH YOU

After our final session of therapy, Maria wrote a letter telling her own story about her evolution. I have broken her letter into several sections, used it to open this chapter, and will let it unfold to show her progress through the various stages of our therapeutic sessions.

Maria was a 16-year-old girl, with one sister, who lived in an urban-dwelling, middle-class family. In many ways, she was so similar to thousands of adolescent girls, but the “problem” with which she presented to therapy was (a) defined and reproduced by the family, (b) reinforced by the society and, consequently, (c) integrated in her self being. My therapeutic approach was to work in the opposite direction: from self being to social being in order to promote Maria’s well-being. Showing how these interrelations between the self, others, and society were achieved is one of the aims of this chapter.

Understanding adolescents and the features of their developmental processes is not an easy task. As noted by Csikszentmihalyi and Larson (1984), “Of all stages of life, adolescence is the most difficult to describe” (p. xiii). Adolescence is not only a psychological phenomenon but it is also directly correlated with social and cultural evolutions, social changes, and representations. While adolescents are often experimenters with life—and themselves—this makes the job of social scientists a great deal harder. From my point of view, this is also true about therapy. The understanding of adolescents in therapy, and therapy for adolescents, has long been and will continue to be a matter for discussion and conceptualization according to different perspectives and models.

COMING TO THE THERAPY AND THE ASSESSMENT

Because of the need to integrate knowledge of family systems and developmental psychology in addition to the usual clinical demands, therapy with adolescents always involves more than one participant (Koocher, 2003). In this sense, it helps to know beforehand who comes to therapy, with whom, and for what. Why Maria came to therapy, who made the decision for her to come, and for what reasons, is part of the assessment process and understanding of her problem. My view was that Maria should attend first, without her parents or significant others. In fact, her mother accompanied her to my office but Maria entered the session alone.

Why do I believe clients should come alone? In coming alone, Maria had the opportunity to choose what she wanted to tell, and show, about herself. It was her first opportunity to actively change as well as an opportunity for the therapist to show acceptance of her possibility for self-management. In this manner, I was giving her the opportunity to be responsible for her own process of change. I could see her as a proactive person capable of actively making decisions for and about herself, as an adolescent in therapy (Keyes & Lopez, 2005).

I met with Maria alone for the first two sessions and, at the third, met with her parents. After gathering information about individual characteristics, the social structure of her living conditions, and her relationships with others, we drew up a list of the main topics to address in therapy—a list that was characterized by weaknesses or fragilities. Altogether they highlighted many negatives in the main domains of Maria’s life: the self, her relationships, her activities, and core places (Freire, 2006a). Although she had several internal resources, Maria held a strong negative self-concept. Working with her proved to be both a great challenge and an opportunity for applying positive psychology to therapy with teenagers.

Maria's life was predominantly defined by her parents, and some of the comments they made about her may help us understand the meanings built about, and attributed to, Maria. Five areas are important.

1. Maria's mother explained that her pregnancy with Maria was a difficult and stressful period, as she suffered a number of serious diseases that put fetal life in danger. The most severe was toxoplasmosis, which occurred in the most critical period of pregnancy.
2. After birth, Maria suffered medical complications that led physicians to give a very reserved prognosis about her developmental abilities.
3. Before she reached the developmental milestones of talking and walking, there was uncertainty about her mental development and whether she had sustained any cerebral lesions.
4. Despite a medical evaluation describing Maria as a "normal" girl when she began school, her parents continued to express their overt doubts about her mental and cognitive development.
5. Because of this uncertainty, Maria's mother remained constantly protective, always helping her daughter to do things and being there to resolve any kind of problems. She believed that without this maternal support, Maria could never do anything successfully.

Thus, Maria was presented as a source of long-standing problems in need of therapeutic assistance. But from a therapeutic perspective, two important questions emerged: How had Maria managed to survive such an adverse life? And what kind of meanings did she give to her life story?

The initial therapy sessions were devoted to the establishment of an empathic relationship based on confidence. This permitted Maria to discover that she was a person with potentials and resources, even though she had long been considered and treated as a "problem." Only after this did I begin to work with Maria on the implementation of positive strategies to enhance skillfulness. At the end of this process, we reinforced the new image of Maria in order to generalize her skills and build the positive image of a skillful person based on the success of her achievements.

Assessment is a necessary tool for any serious therapy process, but only if it defines and drives the therapeutic goals toward the needs of the client. Contrastingly, diagnosis that is centered in psychopathology can narrow the possibilities of positive change right from the beginning of therapy. With this in mind, I tried to maintain a mind-set that looked through the negative information I had been given about Maria and found the positive features about her and her life.

At the time of Maria's therapy, positive psychology was still only an intuitive belief for a small group of psychologists in which I felt included. Today literature shows a strong theoretical body of conceptualizations about positive psychology in therapy, although the tools for evaluation still have room for improvement (Fava & Ruini, 2003; Kazdin, 2003).

From Maria's example, I will share with you the individual intervention strategies we worked with as well as guide you through my thinking about the case, my afterthoughts, and Maria's therapeutic evolution. As it is not possible to describe every moment, every conceptualization, or every intervention of this therapeutic process, I will select and present only certain examples of my positive interventions.

THE STEP-BY-STEP PROCESS

One of the conceptual guides to my work with adolescents in therapy is the experience fluctuation model described by Massimini and Delle Fave (2000). Although not a specific model for therapy, it can be applied as a conceptual framework and a pool of positive therapeutic tools because it concerns daily life, psychological selection, and developmental processes. Through the analysis of how individuals perceive the balance between environmental challenges and their personal skills to cope with them, the model shows how subjective experiences fluctuate and how these experiences influence individual developmental processes. When high challenges and high skills are perceived as the core of the success in a task, optimal experience occurs, and this is considered one of the main sources for positive adolescent development, cognitively, motivationally, and affectively (Delle Fave & Bassi, 2000; Freire, Fonte, & Lima, 2007). In order to synthesize the whole process of Maria's therapy, it will be analyzed according to three main parts: the initial sessions, the intermediate sessions, and the final sessions.

THE INITIAL SESSIONS

The first sessions were aimed at collecting information about Maria's motive for coming to the therapy and, simultaneously, to understand her as a person and as an adolescent. Initially, she was shy, insecure, and had difficulty keeping eye contact. Her gaze was unresponsive so it was hard to get feedback about her emotional state. She was not very clear about why she was in therapy, but after some effort and as a consequence of our dialogue she presented her reason: "I can't do anything in the right way . . . I am not able to do things . . . and I think I'm not happy. Nobody loves me as a person!"

Her words and voice were fragile. She was almost crying. Her physical posture was uneasy.

"I'm too tall, ugly, and fat," she continued. "I don't like the way I look. I wonder if I could be different, another girl. . . ."

Jumping to her perception about her relationships with others, especially with family members, she expressed dependency, ambivalence, and negativity. "I'm not able to do things alone. I need my mother but I hate to need her. I would like to do things by myself . . . but I can't. I'm a failure."

When talking more specifically about her relationship with her mother, Maria told a sad history, with uncertainties and fears of not being a normal girl. She regretted having been born and was afraid of what lay ahead in the future. However, she finished this negative presentation of herself by saying "But I want to be happy! Can it be possible?"

With these brief sentences, she defined the aim of positive therapy with adolescents: not only to remove weaknesses but also to promote happiness. Her sentences echoed Duckworth, Steen, and Seligman (2005) when they stated, "Troubled persons want more satisfaction, contentment, and joy, not just less sadness and worry. They want to build their strengths, not just correct their weaknesses. And they want lives imbued with meaning and purpose." States of happiness "do not come about automatically simply when suffering is removed" (p. 630). Based on this, I consider the movement from vulnerabilities to skillfulness is a must-do element of all therapy with adolescents.

Maria had few friends, and this caused ambivalence. She did not want to have more friends because she did not want to feel different, and thus she avoided social exposure. As a consequence, she developed individual interests, such as writing, watching television, and “just thinking”—activities that led her into introspection and rumination.

My aim in working with Maria was not to expose her to what she already knew about her “problem.” Instead, it was to show her that despite the existence of problems (which I called vulnerabilities), she had strengths and skills to deal with adversity, and that it was possible for her to think, feel, and behave in positive ways. I hoped that this would create an attitude of motivation to the therapy itself and lead her to view it as a context of growth and genuine acceptance.

When problems exist, we want to resolve and remove them from our lives. Vulnerabilities, however, can exist without being a “problem”—simply something we want to improve or work on. In this sense, adolescents, and Maria in particular, can deal with vulnerabilities by using them to reorient action and internal resources, which in turn leads to building skillfulness. For this reason, I prefer to speak about vulnerabilities instead of problems.

What Were Maria’s Vulnerabilities?

Maria had five vulnerabilities:

1. There had been the continually reiterated family stories of a vulnerable and unhealthy personal history that projected her into a protected and dependent role.
2. Probably in large part due to point 1, she had a distorted self-image with an associated negative self-concept and lack of self-esteem.
3. She avoided social exposure and, consequently, had few relationships with friends, either fellow adolescents or adults.
4. She had few social activities, leisure pursuits, or locations outside of her home.
5. She feared the new or novel, whether new activities or new people.

As highlighted by Duckworth et al. (2005):

Viewing even the most distressed persons as more than the sum of damaged habits, drives, childhood conflicts, and malfunctioning brains, positive psychology asks for more serious consideration of those person’s intact faculties, ambitions, positive life experiences, and strengths of character, and how those buffer against disorder (p. 631).

This view is an about-turn in traditional approaches to therapy. With Maria, it meant I was in a position of choice about the directions we could head. I could proceed with attempting to heal her vulnerabilities, or I could proceed by promoting her skillfulness. The first choice was a long-established, legitimate, and well-documented approach to symptom elimination, but the latter was one that would bring much more happiness to Maria because she could build a sense of self-efficacy, confidence, and achievement . . . and so I chose the second approach.

Looking at Maria from this different point of view led me to ask different questions. Instead of asking about how her vulnerabilities had developed, I began to ask how she had survived such physical and psychological adversity. This was the changed focus at the very

core of positive psychology. Maria had survived only because of her resilience, and that meant she had definable strengths and potentialities. She simply did not know she had them because nobody had ever looked for them or shown her just what she possessed. Instead, persons and contexts had highlighted Maria's failures and concluded she was a failure—a conclusion she unquestioningly accepted for herself. This highlights the role of life contexts, relationships, and places in shaping individuals and their life trajectories. The process of therapy with adolescents must take these into account, in order to enhance a multilevel process of change that includes several different targets.

I confronted Maria by saying “For me, as I’m starting to know you, you can be a lot of things but surely you cannot be a failure. You resisted severe illness in your mother’s belly. You resisted serious diseases after birth. You resisted all these negative pressures, and you are here looking for happiness. You are definitively a strong person with so many resources. Your life is a story of success because you have your life! Surely, that is not a life of failure, as you have been saying, but a life of several successes.”

I will never forget Maria’s face in that moment. This was a very happy moment, even for me. I really felt what I was saying to her, and probably she saw that in my face and expression. Her nonverbal behavior changed dramatically. For the first time she smiled and said, “I had never thought in that way . . . but you may be right. Is it possible? How did I manage all these things in my life?”

What Were Maria’s Strengths?

Maria’s question opened the opportunity for us to mutually explore her strengths and potentials. Asking about them and discussing them together, we unveiled quite a number, discovering how vulnerabilities express strengths and orient one toward skillfulness. The main ones were:

- She was a sporty girl (basketball player).
- She had a complex level of thinking and reflection.
- She showed good cognitive development and was doing well academically.
- She was aware of her way of being and was empathic.
- She was motivated to change her current situation.
- She had an adequate family structure in which her parents paid attention to her and her potential.

These changes in her self-image, self-concept, and self-esteem were accomplished by employing four positive strategies.

1. I used cognitive confrontation to help her face up to both her weaknesses and her skills.
2. She was asked to record moments of positive daily experiences as this has been shown to have lasting positive benefits for well-being.
3. Together we planned actions and coping strategies that she could employ.
4. We explored the factors that contributed to successful actions and experiences for her across different situations and life contexts, such as family, school, leisure, and friends.

At this stage, some sessions were conducted with her parents present so as to explain and discuss with them the aimed shift from Maria's vulnerabilities to skillfulness. The same positive interventions were used to involve them and highlight their role and skills as Maria's main educators. Positive therapy with adolescents commonly engages parents in learning and using new ways for being parents with their child. Consequently, Maria *and* her parents were part of the intervention to make possible Maria's movement from self-being toward the social world.

From her posttreatment letter, this is how Maria saw herself at the commencement of therapy:

Before coming to therapy, my self-image was extremely negative. I repeat, extremely negative. The simple act of choosing my clothes was a dilemma, because I felt I was ugly and fat.

In relation to basketball, I just didn't give up because I had no courage to tell my mother and coach that I wanted to quit.

Food was one of my outlets. When I felt depressed I ate but then I felt even more depressed because I had eaten and become fatter and too heavy to exercise. I hated myself and thought that everybody hated me too.

I need to tell something about my mother. She was always there, near me. I was very influenced by her. Sometimes I changed my opinion just to agree with my mother. Today I think she had a big role: She never had been neutral to me. She was able to praise me or to punish me . . . and this helped me although sometimes I desired to be able to do things by myself.

THE INTERMEDIATE SESSIONS

Finding Skillfulness

During the intermediate sessions, my work focused on finding, developing, and generalizing Maria's potentials and skills in order to give her a different, more positive view of herself and of the contexts in which she was living. In general, these positive strategies were aimed at letting her construct new meanings about her life. Although Maria had expressed the desire to be "another girl," my main therapeutic goal was to change the framework in which she saw herself and her life—to help her view herself differently while still being her.

I want to discuss one intervention in particular: Donner's idea about the dual process of therapy on the subjective experience model (2006). This model focuses on (a) importing extratherapeutic life into therapy sessions and (b) generalizing therapeutic accomplishments to everyday life. One important and helpful area for therapists to look for extratherapeutic potentials is in what a client does for leisure or recreation. Engaging leisure as a therapeutic resource has three advantages in adolescent work.

1. As anyone who has ever lived or worked with teenagers will know, trying to discuss problems often highlights weaknesses, vulnerabilities, and uncomfortable feelings. Such conversations run into a brick wall, meet with resistance, and encounter the most commonly used adolescent phrase: "I don't know." By contrast, discussing leisure or sporting pursuits joins the teen in his or her world, finds a common connection, taps into positives, and helps build rapport.
2. Leisure provides a context where challenges arise and where skills for managing them are developed both in a structured and positive way (Freire, 2006a). The

development of leisure activities can offer a rich source of learning experiences, skill acquisition, and personal competencies.

3. The benefits of leisure experience in youth are well documented, clearly showing that structured activities are one of the most important sources of gratification for this age group (Freire, 2006a,b; Freire et al., 2007). As such, I think it is an underdeveloped and underutilized field in applied positive psychology. The role of leisure can provide potent examples for the purposes of positive therapy

“So what do you do for leisure?” I asked Maria.

“I play basketball,” she answered with a tone that indicated she undervalued this activity and herself as a participant in it. Nonetheless, basketball would have offered her opportunities for developing new skills. As a result, it provided a context that could be used to help build her personal strengths and potentials. If she could develop and use skills in the sporting area, could she also develop and generalize these skills to other areas of her life?

Developing Skillfulness

Everything that was necessary to work with Maria was there in the basketball context. One of the most important had to do with her physical image. Previously she had expressed self-doubts about being tall and different, but in basketball to be tall was a distinct advantage. There she was not so different, as most other players are also likely to be tall.

Several times she said, “In basketball, I don’t know why, but I don’t think about my weaknesses.”

Maria was expressing an important paradox: Given a greater feeling of choice she would probably not play basketball but in playing it she experienced a sense of well-being in which her problems disappeared. This is why it is important to ask adolescent clients about, and work with, the meanings they attribute to their particular leisure activity before asking them whether they like or want to participate in that activity. Maria had not placed any particular meaning on her sporting activity, apart from knowing that it shifted her attention away from her weaknesses. One of the main positive strategies I employed was to help her discover new meanings in this activity and learn to use this meaningfulness to enhance her self-concept.

As it turned out, Maria was a good player, she was skillful, and her teammates wanted her on their team. Playing basketball, she felt like a different person, though she did not yet see how this was good or how it represented a positive characteristic of herself. Her sense of negative self-esteem had spread to all contexts and self-images, regardless of the activity.

The four advantages of this sports/leisure pursuit for changing Maria’s meanings, perceptions, and behaviors were:

1. It highlighted that change was a real and possible alternative.
2. It showed that a group context can facilitate learning about relationships and behaviors with goals that balance challenges and skills.
3. As it was a volunteer leisure activity, she in fact had a choice about being involved or not, and she *could* choose for positive and healthy behaviors.
4. As a multiskilled activity, her leisure built positive psychological resources such as cooperation, discipline, social support, and recognition.

These advantages had a direct impact in Maria’s personal development, because they contributed to improving her daily experiences, social identity, intentional learning, physical

development, and motivation. Her leisure proved to be a rich source of skillfulness, within four main parameters: (a) self, (b) activities, (c) companionship, and (d) locations (Freire, 2006a). Through basketball, Maria had the opportunity to become stronger and more aware of her potential to deal with life's pros and cons. This structured leisure context had been a source of optimal experiences and, as a consequence, a main source of higher developmental complexity.

Generalizing Skillfulness

Maria's basketball provides us with a clear example that the things to be worked on in therapy are not necessarily outside of a client's daily life but right there in the very midst of it. Changes do not have to be created in special moments or through special activities that may be far removed from a client's daily experiences or opportunities. On the contrary, changes may be implemented within and throughout day-to-day moments, using known daily contexts, known persons, and known activities.

The second step in Donner's dual therapeutic process is generalizing the therapeutic accomplishments into everyday life (2006). If Maria could promote and practice self-enhancement in the leisure context, could she also do so in other daily contexts? By finding, understanding and developing her skills in basketball, could she also find, understand, and develop her skills in relation to her family, school, and peers—the three most important social contexts of an adolescent's life?

Once again, here are Maria's retrospective thoughts about this therapeutic moment.

I think I am a selfish person, maybe because I grew up thinking that I was not able to do anything in the right way. My mother usually said to me that I was self-determined but I never believed it. Today I think differently. When I want something I get it. The problem is to believe.

Sometimes I still have crises but although feeling some stress, I know that I can find solutions. Today I can handle the negative situations even if in a first moment I need to stop, think, reflect, and analyze the problem. But always I feel that I have skills to do it, and instead of a problem I find a challenge to achieve.

FINAL SESSIONS

During the final stages of therapy, Maria appeared to have achieved her wish. She was a different girl from the one I initially saw coming into the therapy. Gradually she became more confident and, as a consequence, more social. She developed new friendships and activities. She started to express her opinions more in public and reported feeling stronger in the ways she wanted to be. At the same time, she became more independent and autonomous and more proactive about doing things, such as going to a friend's house, buying clothes, or just going shopping by herself. Most importantly greater feelings of happiness and well-being accompanied these activities.

Maria still remained a somewhat reserved person who liked to think before acting, but she began to see that this could also be a skill at times rather than globally lumping it into the basket of weaknesses. She became aware of her limitations without allowing them to be an obstacle for her achievements. She understood what she was capable of doing and what she was not. This in turn gave her a sense of control and, at the same time, a sense of freedom of being.

It was after the final session that she wrote her letter talking about the therapy process and its influence in her change. Her concluding note illustrates how the sequence of psychological events and the change in meanings is more important than personality structure. Maria built her life in a positive way, discovering that she was and could be a skillful person. In moving from vulnerability to skillfulness, she illustrates for us a core principal of positive psychology: to enhance well-being and positive lives is to prevent illness and pathology.

I am an unstable person but in the past I was worse. At least now I can deal with it.

These sessions helped me a lot. They made it possible to believe in myself and in my potentials and strengths.

Now I have no more fear for living. I know and accept how I am but I also know my skills and strengths as a person.

When I achieve my goals I become more confident and I look forward to do more and more. I think I am not anymore a passive girl.

FOLLOW-UP

Maria attended therapy over a six-month period, coming weekly or fortnightly. At a review session one year later, Maria was initiating conversation, telling me about her positive experiences, showing that these were the real source of her actions, goals, and positive self-image. Not only was she continuing to play basketball, but she had become one of the best players and had been selected for the national team.

About two years later, Maria, now 19 years old, came to see me again.

“I am in the university,” she said with pride and confidence. There she had the opportunity to implement her new and defined identity. “I am able to think and to make my own choices and decisions, even if they are different from others.”

She had volunteered to be the coordinator of the students’ group and to represent their interests. In fact, Maria became a real leader.

“Sometimes I still have my own crises,” she added, “but the difference is that now I know that I can deal with them and manage my own feelings. I will never give up because I know that I am able to do it. I am a strong person and I am not ashamed of being the way I am.”

Maria knew that she could be a happy person but also that she needed to work at making it happen. The difference was that now she knew she had vulnerabilities *and* that she was a skillful person able to deal with both positive and negative life situations, whether internal or external.

REFLECTIONS ON MARIA’S THERAPY

While empirical research about the experience of therapy in adolescents is still underdeveloped, Maria’s case affirms that positive intervention is possible and that adolescents can learn about themselves and the external world in a positive way.

In traditional approaches to adolescent therapy, problems are analyzed through clinical diagnosis or conceptual theories that attempt to explain the disease and how symptoms can be removed. But from a developmental perspective based on subjective experience, therapy has to be seen, analyzed, and conceptualized in a different way: as a context of development, growth, and new opportunities for self-knowledge, as happened with Maria.

Therapy does not begin when we sit in front of the adolescent but when we know that we are going to have an adolescent in therapy. This is why we need to bring to the therapeutic process much more than the scientific knowledge of the unhealthy, illness, disease, or problematic side of life. We need to know about developmental, social, and cognitive psychology to understand the positive side of individuals concerning themselves and their relations with others. Adolescents are in a process of growing up and developing across life's daily experiences. Their subjective experiences are a tool to understand meanings in life. Development is action in context, making daily life their laboratory for growth and learning about the internal and the external world. Only by acting with them through this perspective can they become proactive individuals, interested in contributing to a better life.

We need a new scientific conception about adolescence that is not to know and focus on the “hard facts” of adolescence (Csikszentmihalyi & Larson, 1984) but to know about the subjective reality. What is it like to be a teenager? What do teenagers do and think? How do they feel about themselves and their changing lives? (Csikszentmihalyi, Larson, & Prescott, 1977; Freire, 2006a; Kaczmarek & Riva, 1996).

According to this subjective perspective, therapy for adolescents needs to be a context where development can occur under optimal circumstances. Therapy must provide an opportunity to promote and orient adolescent development. This means that it should work not just with personality but be a time and process for restructuring life and life contexts, a moment for shaping meaningful lives. Maria's meanings about her life changed drastically through the opportunity to build her strengths as a buffer against vulnerabilities.

Interestingly, this process also changed the way others saw Maria. The long-held family stories that contributed to her negative self-image altered as her parents expressed their pride in her and their confidence in her future. Finally, they took their place as one of her positive supports. At the same time, Maria was building a new meaningful life story, because now she was engaged with the world, her family, and her friends in a way that she had not been before. Summing up in her final session she said, “If my friends could know what therapy is like, they would never feel ashamed or embarrassed to come. Who doesn't want to know the best of oneself?”

Putting It into Practice

1. In working with adolescents, it may be helpful to see them initially without parents. This allowed Maria to voice her own feelings and thoughts, and feel as if she were being treated as a responsible person.
2. Sometimes the “problem” can be defined and reproduced by family stories or narratives. What are the stories that have shaped your young client? How might unhelpful stories be challenged or rewritten as more constructive narratives?
3. Ask about your client's coping and survival skills. In Maria's case, she had faced many challenges from a very early age. It was appropriate for the therapist to voice interest in how she managed so well for so long with such questions as:

- “How have you managed to survive such difficulties or adversities? What kind of meanings have you given to your life story? What has helped you to find a sense of purpose?”
4. Keep in mind one of the core principles of positive therapy with adolescents: Therapy is not only about the removal of weaknesses but also essentially about the promotion of happiness. How can my young client feel happier? What will help him or her experience greater levels of well-being?
 5. Sometimes it may help to confront a client with the therapist’s positive perceptions. Maria had taken on the family stories that defined her negative self-perception and unquestioningly integrated them into her own self-concept. By confronting and challenging these with the strength and resilience observed by the therapist, Maria came to reexamine her own long-held self-perceptions.
 6. Seek to find the strengths and skillfulness in your young client. This is where being aware of your client’s leisure activities, sporting interests, recreational pursuits, artistic talents, or general achievements can hold benefits. Simply highlighting the awareness of them can build hope and confidence.
 7. Help your client develop the skills and strengths they already possess.
 8. Look at how that skillfulness can be generalized toward resolving the presenting problem. If your client has the ability to develop skills in one area of life, can he or she not also develop skillfulness in other areas?
 9. Maria wrote a letter that helped confirm and validate her progress in her own mind. Can you ask your clients to similarly write a letter, draw a picture, write a song, or tell a story that confirms both the process and outcome of their therapy?

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CHAPTER 10

Do You See the Forest or the Tree?

Utilizing Client Interests and Strengths in a Case of Asperger's Syndrome

Diane Yapko

MEET THE CONTRIBUTOR

Diane Yapko, MA, is a licensed speech-language pathologist residing in Fallbrook, California. She worked at the University of California San Diego Medical Center and in private practice for almost 30 years assessing and treating children with autism spectrum disorders and other neurological and developmental disorders. She writes, conducts workshops internationally, and consults. She is the author of *Autism Spectrum Disorders: Frequently Asked Questions*, two book chapters on the subject of autism spectrum disorders, as well as articles on this and related subjects.

Diane's exposure to positive psychology and the various models of psychological treatments began over 30 years ago when she married her husband, psychologist Michael Yapko. She has traveled internationally with Michael and has integrated many different professional disciplines, such as psychology, hypnosis, play, and humanism, into her work with children. When not working, Diane enjoys spending her time with Michael outdoors hiking, walking on the beach, or just hanging out in their backyard.

In this chapter, I describe the case of Mark (not his real name), an 11-year-old boy with a diagnosis of Asperger's syndrome (AS). I worked with Mark in individual therapy on a weekly basis over the course of several years in my private practice as a speech-language pathologist. The parent of another client whom I was treating referred him to me. The presenting concern was Mark's "pragmatic language." This meant that Mark had difficulty with social language, which translated into difficulties communicating with his peer group and developing friendships.

It has been almost 30 years since I saw my first client with an autism spectrum disorder (ASD), and the challenge of working with this population continues to fascinate me. While there is a growing awareness for people who have autism and Asperger's syndrome worldwide, much of that information is about their *disabilities* (what they *cannot* do, what they struggle with, and how they act “odd” or “unusual”). This chapter provides readers a glimpse into the positive attributes, or *abilities*, that the ASD population possess. I describe Mark's case and how his unique *abilities* were utilized in therapy to facilitate his social language and conversational skills.

AN AUTISM SPECTRUM DIAGNOSIS

The term *autism spectrum disorder* has come to be used to describe a group of five disabilities that have traditionally been called pervasive developmental disorders (PDD). These include:

1. Autism
2. Asperger's syndrome
3. Rett's syndrome
4. Childhood disintegrative disorders
5. Pervasive developmental disorder—not otherwise specified (PDD-NOS)

The diagnosis of ASD is based on a variety of subjective data, such as clinical observation, standardized questionnaires, and test instruments. Currently, there are no objective medical tests, such as brain scans, blood work, or genetic tests that can confirm a diagnosis of ASD. Wherever a person falls on the autism spectrum, from those severely affected by their symptoms to those higher-functioning individuals with less obvious symptomatology, a diagnosis on the autism spectrum essentially means that the person has difficulties in the areas of language, social communication, and behavior to one degree or another (D. Yapko, 2003).

There are inherent contradictions evident in people diagnosed with Asperger's syndrome. For example, despite their normal to above-average intellectual capabilities, they typically struggle to fit in with the social demands and expectations of society. Metaphorically speaking, they often have specific islands of intellectual strengths in an otherwise turbulent ocean of social confusion. Despite their advanced vocabulary skills, they often have significant difficulty understanding or being able to use subtle, indirect, and abstract language skills. And despite their obsessive interest and focused attention on certain idiosyncratic topics of interest, their ability to attend to things outside that singular and narrow sphere can be significantly limited. These contradictions present interesting challenges and unique opportunities to the clinician to make deliberate therapeutic choices about whether to focus on one's strengths and abilities or to reduce weaknesses and pathology.

Positive Psychology in a Therapist's Practice: Focus on Ability or Disability?

Do you see the forest or the tree? One of the basic perceptual rules of attention and a core concept in clinical hypnosis is that what you focus on, you amplify (M. D. Yapko, 2003). If

you focus on the forest you become less aware of an individual tree. Attend to the characteristics of that individual tree and you are less likely to see the big picture of the forest. Similarly, if you focus on disability that, too, is what you are likely to see more of. If you pay attention to ability, what do you see and help foster?

The children I work with have identifiable differences that can, and often do, affect their ability to relate to others in negative ways. The list of things that these children are unable to do is often extensive. But what happens when I choose to focus my attention—and encourage parents and teachers to focus their attention—on what a particular child can do and is doing *well*? In my experience, my interventions are greatly enhanced, and there is good research evidence to support these subjective impressions.

In a classic study, called the Oak School experiment or the Pygmalion effect, Robert Rosenthal, a Harvard University professor, and Leonore Jacobson, a principal of a San Francisco elementary school, demonstrated that when teachers were told that certain children had the ability to blossom and succeed based on their test scores, the teachers treated those children differently (Rosenthal & Jacobson, 1968). The end result was that these children's test scores improved more at the end of the school year than did the scores of others in the classroom. This experiment, done in the late 1960s, highlighted the fact that one's expectation established a self-fulfilling prophecy, which played a critical role in behavior change in terms of what the teachers did with the children as well as how the children responded. Research regarding expectancy and self-fulfilling prophecy can easily be applied to enhancing the positive attributes in children with ASD by focusing on and developing those attributes in various contexts.

As a speech-language pathologist (note that even the formal title of my profession includes the word *pathology*!), my work has been exclusively with children who manifest a variety of different communication problems. You will notice I said “problems,” not strengths. Realistically, when people come to therapy, it is because they are seeking help with something that is not working well for them. So, inherently, we start from a deficit perspective. But how we approach or focus on that perceived or real deficit in treatment is negotiable.

Finding My Focus

I learned to focus on the positive early in my career. One of my very first clients was a teenage girl, about 13 or 14 years old, in a coma. She had sustained a head injury after falling off a horse and was an inpatient at the University of California San Diego Medical Center, where I worked at the time. I will never forget the experience of walking into the intensive care unit (ICU) and seeing this young girl hooked up to tubes and intravenous drips and monitors, appearing lifeless, and watching her mother talk to her as if she was just at rest. I think that was when I first became aware of the “heart” of positive psychology and felt its impact on me and my work. Of course, I did not know then that such an approach would eventually be called positive psychology, but I became aware of the power of positive expectancy and the benefits of placing emphasis on the strengths and interests of my clients (Seligman & Csikszentmihalyi, 2000).

My therapeutic goal, as prescribed by my supervisor at the time, was to stimulate this young girl's senses in the hope it would facilitate her recovery and establish an eventual mode of communication with her. Communicate with her? What was my supervisor thinking? This girl was in a coma! It would have been easy to focus on all the things that she could not

do, but instead, I immediately went to work and began asking her mother questions about Stacy's (not her real name) interests. I encouraged her to bring in some of Stacy's favorite music from home, and I played it for her through headphones on my tape recorder (there were no iPods or MP3 players back then). I asked Stacy's mother to fill old 35 mm film canisters with various products that Stacy could smell. Strong smells like coffee, cinnamon, and lotions were used, as well as colored markers that had smells with familiar flavors ranging from licorice to cherry to lemon. I also asked her mother to bring in favorite items from home that I could put in Stacy's hand, such as a stuffed animal or blanket. Twice a day, five days a week, for a couple of weeks, I stood at Stacy's bedside in the ICU and stimulated her senses of touch, smell, and hearing for 20 to 30 minutes. I suggested her mother do the same when I was not there. I encouraged her to keep talking to Stacy "as if" she were hearing and understanding everything. I told her to talk to her about things such as what was going on in the hospital, about her recovery, and what was happening with friends and family outside of the hospital. I also asked her to talk about things that were planned for the future that Stacy might enjoy (e.g., "When you get out of the hospital, we'll go to the beach and enjoy lying in the sand and swimming").

The results of our efforts fascinated and inspired me. Stacy began responding. Initially there were nostril flares with certain smells, then head turns, and squeezing items placed in her hand. Eventually Stacy made noises to protest and eye blinks to affirm things we said and did. It was several months before Stacy was able to communicate again verbally. To my amazement, she told us that she remembered some of the stimulation techniques her mother and I had used to engage her.

To this day, I do not know what extent my work played in her recovery. I only know that it changed my expectations and my behavior in how I worked with *all* future clients, no matter how hopeless they may have seemed. I never again predetermined what a client could and could not do, especially based on physical appearance or anyone else's preconceived notions of what was possible. I strive to keep my mind open to any strategy or technique that might work with a particular client based on the conditions of the moment (the context) and the client's interests, regardless of whether it fits within any theoretical framework.

THE CASE OF MARK

The Assessment

Mark was the 11-year-old boy with Asperger's syndrome whom I mentioned at the beginning of the chapter. His mother reported that Mark had poor eye contact, difficulty with personal space, odd posture and gait, an unusual tone of voice, poor hygiene, inability to take personal responsibility for his actions, difficulty with recognizing cause and effect as it related to personal relationships, and a rigid cognitive style that included all-or-none thinking. And that was to name just a few of the issues, along with the "pragmatic language" problems, that were identified when he came to therapy. When I spoke with Mark, these issues were immediately apparent in our initial session. However, none of the psychological or educational tests that had been administered to Mark previously had revealed any of these behavioral, cognitive, or social issues. They did, nonetheless, reveal his above-average IQ and his outstanding vocabulary abilities. I conducted a number of standardized language tests as part of a comprehensive protocol required by his school

district to help develop Mark's individualized education plan at school, but the test results were not nearly as helpful in assessing him as was simply talking to him. As is often the case with individuals with AS, test scores do not adequately represent either their abilities or disabilities. Tests may be a starting point for some clinicians or may be required by some bureaucracies, such as a school district or funding agency, but most often it is the "real-life" interactions that allow a clinician to see what a client can and cannot do and what the client wants or needs to do in order to accomplish a goal. My treatment is goal oriented and begins with this question: What does the child want or need to do to be effective in the contexts that are limiting him or her?

Mark easily fell within the average range on all the standardized language tests that were administered. Anyone reading the test results could easily conclude that Mark's language was within normal limits (a strength). But nothing could be further from the truth in terms of his *social language* abilities. Mark's inability to carry on a normal conversation and read the nonverbal cues of others, such as tone of voice and facial expression, were clearly deficits. Thus, the formal tests did not tell me anything about Mark's deficits or his strengths and interests. They did not tell me how extensive Mark's knowledge of trees was or his inexhaustible ability to talk about them. The test results did not show me his artistic abilities or his ability to recall details of his life experience, albeit mostly negative experiences of being bullied. It was only through talking to him that I learned this information. Formal test results lacked an ability to capture Mark's desire to have friends, even though his behaviors led most people to assume otherwise. It bears repeating that there is no substitute for personal interaction, keen observational skills, and a positive emphasis on looking for a client's resources in order to use them in treatment.

Setting the Stage

Unlike adults who typically choose to come to therapy to address a problem for which they want help, children often do not have goals in therapy. In fact, they often question why they are even there in the first place. I usually address this directly by asking kids if they know why they have come to my office. Some do, and will give the explanation that they have heard from their parents. For example, they may say, "You help kids with their speech," or "You help kids learn how to have friends." Other times, though, when kids say they do not know why they have come or perhaps do not want to discuss it, I simply offer a global answer, such as "Your mom [or dad, or teacher] tells me that you can do _____ really well, but you seem to be having some trouble with _____. They thought I could work together with you and we'd figure out how to help you with _____."

I like kids to know from the start that I am aware of something they can do well. I do not want to immediately address a problem that they are likely already too aware of. My goal is to help them resolve it in some collaborative way by first establishing a positive expectancy for change(s) that we can make happen together. Depending on the child's interest, this explanation may continue into a discussion or simply end with no further comments. I follow the child's lead here, as I do in most of my work. When children recognize an area of need, either on their own or in agreement with a presented concern from a parent or teacher, that is usually where I begin my treatment. However, in some instances, when children do not believe they have any problems and may in fact be angry about coming to my office, I suggest that we might simply forget about what the parents and teachers are worried about and play a game of the child's choosing.

This was the case with Mark, who seemed oblivious to his own shortcomings. He simply blamed all those around him for not being polite and listening to him when he talked (as he had been told to do with others). As we played the game (it does not matter what game is chosen, since the game is only a distracting context for engaging the child in conversation in a less direct and threatening way), I encouraged Mark to tell me about things he liked and things he could do really well that he might be able to teach me. He began by telling me that he knew a lot about trees. I asked him what kinds of trees he knew about—and that was the last time I spoke for at least the next 10 minutes. He launched into a monologue leaving no room for a balanced interaction.

Mark rarely paused in the litany of information he gave, there were no questions asked of me, there were no chances for me to comment about a shared piece of information or experience, and the minutia of detail was well beyond any level of interest I had in trees. Mark did not appear to be aware that I was in the room and ostensibly his conversation partner. He often looked around or down rather than at me, seemingly talking to empty space. He was therefore not able to observe any feedback available to him from my body posture or facial expression regarding my level of interest or understanding, much less interpret such cues appropriately and respond to them.

Goal Setting

I could have addressed a number of different goals with Mark when he began therapy. By starting with his area of interest (talking about trees), it was an easy introduction into the art of conversational skills. Had his interest been in pipes and plumbing instead, I might have chosen to start therapy with hygiene issues. Or had his interest been in physics and atoms colliding in space, I could have addressed the issues he had with physical proximity to others.

Mark and I addressed many different goals over the three years we worked together. For this chapter, I have chosen to write about my goal of helping Mark develop his conversational skills for three reasons.

1. This goal is a common one for people with AS and, therefore, I hope it will have broad applicability for clinicians working with this population.
2. This goal encompasses a number of other related goals, including the opportunity for Mark to: develop more flexibility in his thinking, learn about perspective taking, read nonverbal cues, take personal responsibility, and understand cause and effect as it relates to interpersonal skills.
3. It illustrates some of the principles and processes for working from a positive perspective with a client's abilities.

Philosophically, as a therapist, I am inclined to focus on individual strengths and personal resources. Yet, practically, I could not ignore the fact that some of the odd or unusual behaviors that Mark exhibited would not be tolerated within society or his peer group. They would only subject him to ridicule or allow him to be taken advantage of by others. Therefore, I found myself alternating between minimizing Mark's deficits while enhancing and utilizing his strengths. I was modeling the very flexibility that I wanted to teach Mark. I wanted him to learn that our interactions did not have to be "all or none," as was typical of his own rigid thinking style, a cognitive distortion often referred to as dichotomous thinking (Beck, 1976).

The Intervention

I knew from Mark's mother and the reports that were shared with me that Mark did not communicate effectively with or fit into his peer group. It is common in many individuals with AS that their personal areas of interest (trees, in Mark's case) become an exclusive conversational topic maintained at the expense of other people's interests. I generally focus on how I can use the resources that a client presents. In this case, those resources included Mark's memory for details, his knowledge about trees, and his ability to articulate this information using appropriate vocabulary and grammar. After Mark spent about 10 minutes talking about trees, I finally interrupted him and said, "Wow, you really do know a lot about trees!" The next exchange highlights how I proceeded to introduce several of the goal areas we would address in therapy, including the mechanics of conversations such as turn taking, questioning, recognizing, interpreting, utilizing nonverbal cues (eye gaze, facial expressions, tone of voice), taking personal responsibility for being an active conversational partner, and flexibility in how to manage wanting to talk only about trees when others were not interested.

"Do you know what *I* know about trees?" I asked.

"No," replied Mark.

"Why not?" I inquired.

"You didn't tell me," he answered.

"You didn't ask!" I responded.

This was the first opportunity to share with Mark that he had a personal responsibility to be an active partner in this exchange and that learning to ask questions was an important way to do that. To determine whether Mark knew *how* to ask a question or just did not want to ask questions, I simply asked him, "Can you think of a question to ask me about trees?" When he said, "Do you know about the Redwood trees in California?" I discovered he knew about the mechanics of questions. I reinforced this skill and told him that was a really good question, then asked if he could think of any others to ask me. He generated several others, such as: "Do you have a favorite tree?" "What trees are at your house?" "Do you know what the biggest tree is?" Because these questions were not identical in structure to his previous question, it indicated to me that he had yet another resource I could use in therapy. He was able to be flexible in his questioning, at least when the topic was trees. This would eventually be a good starting point to build on his ability to ask various types of questions on other conversational topics.

Mark knew *how* to ask a question; now my goal was to focus on teaching him to know *when* and *why* to ask questions in a conversation. I explained that he was good at asking questions and wondered if he would play a game with me to see how many questions he could ask. He would get 1 point every time he asked a question and 2 points if the question was directly related to something I had just said. I began with the comment, "I like ice cream." Mark asked, "What's your favorite flavor?" I responded, "Great question. Two points!" and promptly made 2 marks on a piece of paper. I offered another arbitrary comment. "I'm going to Australia next month." Mark said, "They have eucalyptus trees there." I picked up the pencil to make a mark on the paper and then stopped and slowly made an exaggerated facial expression, representing uncertainty or curiosity or maybe even confusion. Mark took several seconds to process the situation before he spontaneously asked, "Have you ever seen the eucalyptus trees there?" My pencil immediately hit the paper, my face turned into a broad smile of satisfaction, and I said, "Two points!" I went on

to compliment Mark and said, “You just did something great. Do you know what you did?” Mark was obviously pleased that he had been complimented but was also confused by the question. He responded, “I asked you a good question.” I confirmed that indeed he had asked a good question but that he had done something else really great. He had actually changed his original comment (“They have eucalyptus trees there”) into a question (“*Have you ever seen* the eucalyptus trees there?) by observing many different aspects of the situation. He had to recall that the goal was to ask questions, to recognize that he had not asked a question, to see my face as showing some expression (I did not know at the time whether he had actually processed any meaning from the expression) and he had to observe that I had not made any mark on the paper. He had just demonstrated to me (and to himself) that he could learn to read nonverbal cues! This was only a first step on a long road for all that would be necessary to teach him the skills for understanding nonverbal cues. But it highlighted a strength I could identify and utilize for him, empowering him to know he could do this.

Next, I returned to the issue of *when* and *why* to ask questions in conversation by making a list with Mark. I titled the page “*Why Do We Ask Questions?*” and then started to list the reasons: (1) to gain information, (2) to clarify something that is not understood, (3) to show interest in someone else, and (4) to maintain a conversation. Examples were given and as new situations arose, and as therapy progressed, we added to our list. I developed another list for Mark titled “*When Do We Ask Questions?*” I explained that some of these would be duplicates of “why” we ask questions, for example: “We ask questions when we want to show interest in what someone is talking about.” We added other things to this list regarding the timing of “when” to ask questions, including (1) when there is a break in the conversation, you can ask a question to maintain the conversation; (2) when someone takes a breath, you can ask a question to get clarification; (3) when you want to change the subject, you can ask a question as a bridge from one conversational topic to another.

While this was just the beginning of therapy, it was a positive way to highlight for Mark that he had many strengths and skills he was already using and that we could develop them further. I told him I was confident that we could work together to help him learn to have conversations with his “friends” at school, but it would require much practice and repetition.

Falling back into his routine of a tree monologue was common for Mark. So I explained that we were beginning to “plant the seeds” of what it would take to have a good conversation with someone. The seed metaphor was simply another way to help Mark understand and, I hoped, be interested in what we would be doing together in therapy. I often use metaphor with clients to help them comprehend something they might not otherwise understand or even be interested in understanding. Typically, individuals with ASD do not comprehend subtle or abstract language and have difficulty with figurative language and metaphor. As a generalization, this is true. However, metaphor can be a helpful and a *concrete* way to explain a concept by using one idea to represent another. I have found that many children understand and benefit from metaphor, especially if it utilizes an area of their interest, such as Mark’s trees. It can make a difficult or uninteresting concept more interesting, accessible, and more easily remembered by the client. I frequently referred back to the seed metaphor when Mark became frustrated in therapy, such as when there had been no immediate positive feedback from friends despite him trying some of the strategies he had learned in therapy. I reminded him that it takes a lot of water and sunlight, which I

associated to time and patience, for the tree to grow. This served Mark well in realizing that it would take a lot of practice and repetition before the skills he was learning were more automatic and comfortable for him to use with friends. It also helped Mark build frustration tolerance.

Another important aspect of the conversational goal was the ability to understand other people's perspectives. Comic-strip conversations are a common approach used for this purpose. Developed by Carol Gray (1994), this method can help children on the autism spectrum concretely see what people say and what people think by using the speech and thought bubbles commonly employed in comic strips. I have modified the technique to use the thought and speech bubbles whenever I want a child to see the relationship between one's own thoughts, speech, or actions and those of others. I do not necessarily develop it into a sequential comic strip or story but may instead use only a single drawing to represent the idea I am trying to teach. In Mark's case, the thought and speech bubbles were especially relevant therapeutically when I wanted to show him that he had to take some personal responsibility in a conversation. He needed to see that there was a cause-and-effect relationship between his talking about trees and others' disinterest—and then their ultimate teasing him.

I drew a stick figure (representing Mark) and the speech bubble coming from his mouth with the word *tree* written many times to symbolize that he always talked about trees. Then I drew three other stick figures standing together with thought bubbles coming out of their heads to represent peers and their thoughts as Mark talked about trees. I wrote such things as: "Oh no, here he goes again," "Let's just leave, he's so boring," "Why can't he talk about anything else!" I used this to show Mark in a concrete way (a) that the boys were not interested in trees the way he was, (b) that they were tired of always hearing him talk about the trees, and (c) that whenever they saw him, they associated those thoughts to him. Therefore, he needed to understand that he was part of that picture. He may have been a cause of the undesired effect. I am always cautious when addressing this issue of cause/effect and personal responsibility, because I do not want to blame the child for his or her problems. Yet, at the same time, I have found that too many of the children I work with take no responsibility and blame everyone else without realizing that they contribute, at least in part, to their situation. It may not be socially correct or therapeutically helpful to "blame the patient," and that is why I am careful about the words I use when having this discussion. I use words like "*may* have been a cause" (leaving room for the chance that it might not be the client) or "*part of* the cause" (leaving room for other causes). But there is no doubt a relationship between what the client is doing and the end result, and that is what I want my clients (young children and adolescents alike) to know.

Treatment Summary

My treatment with Mark, and all my clients for that matter, tends to include many different interventions. I do not think of myself as ascribing to any one theoretical orientation. In presenting this case, I have shown the use of positive psychology by recognizing Mark's strengths and orienting my approach to what Mark *could* do as a way of teaching him what he needed to and could learn to do *better*. I also used behavioral therapy principles in my sessions with Mark, as I reinforced positive or desired behaviors and either minimized or ignored negative and ineffective behaviors. And finally, at the heart of my therapy was

Milton Erickson's utilization approach incorporated by using the client's available resources and interests to facilitate a positive change. The techniques naturally vary according to a child's interests and the therapeutic goals, but I always include visual strategies in my work with children. By visual strategies, I mean anything that accompanies the spoken word to help explain and make concrete a concept or skill development. With young children, the visual aspects of therapy are play. With older children, it may be the thought and speech bubbles that I used in Mark's case.

Mark learned many skills and achieved the conversational goals we set after much rehearsal and support from his family and teachers. He continues to present as a unique individual with qualities and characteristics that some people will find odd or eccentric, but Mark has also learned to accept who he is with all his strengths and weaknesses. To his credit, he now chooses to focus on his strengths.

In therapy, we have the choice with each and every interaction whether to focus on positive or negative, strength or weakness, ability or disability—whether, metaphorically, we see the forest or the tree. I hope my discussion of the case of Mark highlights that we can focus on strengths, highlight abilities, and utilize resources to advance our clients' goals, even in complex cases that traditionally have been seen only through the lens of pathology.

Putting It into Practice

1. Focus on strengths.

The principle is simple: What you focus on is what you amplify. When the therapist chooses to focus attention—and encourages clients, parents, and teachers to focus their attention—on what a child can do and is doing well, the therapeutic interventions are greatly enhanced.

2. Highlight abilities.

Ask what your client likes, can do really well, or can teach you. This enabled me to discover Mark's interest in, and intimate knowledge of, trees. Rather than seeing his monologues on trees as a problem, his abilities were highlighted and utilized in the therapeutic process.

3. Set positive expectancy.

Prior to helping the client resolve a problem, it is desirable to establish a positive expectancy for change. Although some children recognize an area of need, some do not believe they have a problem and may even be angry about coming to therapy. Engage the child—such as in a game of his or her choosing—to establish a therapeutic alliance and set positive expectations.

4. Utilize resources.

Recognizing Mark's strengths and orienting both his attention and therapy toward what he *could* do was a way of teaching him what he needed to and could learn to do *better*. He had learned an intimate knowledge of trees; how could he also learn to communicate that better? He knew *how* to ask a question; how could he also know *when* and *why* to ask questions?

5. Build skills.

The interventions with Mark aimed to build three sets of skills.

- a. You can minimize client deficits *and* enhance strengths by modeling the flexibility you want to teach. I wanted Mark to learn that our interactions did not have to be “all or nothing.”
- b. Teach your client to take personal responsibility. By effectively asking questions, Mark became an active partner in conversational exchanges.
- c. Mark knew *how* to ask a question. My goal was to focus on teaching him to know *when* and *why* to ask questions in a conversation.

6. Employ positive therapeutic interventions.

In this case I have sought to give examples of some of the potential therapeutic interventions that could be used for enhancing positive outcomes. These included:

- a. Client-relevant metaphors—such as “plant the seeds”—to help clients understand a concept they might not otherwise understand.
- b. Comic-strip conversations to facilitate a concrete way of seeing what people think and say.
- c. Behavior therapy principles to minimize ineffective behaviors and to reinforce positive or desired behaviors.

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A black and white photograph of a large tree in a field of tall grass. Sunlight filters through the leaves, creating a soft, ethereal glow. The scene is peaceful and natural.

PART TWO

Healing

CHAPTER 11

Now I Can Get on with Life

Pleasure, Engagement, and Meaning in a Case of Major Depression

George W. Burns

MEET THE CONTRIBUTOR

George's Meet the Contributor details are provided at the beginning of Chapter 1.

Facilitating a person's happiness is a different process from helping that person get rid of unhappiness. The elimination of sadness or depression does not necessarily result in the attainment of happiness. To show how the process of facilitating greater levels of happiness can be applied in psychotherapy, I discuss three main domains of happiness: pleasure, engagement, and meaning (Seligman, 2002; Seligman, Rashid, & Parks, 2006). It is not intended that these concepts be seen as either mutually exclusive or exhaustive. Indeed, there is much overlap, as we will see in the case example of Clara. Pleasure often can lead to engagement that, in turn, can lead to experiencing greater meaning. For example, an activity such as tending roses might include all three aspects. There might be immediate pleasure in the sight, fragrance, and beauty one experiences in stopping to watch and smell the roses. Tending to them, planting new roses, pruning, and fertilizing can all be acts of engagement in which the person is so involved that worries or thoughts of day-to-day life slip from conscious awareness. Planning to build a garden of roses, looking forward to it with anticipation, can provide a sense of purpose and meaning. Such pleasure, engagement, and meaning contribute to what Seligman has called the full life (Seligman, 2002; Seligman et al., 2006).

CLARA: A CASE OF MAJOR DEPRESSION

Clara dumped her body into the consulting room chair as if she were dropping a bag of vegetables onto the kitchen counter after a tiring shopping excursion. She sat at an angle, seeming to lack the energy to put her body in a more comfortable position or rest against the back of the chair. She had dragged her body into the office and now sat expressionless, her eyes gazing at the floor.

Her husband handed over a letter from her psychiatrist that read:

Clara suffers obsessive ruminations re her son, Michael, having AIDS. I have diagnosed her with a major depressive disorder with obsessive ruminations of delusional intensity when very unwell. Cognitive-behavior therapy (CBT), medication, and a recent course of electroconvulsive therapy (ECT) have failed to modify the ruminations. We are now considering a course of maintenance ECT. She denies suicidal ideation and no other psychotic phenomena are detected.

Efforts to engage Clara in conversation met with minimal response, and her husband primarily spoke for her. The history was that her 38-year-old son's wife had an extramarital affair. The affair had ended and the couple had decided to work at restoring their relationship, if not for their sake, at least for the sake of their three children. Some months after the son had become ill. He lacked energy and felt sick but was reluctant to see a doctor. Clara became concerned that the daughter-in-law might have contracted AIDS in her affair and brought this home to her husband. She went online to find out about AIDS and was able to match a number of the symptoms to the symptoms that her son was experiencing. The thoughts began to plague her more and were fueled by the fact that her son would not seek medical assistance. When he finally did go, he was diagnosed with glandular fever. Clara refused to believe this, thought the doctor had got it wrong, and ruminated more on her worries that he had AIDS. Seeking to appease his mother, Michael got tested for AIDS. The results were negative, but this did not alter Clara's beliefs. In fact, it seemed to make her more concerned that the medical profession had made a mistake and her son really was dying as a result of his wife's affair.

Engulfed in these fears, Clara's coping skills began to diminish. She started to suffer with insomnia, awaking during the night with panic attacks, and lacked the energy and motivation to get out of bed in the morning. As a result, she began to miss more and more days at work until, fearing she could not cope with the demands of her job anymore, she retired. She had grown increasingly withdrawn, avoiding her friends and, as her husband put it, she "had a change of personality." Her appetite had faded, and she seemed to have lost interest in just about everything except her worries for her son. When asked what she did for fun, she replied that she had "tried to go to the gym but it didn't work."

One thing was obvious from the referring psychiatrist's letter and from the history provided largely by her husband: We had a clear picture of what *did not work*. Six approaches to assist, encourage, or cajole Clara into letting go of her fixed ideas that her son had AIDS had simply not modified her thoughts:

1. Efforts to provide reason and facts—such as the medical reports by Michael's doctors—had not convinced her that he was free of AIDS.
2. Being told by influential people such as close relatives or qualified medical practitioners again had not altered the ruminative thought patterns.

3. Her son's health had gradually improved. Clara acknowledged that he was generally healthier than before but observing his progress had similarly not modified her thoughts.
4. Courses of various antidepressant and antipsychotic medications over the last two years had failed to eliminate the ruminations or lift her mood.
5. Fifteen weeks in a psychiatric hospital with both group and individual CBT similarly had not altered her suffering.
6. A course of 12 ECT treatments had met with similar lack of benefit. In light of these facts, it concerned me that a further course of ECT was being considered when there was clear evidence that it had not worked for her previously.

FORMING A THERAPEUTIC PLAN

Knowing what had not worked raised the important therapeutic question: What might be helpful for Clara? If various approaches of symptom elimination had been unsuccessful, would a therapeutic approach of enhancing the positive be more beneficial? If a therapeutic goal of neutrality was not of functional assistance to Clara, how could we set a therapeutic goal of positive cognitions and greater levels of happiness (see discussion in Burns, Chapter 17 of this volume)?

At this point, Clara's life lacked pleasure, engagement, and meaning, the core pillars of happiness (Seligman, 2002; Seligman et al., 2006). However, her life might have been considered very full of the negative. Her life was absorbingly preoccupied with worrisome, negative, disempowering, and ruminative thoughts. If therapy was to help her build a fuller, more complete, and more enjoyable life, then maybe it could teach her ways to build more positive emotions, more positive engagement, and more positive meaning. The therapeutic plan to do this would involve five steps:

1. The first step was to accept her beliefs rather than challenge or question them, as previously unsuccessful therapeutic interventions had attempted. Negative thoughts and events often capture our attention more readily than positive ones. From an evolutionary perspective, this makes perfect sense. Our early ancestors in the jungles of Africa who anticipated the real or potential threat of a hungry lion had better chances of survival than those who blithely wandered down a jungle trail without anticipation of the dangers. Clara's system had sensed danger or a threat to life and well-being—initially her son's but, in turn, her own. Naturally, she was reluctant to let go of this perceived threat. For the therapist to accept her beliefs and join her in that framework would prevent any resistance to the therapeutic efforts (see Hased, Chapter 14, this volume, and Walser & Chartier, Chapter 15, this volume).
2. I wanted to validate her concerns as a mother. Of course, her natural maternal instincts were to protect and ensure the well-being of her son. Wanting to applaud this, instead of fighting against it, would provide the chance to join her in reshaping counterproductive ruminations to thoughts that were more likely to benefit both her son's and her own well-being.
3. Clara had an extremely limited and limiting approach to the challenging concerns that her son might have AIDS. Her approach to handling it was basically to worry excessively and to withdraw. The next step in the planned therapeutic interventions

was therefore to help her broaden her emotional range by developing more positive, pleasurable, and enjoyable thoughts and feelings. Often in working with a client to build pleasure, engagement, and meaning in life, it is easier to start with the pleasurable. Experiences of pleasure are often readily available, relatively simple to achieve, and provide immediate positive feedback. They are easy to replicate and, from these perspectives, often serve as a better starting point than asking clients to tackle the bigger-picture concepts of meaning in their life.

4. The next therapeutic step would be to help Clara build more engagement with positive life experiences.
5. Finally, the plan was to work with her in creating new positive meanings in her life. This was seen as a way of helping her to let go of, and step beyond, the current unhelpful meanings that were resulting in her severe depression. The worry about her son had become her sole meaning and sole reason for existing. If she could find more positive meaning, then she would be less likely to be worried about the negative and more likely to be enjoying a fuller life.

BUILDING EXPERIENCES OF PLEASURE

The pleasant life is one that is rich in positive emotions about the past, present, and future. Pleasurable associations with the past include positive emotions such as contentment, satisfaction, and serenity. Positive emotions of the present may include somatic pleasures, such as momentary sensory delights, and more complex pleasures that are acquired through learning and education, while future-oriented pleasures include optimism, hope, and faith. Such positive emotions are not only correlated with lower depression and anxiety but seem to have a direct causal effect. In other words, if you help a client build more positive emotions, this counteracts the detrimental effects of negative emotions in regard to physiology, attention, and creativity (Fredrickson, 2005, 2008).

From a therapeutic perspective, remembering past pleasurable associations, being mindful of current sensory delights, or looking forward with hope to a light at the end of the tunnel can be good starting positions for change. It is often easier for a depressed person to create or experience a brief moment of pleasure than to attain the bigger, more complex leap of finding positive meaning in a current depressive experience. What interventions were used to help Clara build more positive emotions?

Inquiring about Pleasurable Activities

“What do you do for fun?” I asked Clara.

“I don’t” came the reply. “I tried to go to the gym, but that didn’t work.”

In the absence of pleasurable activities in the present, I sought to inquire about past, positive experiences by asking “What have you done for fun in the past?”

“I used to go out with my girlfriends for a coffee. Every now and again, we would have a girls’ weekend away.”

“What else?” I asked.

“I used to enjoy playing with my five grandkids but now they just seem to be noisy and a nuisance.”

Wanting to help direct her attention to the future and to explore what she might anticipate in pleasures that lay ahead, I asked, “What do you see yourself doing in the future that might be fun, enjoyable, or pleasant?”

“Going out with my girlfriends and playing with the grandkids,” she replied.

Over the next few weeks (I saw Clara for a total of five weekly sessions), I encouraged Clara to seek out and engage in either past pleasurable activities or activities she could anticipate enjoying in the future. She came back to one session and reported that she and her husband had taken the grandchildren for a picnic in a city park. “It felt good,” she said, “just to watch them laughing and playing.” Another fun thing that she said she would like to do was to see a particular movie that was showing; of course, she was encouraged to do so. At the session after going to the movie with her husband, her face lifted into the first smile that I had seen and she said, with a look of surprise on her face, “I even found myself laughing.”

“Did you have any thoughts about Michael while you were watching the movie or laughing?” I asked.

“None at all,” she replied.

Clara was beginning to learn that it was possible to have pleasurable experiences in her life and that those pleasurable experiences could at least temporarily eliminate her previous ruminative thoughts about her son.

Developing Gratitude

Activities such as taking time to acknowledge the things that you are grateful for (Emmons, 2008; Emmons & McCulloch, 2003; Seligman, Steen, Park, & Peterson, 2005) and “counting your blessings” (Lyubomirsky, Sheldon, & Schkade, 2005) can add to the creation and maintenance of happier feelings. On the basis of this evidence, I asked Clara to engage in two exercises. The first was to write down three things that she could feel grateful for or acknowledge as a blessing in her life each day. The second task was when she and her husband went to bed at night, she was to ask him about the three things that he was grateful for in the day and discuss their mutual blessings. Clara brought the record along to the next session. It included things like being appreciative of her husband’s cooking, enjoying the picnic with her grandkids in the park, and feeling grateful for the days it rained in our drought-stricken state. Again there was a noticeable lift in her mood as she discussed these matters.

Focusing on Sensory Awareness

In her depression, Clara was overwhelmed with ruminative thoughts, shut off in her bedroom, reluctant to get up in the morning and face the day. She was experiencing a state of sensory deprivation, characteristic of her mood. Our senses of sight, sound, smell, taste, and touch are what put us in contact with the world around us and the potential stimulation we may gain from it. I hoped that by helping her to be aware of, and focus on, pleasurable sensory experiences, the enhanced sensory stimulation might in turn facilitate the lifting of her depression (Burns, 1998, 2005, 2009).

To this end, I administered the Sensory Awareness Inventory (SAI) at the end of Clara’s first consultation (for further discussion, see Chapter 20, this volume). Her immediate response was “I don’t think I’ll be able to do anything for you.”

I encouraged that she give it a go and see what she discovered. At the next session, she reported that simply filling out the SAI had been beneficial. (The completed inventory is presented

Table 11.1 Clara's Sensory Awareness Inventory

Under each heading, please list 10 to 20 items or activities from which you get pleasure, enjoyment, or comfort.

Sight	Sound	Smell	Taste	Touch	Activity
Grandkids	Rain	Onions cooking	Chocolate	Having a bath	Going to gym
Watching sunsets	Wind	Roast dinner	Macadamia nuts	Warm sunshine	Being with grandkids
Watching stars	Kids playing	Flowers	Lamb chops	Soft fabrics	Walking
	Laughter			Hugging grandkids	

in Table 11.1.) Just doing the task entailed thinking about, remembering, and recording past positive experiences in each of her different sense modalities. Her mood had lifted briefly, and for a time she had not been ruminating on her son having AIDS. A fleeting change, yes, but a change that showed Clara the potential for more, and thus offered a glimmer of hope.

Building on this, I asked her to select something pleasurable to do from her SAI three times per day. I wanted to be prescriptive here and give her a clearly defined task rather than offer a more ambiguous directive such as “Do something nice for yourself each day.” I had observed how she responded to her husband’s directives but doubted she was yet ready to find her own directives. Together we examined the things she might do, such as watch a sunset or step outside to look at the stars on a clear night. One theme on her SAI that covered several sensory modalities was her grandchildren. They rated as providing her with pleasurable experiences of sight, sound, touch, and activity. Making contact and interacting with her grandchildren was a source of pleasure that had the potential to satisfy several sensory modalities in one experience.

I also asked Clara to add new items of pleasure to her SAI as she discovered them and to keep it in a visible place—such as on the refrigerator door or dressing table mirror—so that she could use the list to find and engage in pleasurable sensory experiences each day.

FOSTERING ENGAGEMENT

A life in which a person feels engaged, involved, and absorbed in the three core areas of intimate relationships, work, and leisure tends to be a life of greater happiness. Csikszentmihalyi (1990, 2000) describes this engagement as “flow.” Flow involves a number of components, such as focused concentration, a task of challenge, skills that have clear goals, and immediate feedback. During such experiences of flow, there is usually a deep effortless

involvement in which a person has a sense of control and in which the sense of self tends to vanish. Time is distorted, either stopping or seeming to fly by rapidly; for example, when one is engrossed in an exciting game of football or a good concert, hours seem to have gone by in minutes. This engagement contributes to optimal life experiences (see Delle Fave, Chapter 8, this volume). One might be engaged in a good book, focused on a task at work, absorbed in a movie, intimately engaged in making love, or involved in helping another. One way to build the engaged life is to help a person identify his or her highest strengths, skills, or resources and then to engage in using those strengths more (Seligman, 2002).

Clara was highly engaged, involved, and absorbed in her rumination worries. As such, she provides us with a very clear example of where it is beneficial for the therapist to see the process rather than the content. The *content* of her engagement was extremely distressing and unhelpful for her. It had led her into a major depression, and it was this distressing content that previous therapeutic approaches had sought to eliminate in their well-motivated desire to relieve her of her distress. However, if we look at *process* and resources, if we ask, “What is right with this person?” we see that Clara had a great ability for absorption and engagement (see Erickson, Chapter 3, this volume). If it was possible for Clara to be this engaged with negative cognitions and experiences, then perhaps it was equally possible for her to be engaged with positive, pleasurable thoughts and experiences. Seeing this leads to the question: What therapeutic interventions might help her utilize this skill of absorption in more positive and beneficial directions?

Finding Signature Strengths

To find their signature strengths, clients can be directed to Seligman’s web site, www.authentichappiness.com. However, given Clara’s significantly depressed state, I doubted that she would have the self-initiated motivation to (a) remember a verbally offered task, (b) go to the family computer and get online, (c) complete the inventory, or (d) remember to bring it back to therapy a week later. As she had previously responded to completing a hard copy of the SAI, I therefore gave her a hard copy of the Values in Action (VIA) Strength Survey. I believed that leaving the office with something in her hand might attract the attention of her husband, who had been sitting in the waiting room. He might further encourage her to complete the task.

Fortunately, this approach worked. She came back to therapy the next week with the completed inventory and listed her top five strengths as:

1. *Kindness and generosity*. Clara saw herself as a person who was kind and generous toward others. She acknowledged the worth of other people and was likely to put them before herself, perhaps as she did with her concerns about her son. She was someone who put the other person’s best interests first, even though they might override her own immediate wishes and needs.
2. *Fairness and equity*. On this strength, Clara rated herself as a person who gave everyone a chance, someone who was willing to take care of the welfare of others and was not biased by her own personal feelings or prejudices.
3. *Spirituality, a sense of purpose, faith, and religiousness*. Clara was a religious person who had previously attended church regularly but had let her religious practices slip

over the last two years as she became withdrawn from most activities and people. Nonetheless, she still held to her faith, her belief in God, and the principles of her religion.

4. *Integrity, genuineness, and honesty.* Clara believed that she lived her life in a genuine and authentic way. She saw herself as sincere and true to her beliefs and ideas. In fact, she considered that she was being true to her belief about Michael having AIDS. If it was possible for her to possess this strength around a matter of negative content, then it also seemed possible for her to utilize this strength in a more positive direction.
5. *Perseverance, industry, and diligence.* Clara discussed this more in the past tense, saying that she always had been an industrious person, particularly in regard to her work. She liked to finish what she started, whether at home or at work. It concerned her somewhat that she had now been neglecting her domestic duties, but she did have perseverance and again this was an indication of her strength that could be engaged therapeutically.

As Seligman et al. (2006) said: “We hypothesize that identifying the signature strengths of clients and teaching practical ways to use these strengths will significantly relieve the negative symptoms of depression” (p. 777).

Clara had been feeling disempowered for a long time. Almost everyone in her life had been pointing out that her beliefs were wrong, faulty, and even pathological. People had been highlighting her weaknesses in terms of what she could not do, how she lacked motivation, would not get out of bed, and disengaged with life and friends. Undertaking and discussing the VIA Strength Survey started to change this pattern by inviting Clara to look at what she was good at, where her strengths lay, and what capabilities she had. From thinking that she was all bad, weak, and helpless, she was beginning to discover her personal strengths. In completing the survey, there was nothing to resist or deny. What she discovered were her own self-acknowledged strengths.

Having defined her top five strengths, we began to discuss ways that she could use these more in her daily life. “If your top strength is one of kindness and generosity,” I asked, “how do you see you might use this over the next week?”

“By being kinder to my husband,” was her immediate response. “He has been so worried about me. If I start to get up in the morning, if I start to do things a bit more for myself, I am sure he is going to feel a lot happier.”

My next question, “How can you do that?” initiated a discussion of practical ways she could show her kindness toward him.

Engaging in Sensory Awareness

Mindfulness is one way to help a person be engaged, be in the moment, experience awareness of that moment, and disengage from other factors (see Hassed, Chapter 14, this volume). Clara was taught a simple mindfulness exercise of focusing into each sense in turn. Based on her responses to the Sensory Awareness Inventory, she was then invited to use this sensory focus when engaged in activities where she wanted to have optimal experiences. When with her grandchildren, she was asked to consciously attend to each sense in turn. If she was watching them, what sights did she enjoy? What did she see in the looks on their faces as they laughed or in the movements of their bodies as they played? What were the sounds that she

heard in their laughter and in their play? What could she appreciate in her sense of smell as she held them close to her? What were the tactile sensations that she experienced when they gave her a hug and she gave them a hug? What did she experience in her own movements, mood, and mind as she got up to play with them or sit on a swing with one of them on her lap?

Tuning into our senses in such mindful ways is a means by which it is possible to become engaged, involved, and absorbed. Such sensory focus can enhance positive engagement by focusing concentration, facilitating deep, effortless involvement, building a greater sense of control, and, in Clara's case, distancing her from absorption in negative, ruminative thoughts.

FINDING MEANING IN LIFE

The pursuit of meaning, the discovery of purpose, and the service of something bigger than the self are core ingredients of the happy life. Meaning in many ways is very amorphous, and people find meaning in extremely divergent concepts. In addition, meaning is probably more difficult to study and, consequently, has been the focus of less scientific research than pleasure and engagement. However, we all know the value of meaning in our lives. When we have a purpose, direction, or goal to be living for, we generally feel happier and more contented.

Conversely, the lack of meaning can be a causal factor in depression. When depressed, a common symptom is the absence of positive meaning. When a person has no meaning in life, what is there to live for? And if there is nothing to live for, then it seems a likely conclusion to feel depressed. Therapy—or indeed any activity in life that builds meaning—is also likely to relieve depression. If that is so, how could I assist Clara to use her strengths and abilities in the service of something larger than herself? How might she find meaning that helped her produce a sense of satisfaction and the belief that she was living her life well?

Meaning in Strengths

Clara's top five strengths were her kindness, fairness, faith, genuineness, and diligence. As we discussed how she might use these, she commented that she wanted to go back to church. I encouraged this during our therapeutic conversations, as it seemed that such action would engage her in finding meaning through her faith, provide a social network, and perhaps give her the chance to practice her kindness and generosity (Myers, 2008). Not long after attending church again, she was asked if she would volunteer to help with an after-school care program that the church provided for parents who were working. Allocated to her special care were a couple of recent immigrant children who knew little English and were adjusting to a culturally different lifestyle. Clara became acquainted with the family, she and her husband assisted them to settle into their new country and lifestyle, and her reasons for living expanded. With things to enjoy and look forward to (pleasure), with a focus of attention on her strengths (engagement), and with a new sense of purpose and direction from utilizing those strengths in the service of others (meaning), Clara dropped into this role like a hand into a familiar glove—because it tapped into several of her strengths: her sense of fairness, her kindness and generosity, and her service to her belief system.

THE OUTCOME

After five sessions, Clara was progressing well. She still sat a little awkwardly in the chair but now allowed herself to relax against the backrest. She made eye contact, and a smile was more common on her face. She said that in the weekend prior to our last session, she had gone away with seven girlfriends for a winter's weekend at a seaside resort. She confessed that she had been of "two minds" about whether to go but had accepted the invitation because her husband encouraged her to do so and she wanted to be kind to him. She said that her friends knew she had not been well and were accepting of her. They shared lots of humor and laughs, and took long walks along the beach. On one walk they got caught in a rainstorm, but Clara laughed in relating it and said, "I just reminded myself how grateful I am for the rain."

Given Clara's progress and the fact that I was to be away teaching for several weeks, we set up several tasks for her to accomplish over that period. She was to join an exercise class twice a week, engage in regular weekend outings with her husband or girlfriends, spend quality time with her grandchildren, maintain her exercises in gratitude and sensory awareness, and continue helping her two special children in the after-school program. I offered to arrange for her to consult a fellow clinical psychologist in our practice during my absence, but she said she felt she was coping well and would only do so if it were urgent. She never did. I also telephoned her psychiatrist to advise of her progress and ensure that he was available as a backup if she needed it. Given her progress, we mutually agreed that the considered course of maintenance ECT should be put on hold.

Clara was one of those people with whom it is a real pleasure and privilege to work. She turned her life around by being open to, and willing to explore, the possibility that life could hold greater pleasure, greater engagement, and greater meaning. She saw how by starting to enjoy simple and immediate pleasures it was possible to move on to greater involvement and absorption in life's optimal experiences and to find a purpose and direction beyond the self. She also reaffirmed the concept that merely getting rid of depression (which had been tried and failed with her) was not sufficient for a person to be living a happy and fulfilling life. Creating happiness is a different process from getting rid of unhappiness. Freeing oneself from the shackles of depression may well be a natural by-product of enhancing the full life.

FOLLOW-UP

I next saw Clara three months later. She arrived wearing makeup, including a bright lipstick, for the first time. This, and her general appearance, suggested she was looking after and caring for herself more. Her body moved in a freer, more relaxed manner, and she sat more comfortably in the chair. A smile lit her face and she laughed out loud in relating funny incidents from when a young grandson had slept over at their home for the weekend.

"The depression has gone," she announced, "though I still get days of feeling anxious."

"How often is that happening now?" I asked.

"Well, I had one bad day this last week when I got caught up with those thoughts about Michael again."

"Just one?" I commented, wanting to highlight for her the progress she had made since we first met—a time when such ruminative thoughts were almost constant.

“I suppose that’s not bad when you think of it like that,” she responded. “That really means I had six good days, doesn’t it?” Then she asked contemplatively, “What’s one day?” She answered her own question by adding, “Just 15 percent of the week. That means 85 percent of the week was pretty good. I would be happy if I got that on an exam.”

When I saw her last, was Clara completely free of the thoughts about her son having AIDS? The answer to that is simple: no. The thoughts were still there, they came back from time to time, but they had ceased to be delusional, obsessive, or even ruminative. Rather than her life being filled with worries and despair, it was now much richer in pleasure, engagement, and meaning. It was a much fuller life.

Clara said, “I can accept when those old thoughts come. I can acknowledge that it is part of my normal care as a mother for her son, that I always will be concerned about his well-being. And I know that now I can get on with my life and be of help to others.”

Putting It into Practice

1. Help your client build experiences of pleasure.

The pleasant life is one that is rich in positive emotions about the past, present, and future. Clara’s example illustrates several ways to help build such pleasurable experiences:

a. Inquiring about pleasurable activities.

Ask your clients, What do you do for fun? Explore the pleasurable things they have done in the past, do in the present, or can envisage themselves doing in the future. Assist them to engage in these activities more.

b. Developing gratitude.

Set your clients exercises to acknowledge the things they are grateful for and can count as blessings. Clara was asked to write down three things she felt grateful for each day and to share them with her husband.

c. Focusing on sensory awareness.

Our senses of sight, sound, smell, taste, and touch are what put us in contact with potentially pleasurable stimulation. As done with Clara, you may consider using the Sensory Awareness Inventory.

2. Help your client foster engagement.

A life in which a person feels engaged, involved, and absorbed is a life of greater happiness.

a. Finding signature strengths.

To help clients find their signature strengths, they can be directed to www.authentichappiness.com. Doing a paper version of this exercise helped Clara shift from feeling disempowered to look at what she was good at, where her strengths lie, and what capabilities she had. What she discovered were her own self-acknowledged strengths.

b. Engaging in sensory awareness.

(Continued)

(Continued)

Clara was taught a simple mindfulness exercise of focusing on each sense modality. Helping clients tune in to their senses in mindful ways facilitates engagement and optimal experiences.

3. Help your client find meaning in life.

The pursuit of meaning, the discovery of purpose, and the service of something bigger than the self are core ingredients of the happy life. Once Clara had discovered her top five strengths, the next step was to ask how she could use them to add meaning and purpose to her life. Exploring this question led her to become meaningfully engaged in an after-school care program, thus utilizing her strengths of fairness, kindness, generosity, and service to her belief system.

With things to enjoy and look forward to (pleasure), with a focus of attention on one's strengths (engagement), and with a new sense of purpose and direction from utilizing those strengths in the service of others (meaning), clients are empowered to live much fuller and happier lives.

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CHAPTER 12

Empowering Lisa

The Power of Metaphor for a Depressed and Suicidal Teen

Ramona Garnier and Michael D. Yapko

MEET THE CONTRIBUTORS

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CASE BACKGROUND

Lisa, age 16, was referred to the senior author's private practice (RG) for individual therapy following a suicide attempt. The second author (MY) provided occasional consultation on the case. Lisa lives with her mother and has one sibling, an 18-year-old brother. She had no prior history of either attempting suicide or reporting suicidal ideation. Lisa's mother reported she had not observed any warning signs that would have indicated an impending suicide attempt. She was shocked and deeply troubled by Lisa's attempt. However, her mother did say that five years ago, at the time of her divorce from Lisa's father, Lisa had become sad and depressed about the divorce. Lisa saw a counselor at the time to "work through" her sadness, but did not like the counselor and, after just a few sessions, did not continue treatment.

Lisa's mother informed me that her suicide attempt followed an episode in which Lisa had been caught sneaking out of the house one night and was grounded as punishment. A few days later, with no obvious indicators of unusual distress, Lisa took a deliberate overdose of aspirin with the intent of killing herself. Lisa's mother came home from work and found Lisa curled up in her bed, complaining of being sick and very tired. After persistent questioning by her mother as to the reasons for her obviously distressed physical condition, Lisa disclosed that she had taken an entire bottle of aspirin. Lisa's mother immediately called 911, and Lisa was rushed to the hospital. She had her stomach pumped and was kept overnight for observation. Thankfully, her medical situation was not life threatening. A hospital social worker assigned to her case recommended she immediately get into therapy and referred her to the senior author for treatment. Lisa did not resist the recommendation and, although more than slightly apprehensive about therapy, came to my office for her first session.

Client Assessment

A suicide attempt is a serious matter. In assessing Lisa, the focus was much more on how she came to the conclusion that dying was preferable to living than on the specific issues she was facing. *How* she was coping matters more than *what* she was having to cope with. Thus, the assessment focused on key self-organizational patterns. These include factors such as attributional style, expectancy, cognitive style, relational style, and problem-solving skills. These patterns are revealed through spontaneous conversation in response to the typical questions any clinician might ask, and they indicate specific patterns that can serve to increase or decrease risks for depression and suicidality (Yapko, 1997, 2001).

For example, Lisa began her narrative by telling me, with tears in her eyes, that her "life sucks." I asked her if she could be more specific about what in her life "sucked." She said emphatically, "All of it!" Her declaration of her life being globally bad (a global attribution), her sense of powerlessness to do anything to change it ("There's no way out"), her impulsivity ("I didn't think about dying, I just wanted to go to sleep and not wake up"), and her sense of being a burden to her family ("I just make it harder for my mom by being alive") explained a great deal as to how she became so emotionally overwhelmed that suicide seemed to be the only solution to her problems.

Three therapeutic goals were established:

1. Increase Lisa's sense of control over her experience in order to be more proactive rather than reactive in making good life choices.

2. Increase her ability to think in more specific rather than global terms in order to improve her problem-solving skills, reduce her impulsivity, and reduce her sense of being overwhelmed.
3. Help her redefine her relationship with her mother so she doesn't feel so burdensome to her.

These goals provided a framework for Lisa's treatment and are consistent with the need to help her build skills she clearly needed. They are also consistent with the goals defined in the clinical literature as being essential to helping people overcome depression and suicidality, manage ongoing psychosocial stressors, and develop skills for their future well-being.

CLIENT RESOURCES

Lisa was bright and, after overcoming some of her initial apprehension, both cooperative and interested in hearing what I had to say. Despite her current circumstances, she had a history of being successful in school, was well liked by her friends and peers, was competitive in spirit, was socially responsible in caring about others, and had a well-developed sense of commitment and responsibility to her family. All of these were potential resources to amplify and build on in treatment. The ability to care enough to get attached, whether to people or goals, is a powerful starting place for actively creating improvements in one's life. The antithesis to the apathy that leads to passivity, caring makes people want to expend effort. This was a strength I wanted to develop further and help Lisa use in life-enhancing ways.

WHY CHOOSE A POSITIVE PSYCHOLOGY APPROACH?

Is the goal of therapy to reduce pathology or to enhance strengths? More than a philosophical question, one's answer directly shapes the direction of one's interventions. In Lisa's case, she made a suicide attempt not because she wanted to die but because she became overwhelmed with the challenges she faced. She just could not sort them out or find ways to manage them effectively. The fact that she did not have the specific skills she needed to problem-solve says much more about what she did not know than about her potential to learn and develop the very skills that would make her life more manageable and enjoyable. In fact, because positive psychology approaches are not a specific form of therapy in our viewpoint, their orientation toward amplifying people's innate resources fits well with other established approaches, such as cognitive-behavior therapy (CBT) and strategic therapies. Thus, it was not a matter of choosing positive psychology approaches instead of other forms of treatment but rather applying the methods and principles in combination with other approaches. Applying CBT methods and experiential processes was important in Lisa's case since she needed specific tools for gathering and weighing information and making good decisions that were based more on evidence than on (overwhelmed) feelings.

INTERVENTIONS WITH SPECIFIC GOALS IN MIND

In Lisa's case, it seemed necessary to prioritize the need to address her sense of helplessness since none of the goals for her treatment could be achieved without her being proactive in the

learning and change processes. So, the very first session aimed at her helplessness and at her global style of thinking that “life sucks.” I asked her to start with just one specific problem she could describe. From these first moments together, I began modeling effective, proactive problem-solving by going from global to specific in first defining a problem and then breaking it down into manageable components before attempting to solve it.

Positive Resource Accessing: Being Proactive in Achieving Specific Goals

As a starting point, I wanted to introduce Lisa to the general idea that she had more resources than she realized and that using these resources in her own behalf would be an important source of self-care and skillful problem solving. To facilitate this possibility, I wanted to get Lisa focused on at least one of her accomplishments and explore its merits. I asked her to remember a time in her life when she successfully dealt with a problem. This is a simple resource accessing exercise that has the potential to reawaken feelings of competence. As Burns and Street (2003) suggested, if one has previously discovered an ability for accessing happiness, one then knows one has the ability to do so again.

After some thought, she told me about a time when she wanted to play varsity volleyball but the coach would not let her. The coach simply did not believe Lisa was good enough to play at the varsity level. Lisa became stubbornly determined to show the coach she was good enough; she went to every team practice and when she played, she played aggressively and well. She successfully proved her ability, for at the end of the semester, the coach told her she was very impressed with her performance and said she could now try out for varsity. Such leisure and sporting activities often are good sources of resources, learning, and achievement in adolescents (see Friere, Chapter 9, this volume).

I asked her how she felt when she achieved what she had set out to achieve. She said, “I felt so good.” In saying this, I saw the first genuine smile on her face.

I then said, “This may sound obvious, but do you know why you felt so good?”

She said, “Yeah, because I worked really hard.”

I told Lisa, “Of course that’s true and that is obviously part of the reason you can feel good about what you achieved. But the other part of that situation that you may not have thought much about is that you had an important goal. You were absolutely dedicated to the idea of playing varsity volleyball. You set your eyes on the goal and then you took the steps to achieve that goal. You had a specific plan of being at every practice to show your dedication, and you had a plan of playing aggressively to show your determination and skill. No matter how inconvenient it was at times to show up for practice and play hard, you did it anyway. And now consider this carefully: What do you want for yourself in your life now, and what plan do you have to make it happen?”

Wanting to make sure she did not erroneously conclude that I meant she could control external circumstances entirely through her own determination, I reminded her:

Things sometimes don’t work out the way we would like them to. Nevertheless, when a human being perseveres at something worthwhile, it changes his or her character. It can give you a sense of internal accomplishment knowing you did your absolute best, even if no one else recognizes it. It means success can be measured in more ways than just one. It is how you develop a good feeling about yourself: At the end of a day, you can look back at all you did that day and say to yourself, “I like the way I thought about the events of my day, the way I reacted to and the way I handled things today.” To be able to say that to yourself takes thought, planning, and strategizing, perhaps seeking advice, and executing the plan, just the way you did in making the varsity team.

In the language of hope theory, Lisa clearly demonstrated that she could set a goal (play varsity volleyball), find and enact pathways (make practical plans for action), and have the agency (be motivated and determined to put them into practice) (see Cheavens & Gum, Chapter 5, this volume). If this was possible for her to do in one area of her life, might it also be possible for her to do the same with her current problem? I told Lisa that her story about having worked so hard for the varsity spot on her volleyball team showed she already had the ability to plan and persevere and achieve, and that these very same skills could now start to be extended into other areas of her life where they could serve her well. She listened intently, eyes focused on me, never diverting her gaze even momentarily.

A Metaphor to Encourage Lisa's Positive Communication with Her Mother

In the next session, Lisa reported feeling much better about herself. She realized she could handle things better than she had been but said that she “never took the time to think about what I could do. I was too focused on what I *couldn't* do.” I introduced the topic of her relationship with her mother next. I wanted to address her perception that she was a burden to her mother. This perception was not only incorrect but was a potentially hazardous rationale for possible future suicide attempts.

Teens in particular can be especially resistant to direct input because, developmentally, they are in an early phase of trying to become independent thinkers. As they strive to transition to more adult responsibilities and viewpoints, they often need to be given the opportunity to figure things out for themselves. Lisa indicated this very point to me many times when she said things such as “My mom treats me like I’m two years old. She thinks I am incapable of making intelligent decisions.” The use of metaphor can be ideal in such cases. Metaphor is by its very nature an indirect form of intervention. It does not require the client to be compliant. Instead, it encourages consideration of the metaphor’s meaning from a safe emotional distance. Through metaphor, the client can build an identification with a character in the story, view a parallel situation from a more multidimensional and less personal perspective, and search for the personal relevance of the story while absorbing potential solutions (Burns, 2005, 2006, 2007; Zeig, 1980).

The more stories I told Lisa, the more she considered them and looked forward to discovering their meaning. When I smiled and said, “Well done! How insightful of you!” she would smile and wait in eager anticipation of the next story.

Lisa needed to develop her own effective decision-making strategies so that they were beneficial for her rather than simply modeling the styles of her mother or others that were ineffective. For example, she would often yell and scream back at her mother in their arguments. The very thing she hated that her mother did, she did, too. When she realized she could strive to do better and actually began to *do* better, her self-image began to change in positive ways.

In order to help Lisa begin the process of developing a better strategy for communicating with her mother, I told her the Aesop fable “The Sun and the North Wind” (Ashliman & Rackham, 2004):

One day a great battle broke out between the Sun and the North Wind.
The North Wind said to the Sun, “I am more powerful than you are.”
The Sun said, “No, you are not.”
“Oh, yes I am!”

“No, you are not!” This argument went on for quite some time.

Finally, the North Wind said, “Okay, let’s see who is the more powerful one of the two of us.” At that moment, the North Wind looked down the road, saw a lone traveler walking, and said, “The first to get that man’s coat off is more powerful.”

“Okay,” said the Sun.

The wind went first. The wind mustered up all its energy and blew on the poor man trying to walk down the road. He blew and blew, trying to separate the man from his coat. The harder the wind blew, the more tightly the man held on to his coat. The Sun watched this failed effort and began to smile.

The wind exhausted itself and gradually died down. Frustrated, but sure the sun wouldn’t fare any better, the wind said, “Okay, let’s see you do any better.”

Slowly, the Sun began to come out from behind the clouds, effortlessly and gently. The Sun began to radiate its gentle warmth, slowly growing warmer and warmer. After a few minutes of getting hotter and hotter, the man looked for some cool shade, sat under a tree . . . and gladly took off his coat!

I paused after completing the story to wait for Lisa’s reaction. She said, “That is the coolest story!” I asked her why she thought I told her the story. She responded, “Because sometimes we think we can force people to agree with us when maybe we are wrong. Maybe there is a better way of doing something.”

I nodded in agreement, smiled appreciatively at her insight, and gave her a minute to reflect silently. She did so. Then I asked, “How do you think this story could be relevant to you?”

She said, “It reminds me of me and my mother. At home she yells and I yell and neither one of us will be quiet and listen to the other.”

The “moral,” or key point, of the story is that sometimes you can achieve more with gentleness than with force. I then told Lisa that yelling back, escalating a fight between her and her mother, is *not* how she would ultimately get what she wanted. “Keep your eyes on the ball,” I said, using a metaphor that might link her successful volleyball skills to successful strategies in the mother-daughter relationship. “You are 16 years old, you need to make college plans, whether with a scholarship or with student loans. You will be out of your mother’s house in only two years! You don’t need to fight with your mother or win the arguments. You just need to hang on until you can move on to something more productive and rewarding in your life, the future you’re building toward.”

A Metaphor to Encourage Realistic Assessments of Others

Another distressing problem that Lisa did not know how to address effectively related to her feeling betrayed by a boyfriend. Lisa’s appraisal of him was to simply (globally) call him a “jerk.” Similarly, she often felt betrayed by her father. It was clear that her expectations of others were sufficiently high that she felt let down by them. It was a goal in the next session to help her develop more realistic expectations of people so she could prevent some of the hurts she perceived others inflicted on her.

I asked her a question to see if she could identify and articulate how she evaluated other people in order to know how to best relate to them: “When you meet someone, a guy perhaps, how do you determine whether he’d make a good friend or boyfriend?” She looked at me as if I were speaking a foreign language but eventually answered: “If he seems like a nice guy and he’s interested in me.” It became instantly apparent that she had no specific, detailed strategy for assessing carefully a boy’s characteristics in order to make a good decision regarding his relationship potential.

Thus, it became a therapeutic goal to help her develop better insight into other people, in order to better manage her relationships with them. To help her learn to identify specific personality characteristics in others in a more detailed way, I told her an old Wintu tribal story, traditionally told by their elders, titled “How the Eagle Chooses Her Mate” (Bates, 2006).

When it comes time for the female eagle to choose her mate, she prepares herself for many suitors. And many come before her. She looks them over quite well and then picks one to fly with for a while. If she likes the way he flies, she finds a small stick, picks it up, and flies high with it. At some point, she will drop the stick to see if the male can catch it. If he does, then she finds a larger stick and flies with it much higher this time. Each time the male catches the stick, she picks up a larger one. When she finds the largest, heaviest stick that she herself can carry, the stick is at almost the size of a small log! However, she can still fly very high with this large stick. At any time in this process, if the male fails to catch the stick, she flies away from him as her signal that the test is over. She begins her search all over again. And when she again finds a male she is interested in, she starts testing him in the exact same way. She will continue this “testing” until she finds the male eagle who can catch all the sticks. When she does, she chooses him, and will mate with him for life!

Lisa was fascinated by this story and said, “The female eagle would need to have a lot of patience.” I asked her, “Why?”

“That process could take a long time. What if none of the males could catch the sticks?”

“Why do you think the female eagle goes through such a long arduous process?”

“Maybe because she needs him to be strong and faithful. Or maybe she wanted to see how serious he was in pursuing her.”

At this point, I told her that the reason the female eagle goes through this process, according to the explanations of the Wintu tribal elders, is because at some point she and her mate will build a nest together high up and will have eaglets. When the babies begin to learn to fly, they sometimes fall. It is imperative to the survival of their species that the male is able to catch them when they fall. And, one hopes, he does.

Lisa then said, “It is amazing to me that a bird would be that picky, but now I see why. The male has to be able to do what is necessary to keep their babies safe.”

Lisa did not seem to make the connection to herself just yet, so I added, “Unlike the eagles, people don’t seem to give much thought to selecting a mate carefully.” Lisa paused thoughtfully, then said, “I am not thinking about a husband yet. I’m only 16! But I can see your point that I gave no thought to choosing a potential boyfriend. I don’t know why either. I guess I never really thought about it before. I guess I just thought that when you like someone, you like them. I didn’t think to ask, is he going to be good for me?”

This conversation following the eagle metaphor led to her insightfully considering her mother’s choice of her father. It occurred to her that her mother did the same thing as she! She said her mother had often told her that she did not really know Lisa’s father that well and that she even had reservations regarding their relationship. Yet, foolishly, she proceeded to marry him anyway. Lisa was starting to see that poor decisions could have serious and lifelong consequences.

I began to see a new strength emerge from within her. She was able to make an important inference using information and perspective rather than just getting lost in her feelings. She was opening up to realizing there was much more available to consider before just reacting to circumstances and that being considerate and purposeful in her decision making could make a big difference in her life.

LISA EMPOWERED: CREATING HER OWN METAPHOR

In the preceding sessions, we had focused on (a) empowerment, (b) being more specific in thinking and problem solving, (c) redefining her relationships with others (including her mother, ex-boyfriend, and father), and (d) improving her decision making. As Lisa's therapy neared its end, it seemed a worthwhile goal to deepen her integration of the insights and skills she had learned. Given how well she responded to metaphor, I decided to reverse the pattern. Instead of me providing a metaphor for her, I decided to have her prepare her own. So, one day I asked Lisa, "If you could write a story representing your own life, what would it be about?" She eagerly went about fulfilling the task and came to the next session with this metaphor:

There was a young woman who decided she needed to go on a journey alone. She realized after a lot of thinking that she must figure some things out on her own. She told her parents she needed to go. Somehow, they knew she would not have peace until she discovered what was missing in her life. So, with lots of tears and hugs, she set out on her journey. The young woman was very afraid of what she might discover, but she knew this was a time she needed to be courageous and strong or she would always be left wondering what she should know. She knew she needed to rely on all the strategies she had learned from the wise old woman who lived in her village. Many times after school she would stop at the wise old woman's yard, as she was planting flowers or vegetables, and listen to the stories and adventures that had become her long-ago memories, kept neatly organized in her mind, for years and years. The young woman would often tell the wise old woman about things that were troubling her. The wise woman seemed to always have just the right thing to say. One day the wise old woman told her that a contented and happy life is one you must discover on your own, through hard work and many journeys. This is what stirred the young woman to go in search of this more contented and happier life. As the young woman went from town to town, meeting different people, she often thought about the wise old woman and she longed to be like her: Strong, insightful, thoughtful, encouraging, brave, adventurous, smart, and funny.

She was gone for a long time. Many months passed by. She had met so many people and made many new friends along the way.

One day she was sitting on the cool grass, thinking about where she would go next when a little girl came by and asked her, "Why are you sitting out here by yourself?"

"Just resting," said the young woman.

"Do you live near here?"

"No, I have traveled a long distance."

"Where are you going?" asked the little girl.

"I am not sure. I am in search of greater happiness and contentment."

"Why are you searching for it?" asked the small child. "Didn't you have it with your family and friends?"

The young woman thought for a long time. She began to think about all the wonderful memories she had with her mother and brother and even her father. She began to think of all the Fourth of July celebrations, great Christmas times, vacations, sleepovers with her friends, summers at the beach, late-night talks with her mom, pillow fights with her brother, and wonderful hugs from her dad. She began to cry.

"Why are you crying?" asked the little girl.

"Because I focused on all the things that did not make me happy and content, instead of remembering the things that did, and working to figure out how I could change the things that did not, if I could."

The young woman recalled how the wise old woman remembered all the wonderful things that had happened in her life as well as the things that were not so wonderful. But the things that made her happy and made her content with her life, these were the things the old woman focused on. She suddenly realized what the wise old woman meant when she said, "A happy and

contented life is one you must discover on your own, with hard work and many journeys.” She meant the journey of life—everyday life! Every day you must give all you have to give. A happy life requires the hard work of figuring out what works and what does not, then putting what does work into action. Then you can be happy with yourself and your own accomplishments as you go through the journey of life!

The young woman was so happy she jumped up hugged the little girl and said, “Always focus on what works and strive to change what does not!”

She then ran with enthusiasm and contentment until she reached her home. Everything looked different. The sky appeared to be bluer, and suddenly life looked more optimistic.

As she opened the door and ran to her parents and hugged them, she said, “Life really is what you make it and I’m tired of always settling for lemons.”

LISA’S METAPHOR: SIMPLE BUT POIGNANT

Lisa’s story was a nice but familiar one, a personal variation of the classic *The Wizard of Oz* “There’s no place like home” story. As simple as it was in its obvious parallels to our time together in therapy, what makes the story she wrote significant is its meaning for *her*. She proactively invested time and energy in creating a story that would guide her perspective about herself, her family, and her life. The story suggested Lisa had integrated the things she had learned in therapy and understood the importance of incorporating them into her life. Lisa discovered that true insight comes from understanding the importance of making good decisions, following up on those decisions, and taking responsibility for one’s own success. In the story she wrote, she went on the journey alone, discovered her blind spot, and was mindful enough to see the wisdom even in a small child’s question. Lisa learned that the search for happiness is not about a place or an experience. It is about a perspective, a perception that even though life is not always easy, there are almost always ways to transcend adversity and still engage with life’s positive possibilities.

FOLLOW-UP

It pleases us to report that Lisa is doing well. She will have graduated from high school by the time this chapter is published. At the time of this writing, she is in the process of applying to colleges. She has received several letters of interest, and there is a legitimate basis for believing she will get into one and begin a new chapter in her life, with a new clarity of purpose. It also pleases us to report that she continued with her volleyball team and retained her captaincy. She is playing with great success, and it would not be a surprise if she earned an athletic scholarship to college. Lisa is no longer anxious and she reports no depression or suicidal thoughts, at all. To her great credit, Lisa and her mother have learned good, effective strategies of communication, and the level of conflict between them now is greatly reduced. They both come in for therapy about once a month to talk things through if they are stuck on some issue and to affectionately support each other if they are not.

Lisa absorbed well the lessons about problem solving. Occasionally she will contact me to say “I was faced with a problem and I used the problem-solving strategies you taught me and I was able to figure out what to do. Sometimes I don’t know what to do, though, and those are the times I ask for help. It’s so much easier than just getting bummed out!” Lisa genuinely feels hopeful about the future in general and hers in particular.

As therapists, it is most rewarding when good and deserving people discover their strengths and virtues and learn to use them skillfully. Lisa is in the earliest stages of becoming a truly remarkable woman.

SOME FINAL THOUGHTS

People do not try to kill themselves because they think their lives will improve. It is an essential reframing in working with depressed individuals, whether suicidal or not, to communicate the message that things can change and that by doing something different, things *will* change. Different people absorb this message at different rates. It is to Lisa's credit that she was bright enough, thoughtful and motivated enough, to absorb this message almost from the first minutes we met.

In Lisa's case, the therapy went on for several months, each session filled with earnest conversation about life's challenges and how to handle them, plans for the future, when the new challenge will be leaving home and developing a more adult and self-directed lifestyle, and more immediate situations requiring shorter-term coping strategies. The emphasis was on learning skills directly through homework assignments and behavioral experiments and on less direct approaches of learning through metaphor. In Lisa's case, metaphor was an especially welcome style of intervention. She simply had not had any adult in her life who took the time to soothe her, educate her, and invest in her as worthwhile in this way. She responded powerfully.

Lisa validated our shared investment in focusing on and using people's strengths rather than focusing on pathology. Following her suicide attempt, she left the hospital with a diagnosis of major depression and a prescription for antidepressants. What she found in a therapy incorporating principles of positive psychology was that when she had good information and methods, she could succeed in her endeavors. She was not treated as a diagnosis. She was treated as a person who had resources, however undeveloped they might be, in specific areas. What a difference to respond to someone's potential rather than only to someone's symptoms!

Is it a new idea to think of positive psychology as a means of catalyzing other forms of treatment? We do not know how to answer that question in a definitive sense. But we have come to appreciate that the concepts and methods of positive psychology hold great potential for making therapy a more effective and empowering experience, as it did for Lisa.

Putting It into Practice

1. Listen for your client's attributional style.

Lisa's style of thinking was global ("Life sucks"), powerless ("There's no way out"), impulsive ("I didn't think about dying, I just wanted to go to sleep and not wake up"), and guilt ridden ("I just make it harder for my mom by being alive"). Listen carefully to the ways your clients are thinking that may not be helpful or constructive for them.

2. Help your client think more specifically.

Assisting Lisa to think in more specific rather than global terms helped her to improve her problem-solving skills, reduce her impulsivity, and reduce her sense of being overwhelmed. When clients are thinking globally (as in “Life sucks”), problems can seem overwhelming. When broken down to more bite-size bits, problems can be more manageable and easier to address effectively. Help your client break the problem down to the specifics.

3. Increase your client’s sense of control.

If your client is attributing problems to external sources, help him or her shift the focus of control more toward the internal with such questions as: “What can *you* do to change what is happening?” As Lisa developed a greater sense of control over her experience, she became more proactive rather than reactive in making good life choices for herself.

4. Assess the client’s positive resources.

An apparent resource of Lisa’s was her absolute dedication to playing varsity volleyball. If she could apply such dedication in one area, could she also do so in another? If she had the resources to set a goal about volleyball, have a specific plan, and take the steps to achieve that goal, these seemed like pretty important life skills. In what areas does your client do well? What are the skills that have enabled the client to do this? How might clients employ those skills to achieve their therapeutic goals?

5. Consider metaphors for positive communication.

As teens in particular can be especially resistant to direct input, the use of metaphor as an indirect and engaging form of communication should be considered. Through metaphor, the client has the opportunity to build identification with a character in the story, view a parallel situation from a more multidimensional and less personal perspective, and search for the personal relevance of the story while absorbing potential solutions.

6. Help facilitate the client’s empowerment.

As Lisa became more specific in her thinking and problem solving, redefined her relationships with others, and improved her decision-making skills, she felt more empowered. She communicated that empowerment through her own metaphor that incorporated what she had learned and affirmed her progress.

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CHAPTER 13

Can Helping Others Help Oneself?

Reflections on Altruism, Health, and Well-Being

Carolyn E. Schwartz

MEET THE CONTRIBUTOR

Carolyn E. Schwartz, ScD, is a behavioral scientist who is motivated by a desire to understand how patient factors can influence health and well-being and to capitalize on those factors to help people help themselves. She is a research professor of medicine and orthopedic surgery at Tufts University School of Medicine in Boston, Massachusetts. Carolyn holds a doctor of science degree from the Harvard School of Public Health and has published almost 100 scientific works, including over twenty book chapters and one book. Her research

has spanned numerous therapeutic areas including neurology, oncology, geriatrics, palliative care, endocrinology, rehabilitation, rheumatology, and orthopedics. Her research focuses on how response shift and cognitive appraisal processes influence perceived quality of life in medically ill populations as well as altruism and health. Her hobbies include playing the piano, swimming, reading, walking in the woods, and cooking. She lives with her husband and two young children in historic and bucolic Concord, Massachusetts.

True love is only found in the heart.

—CHINESE FORTUNE COOKIE

They say that the path of scientific inquiry is paved with serendipitous findings followed up by conscientious science. Yet much of what we know is perceived in a blink (Gladwell, 2005) and takes substantial data collection to provide rigorous support. In my case, I

stumbled on the benefits of altruism when I was a postdoctoral fellow at Harvard Medical School. It has been about 15 years since that first step on this investigational path, and my intuitive grasp of the importance of altruism to health and well-being still exceeds my empirical support. Nonetheless, there are things that we do know and that may be helpful for therapists to be aware of in working with their clients—things that could indeed alter the direction of some conventional therapeutic approaches and, in turn, enhance clients' levels of well-being.

In this chapter, I do four things:

1. Reflect on my growing personal evolution of understanding altruism.
2. Describe both the knowledge and the wisdom we have about altruism, in the hope that future clinical work can build on both.
3. Present a conceptual model that may provide a guide for therapeutic interventions.
4. Show how the model can be applied in the case example of Brian, an Australian farmer who faced drought, bankruptcy, the loss of his beloved farm, a failing marriage, depression, and active suicidal thoughts. Was it possible for him to experience a shift in his quality of life? And could altruism play a part in that shift?

THE CRITICAL FIRST STEP: STUMBLING ONTO THE BENEFITS OF LISTENING TO OTHERS

My postdoctoral research was a clinical trial comparing the health-related quality-of-life benefits of two psychosocial interventions for people with multiple sclerosis. The first intervention, a coping skills group aimed at teaching participants coping flexibility, was considered the active intervention and was expected to yield the most benefit (Schwartz & Rogers, 1994). The second intervention, peer telephoned support, was conceptualized as a control group intervention, where similar amounts of time and attention were expected of study participants, but the gain was not anticipated—or found to be—as great (Schwartz, 1999). In this control intervention, five laypeople with multiple sclerosis were trained in active listening to provide nondirective support to a caseload of five to fifteen others with multiple sclerosis, for fifteen minutes once a month for one year. These supporters were selected on the basis of referrals from a variety of sources, including healthcare providers, the local chapter of the National Multiple Sclerosis Society, and my broader social network. They were all women and represented a broad range of disability (from none apparent to a wheelchair-bound supporter with only one functional finger) and age range (early 30s to early 60s).

To ensure that the trial protocol was followed closely, the peer supporters met with me monthly as a group. In between our meetings, they were expected to continue their brief monthly calls. Calls were scheduled like a planned meeting with the participant, and telephone supporters were trained in Rogerian active listening skills (Rogers, 1942, 1951). They were not to divulge their own personal information but rather to listen deeply, responding either with statements that rephrased the participants' own words so that the participants felt heard and understood or to ask questions that deepened the communication and allowed a further exploration of themes or feelings raised by the other person.

I met with this group for about two years, from the first randomization through one year of follow-up for all study participants. I also collected the same outcome data on these supporters as on the randomized patients, perhaps because of an intuition that something could happen to these people that was worth tracking or perhaps because it was easy enough to collect it. Who knew what we would find?

Noticing that these five supporters seemed to blossom before my eyes, I turned my investigations from the supported to the supporters—and discovered that, indeed, this peer support work seemed to be transformational for the peer supporters (Schwartz & Sendor, 1999). The givers were the ones who were receiving! They remarked that the experience changed their own illnesses from something that victimized them to a vehicle for having a positive and enhancing role in others' lives. They felt less depressed by the restrictions imposed by their illness, more peaceful, and even noted that a sense of quietude had become a habit for them. When they listened to others, they no longer were focused on what they would say next but rather allowed a depth to their listening that they had not known before taking on this role in others' lives.

THE KNOWLEDGE VERSUS THE WISDOM

From a scientific perspective, this study was far from robust. However, I was able to document something staggering: The average quality-of-life outcomes for the peer supporters was three to seven times greater than for the randomized patients (Schwartz & Sendor, 1999). In other words, the helpers gained more than the helped. There may be many competing explanations for these findings. First and foremost, these peer supporters were hand-picked because of their willingness and interest to take on this role. Although they were paid for their time, the pay was a fraction of what they earned in their day jobs or via their disability income. Additionally, our monthly meetings to ensure adherence to the protocol probably qualified as a support group. In these meetings, we problem-solved dealing with difficult patients and role-played how to improve interactions that had not worked so well. Thus, selection bias and other unintended benefits probably mitigated the magnitude of the effects attributable to the activity of listening to others. As a scientist, I knew these were important issues. As an intuitive mind, however, I sensed that these findings were both real and robust and that even a strong design to mitigate these confounders still would yield the conclusion that helping others helps oneself.

The wisdom I gleaned from these qualitative and quantitative data was that listening deeply to others was freeing to the listeners. It helped them get out of themselves and gain a refreshed perspective on the problems or circumstances that weighed them down. I also learned that listening to others was experienced as *helping others*. Consequently, I started to think of this process as a connection between altruism and health.

A GROWING SCIENTIFIC BASE

At the time of this initial study, there was very little scientific literature on the benefits of helping others. Now there is a growing scientific base, thanks to the impressive efforts of

Stephen Post to integrate information and publish both professional and lay resources on the topic (Post, 2005, 2007; Post & Neimark, 2007).

I have subsequently implemented two studies on healthy populations that have expanded our understanding of the quality-of-life benefits and moderators of the benefits of helping others. The first was a secondary analysis of data collected on adults by the Presbyterian Church USA. This panel study had longitudinal data on over 2,000 adults and asked a few questions focused on how much individuals spent time providing emotional support to others in their congregation as compared to time spent receiving emotional support. It also asked about feeling overwhelmed by others' needs. As an outcome measure, the panel data included the SF-36 (Ware & Sherbourne, 1992), which is a widely used generic health measure that yields summary scores for physical functioning and mental functioning. Our results showed that there was a significant and enduring relationship between providing support to others and better mental health (Schwartz, Meisenhelder, Ma, & Reed, 2003). This relationship was independent of the impact of receiving support as well as a host of possible confounders but was mitigated by feeling overwhelmed by the needs of others. Thus, *helping others was beneficial as long as it was balanced by a recognition of one's own capacity and needs.*

We also examined what personal factors predicted engaging in other-centered activity. We found that people who spent time listening to others reported a stronger spiritual connection in their religious practice and were more likely to be older and female (Schwartz et al., 2003). Thus, gender differences may be important.

The study also left me wondering if one had to have some sort of "affective reserve" (Weiss & Bates, 2008) even to be able to engage in altruistic behaviors. If so, was this "affective reserve" something that could be nurtured by engaging in altruistic behaviors? Research by Otake, Shimai, Tanaka-Matsumi, Otsui, and Fredrickson (2006) has found that subjective happiness can be increased simply by counting one's own acts of kindness, and that doing such resulted in people becoming even kinder and more grateful as well as happier. What an intriguing positive feedback loop! And what important implications for therapy: *Encourage your clients to acknowledge their acts of kindness, and they are likely to become both kinder and happier.*

My next opportunity for this line of research came a couple of years later via a small grant from the Institute for Research on Unlimited Love. They wanted my group to do a study of altruism in teens, so we contacted the Presbyterian Church USA and decided to collaborate on a study of 457 teen members nationwide. The idea was to measure other helping behaviors besides deep listening to others and to investigate how these behaviors were associated with health and well-being. The new altruism measure included three subscales: Family Helping Behaviors, General Helping Behaviors, and Helping Orientation (Schwartz, Keyl, Bode, & Marcum, 2009). Whereas the first two subscales measured behaviors, the third measured an attitudinal concept.

Results of this study suggested a great contrast with the earlier findings on adults: Providing emotional support via listening to others was associated with *no* benefits for male or female adolescents (Schwartz et al., 2009). Other altruistic behaviors were associated with positive quality-of-life or well-being outcomes, and these relationships were different for male and female adolescents. For male adolescents, family helping was the most salient aspect of altruism, showing associations with positive social relations, purpose in life, and self-acceptance. For females, general helping behavior (i.e., in the greater world, not limited to within the family) was associated with positive social relations, and helping orientation

was associated with better purpose in life. Family helping was associated with better physical health in females but not for males. The only correlates of altruism were higher age, more physical activity, and engaging in positive religious coping.

This set of findings confirms the concept that helping others is beneficial for the helper but also shows that there may be different pathways for males and females. For therapists working with adolescent males, setting assignments of helping within the family seems most critical. When the teenage male engages in regular “good citizen” behavior within the family, his existential well-being grows and blossoms. For girls, such family-focused helping behavior was not associated with well-being outcomes but rather with physical health. Perhaps the girls were more generally expected to be helpful around the house and were excused from doing so only when they were less physically healthy. In contrast, encouraging adolescent females to engage in more helping behaviors in the greater world may enhance benefits primarily in their sense of social connectedness.

A CONCEPTUAL MODEL OF ALTRUISM: BUILDING ON RESPONSE SHIFT THEORY

These three studies led me to wonder about how helping others created these benefits and whether these benefits could be framed in a conceptual model that could make them replicable by others. Was there a framework that people could follow for themselves or that therapists and counselors could employ to assist clients in moving toward a better quality of life? The conceptual model I have presented in Figure 13.1 builds on response shift theory (Rapkin & Schwartz, 2004; Schwartz & Sendor, 1999; Sprangers & Schwartz, 1999). *Response shift* refers to the idea that when individuals experience changes in their state of health or well-being, they may change their internal standards, their values, or their conceptualization of a target construct, such as quality of life, health, pain, and so on (Schwartz & Sprangers, 1999; Sprangers & Schwartz, 1999). What we have learned from the studies of altruism is that they extend the response shift theory by describing how engaging in other-directed activities helps one to disengage from prior forms of self-reference and be more open to changes in internal standards, values, and conceptualizations of the quality of life (Schwartz et al., 2009; Schwartz & Sendor, 1999). I will step through each stage of the model, illustrating the process with the case example of Brian Egan, whom I mentioned at the beginning. Brian was an Australian farmer who has generously given permission for his story to be told here. Faced with drought, bankruptcy, the loss of his farm, a failing marriage, depression, and active suicidal thoughts, was it possible for him to experience a shift in his quality of life? Did altruism play a part in that shift? And are there things we can learn from Brian’s story that will help other clients?

The Antecedents

The antecedents refer to the preexisting, stable characteristics of the individual. For example, personality characteristics, educational background, and spiritual or religious identity can influence how one reacts to life’s challenges. Brian and his wife, Nerida, were city-dwelling parents of four children who wanted to offer their children the benefits of a country lifestyle.

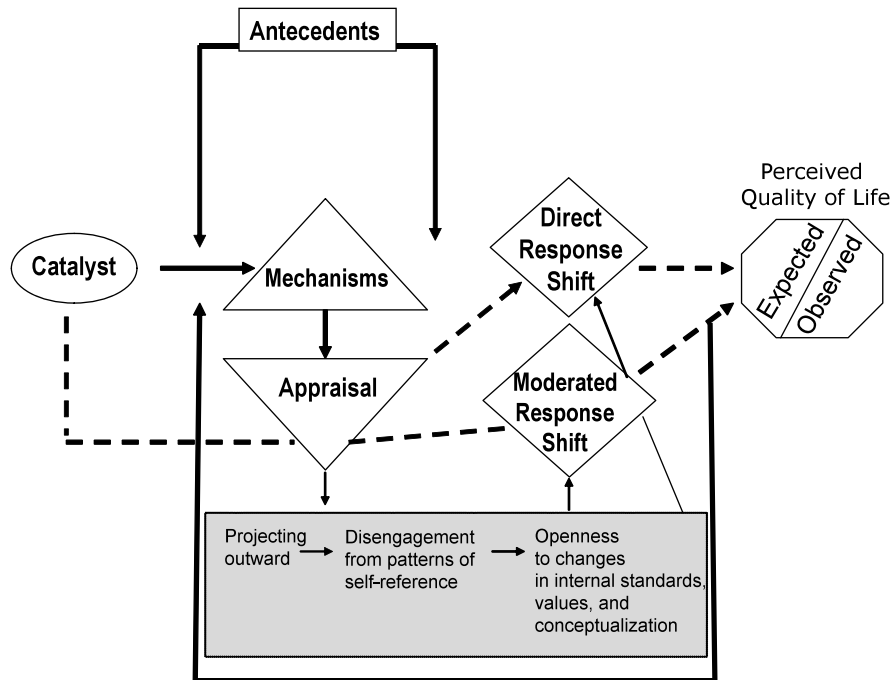


Figure 13.1 A Theoretical Model of How Altruistic Practice Enables Response Shifts in Quality of Life

Source: Adapted and reprinted from C. E. Schwartz, P. Keyl, R. Bode, and J. Marcum, “Helping Others Shows Differential Benefits on Health and Well-Being for Male and Female Teens,” *Journal of Happiness Studies*, 2008.

Brian’s long-held interest in farming combined with their purchase of a small property to fulfill the dream would be an antecedent characteristic in our model.

The Catalyst

In response shift theory, a catalyst is a challenge to a person’s quality of life, such as the diagnosis of a major illness or some other challenging disruption. This is usually the point at which most clients present to a therapist. Such a challenge can create a discrepancy between the way a person had expected his or her life to be going and the way it actually is. This, in turn, places the person in a position of reassessing his or her life’s directions and values and can thus be pivotal to his or her future well-being.

The catalyst for Brian came after several good and happy years on the farm. A devastating drought struck. As Brian said in his understated manner, “If you don’t have water, you can’t do much.”

The farm could no longer support the family, and Brian had to work away from home for extended periods. During one such period, he phoned his wife to say “I’ve got to come

home. I'm sick." Nerida described him as an emotional mess, saying that she would find him sitting outside alone crying, depressed, and suicidal.

Brian's own retrospective comment was "I didn't realize what was happening to me. I didn't know where to go for help. It was like somebody, something external, had taken over my life. I used to call it the beast." He could no longer drive a car, a truck, or a tractor and was too mentally unstable to sign documents or make decisions pertaining to the farm. After three years of hard drought and personal depression, they walked off the farm, leaving everything behind except for their furniture and dog.

The pressure on Nerida and the children was such that she left him twice for short periods but, knowing he had no one else, she decided to go back and stick by him.

Thoughts of suicide escalated. Reflecting on them, Brian said, "The first time I tried to jump out of a car at 80 miles per hour." But it did not stop there. He chose a place in which to hang himself, feeling such action would get rid of the beast that had been plaguing him. "I actually told the beast, 'I'm going to kill you,' knowing that it also meant killing myself. Strangely, the feeling was one of an overwhelming sense of relief."

The Mechanisms

The mechanisms are the cognitive, affective, or behavioral skills, in interaction with the antecedents, that enable a person to adjust to the catalyst. For example, emotion-focused or problem-focused coping strategies, downward or upward social comparison, and spiritual practice are among the mechanisms that can result in response shifts.

Brian's quality-of-life trajectory was on a continuous downward slope due to the successive series of personal and financial losses (catalysts). These circumstances culminated in major depression and suicide attempts. When so depressed, it is often difficult for people to alter their own situation, and it is here that a therapeutic or other external intervention can often be helpful.

"The next thing I knew," said Brian, "I was in hospital." And it was there that his psychologist said something that changed his life . . . and the lives of many others. "Brian," he was advised, "maybe the best thing for you is to go out and find somebody who's worse off than you are and see if you can help them."

"I just laughed," commented Brian. "I said, 'Who could be worse off than I am? I am 56 years old. I haven't got any money. I don't have a house. I have very few belongings. I'm literally a pauper.'"

"You'll find someone" came the reply. The therapist was suggesting engaging in both downward comparison (i.e., that Brian find someone who was worse off than he) and altruistic practice (i.e., helping this person).

The Appraisal

By engaging in altruistic practice, Brian utilized three different processes that would have changed his appraisal of the quality of his life:

1. Projecting outward
2. Disengagement from patterns of self-reference
3. Openness to changes

Projecting Outward

Projecting outward is where altruistic practice begins. It is about looking beyond the self, seeing the needs of others, and offering a helping hand.

“It was just a seed that was planted there,” Brian later reflected on his therapist’s suggestion. That seed led him not only to consider the suggestion but also to act on it by joining a voluntary organization in the city and helping others for the next year or so.

Disengagement from Patterns of Self-Reference

As I discovered in my initial multiple sclerosis study, when the supporters listened to others, they were no longer focused on themselves, their issues, their illnesses, or their depression. Being other-focused facilitates disengagement from the self.

Brian’s therapist began to notice a change happening in his client as soon as Brian started his volunteer work. The things that were worrying him before had become less significant. Now he was awakening each day with a sense of purpose and self-esteem.

The feedback loop of projecting outward and reflecting inward began to show when “the things that were worrying him before had become less significant.” The quality-of-life benefits showed up as “he was awakening each day with a sense of purpose and a sense of self-esteem.”

Openness to Changes

The changes for Brian did not stop there. In fact, they just seemed to open more opportunities for change, not only in internal standards, values, and conceptualization but also in external actions.

Brian’s volunteer work had been in the city, but his heart was still with the rural people who, like him, were struggling. Wanting to help them, he decided to start his own charity called Aussie Helpers. He and Nerida took food out of their own pantry and raffled it at a country hotel. This became a regular event until they had raised enough money to start their thrift shop. Eventually they added a second shop, and from the proceeds, they purchased a vehicle to deliver gifts of groceries and personal hygiene items to farmers in drought-stricken areas.

Becoming aware that suffering farmers desperately needed laborers, Brian showed his openness to change. “I had to do a bit of brainstorming about how we could get the labor they could not afford.” Then the idea came: Why not see if homeless people in the city would like to volunteer some help in the country?

Brian went to a homeless shelter and found his first three recruits. And, as might be expected—in accord with the knowledge and wisdom we have about altruism—this proved to be a very reciprocally beneficial action. While the farmers benefited from the assistance, so too did the volunteers. One said, “I’m staying out here now. I like working with cattle, learning new stuff, and riding motorbikes and horses. I reckon Brian’s helped me in the most exciting way, bringing me out here, dropping me off, and leaving me here to try and survive for myself.” Another commented, “It’s straightened me out a bit, helped me get off the drugs, and got me a bit more motivated to get out and do something.”

Brian is now creating opportunities for others to experience the benefits that he himself has gained from acts of altruism.

Direct and Moderated Response Shift

In the Rapkin and Schwartz (2004) model, response shift is understood as an epiphenomenon that occurs when changes in appraisal explain discrepancies between expected and observed changes in quality of life. Changes in appraisal can affect quality-of-life ratings directly (“direct response shift” path) or by attenuating the impact of catalysts (“moderated response shift” path). In Brian’s example, his process of projecting outward, disengaging from patterns of self-reference, and openness to change affected his appraisal processes in a direct response shift because it seemed to happen for him and all the people he enlisted as volunteers. He may have also evidenced a moderated response shift in the sense that the leadership role he found himself taking in this evolution fundamentally changed his subjective algorithm for combining and weighting experiences. In particular, he commented, “Now I live in a rented house. I basically have no material possessions. My marriage is better than it ever has been, and I’ve never been happier in my life.”

Confirmation comes from Nerida. “From the moment Brian decided to start up Aussie Helpers, he changed himself. From being this withdrawn man, he has shown compassion toward others that he hadn’t shown before. I now see emotions that I’d never seen in all the years we were married prior to that. It’s not about what can I do for someone but how much more can I do for them.”

Perceived Quality of Life

Where are things now for Brian? How is his perceived quality of life compared to when he was suffering such a major depression and associated thoughts of suicide?

“I often call Aussie Helpers my medicine,” he says. “I don’t take tablets any more. My personal philosophy that giving is receiving, and my work of putting this into practice, helps me keep a very positive mental attitude. If it hadn’t been for my therapist’s suggestion to help someone worse off than me, I wouldn’t be here today. It saved my life.”

THE ALTRUISTIC WEB

As when one drops a stone in a pool, one does not always know how far the ripples of a single action of altruism, kindness or compassion will extend. From the simple therapeutic suggestion to help someone worse off, Aussie Helpers was born . . . and continues to grow. It has a business plan to extend across the whole of the Australian continent within two years and include around 100 volunteers.

Whereas Brian’s losses had previously debilitated him into a state of major depression, his new altruism-activated empowerment has enabled him to create and successfully develop an organization that involves homeless people in voluntarily helping others. Perhaps most important for Brian, Aussie Helpers has become his “medicine.” His personal philosophy that “giving is receiving, and [his] work of putting this into practice, helps [him] keep a very positive mental attitude.” By projecting outward, Brian got out of himself. When he came back to his problems and concerns, they seemed less daunting and disabling. By reaching out and involving others in a shared vision, he has woven a community web that has helped not just himself but many, many others. This is a clear example of what can happen when

therapists assist clients to discover the well-being benefits that can be derived from acts of altruism, kindness, and compassion. The theoretical model I have described posits that reaching out to others and providing caring, empathetic attention allows one to transcend a self-centered zeitgeist and, subsequently, to achieve a refreshed view of oneself and one's place in the world. It helps create a net that connects the helper to an increasingly broader community.

A substantial body of research suggests that social isolation has significant health consequences (House, Landis, & Umberson, 2003). The notable rise in recent years in the prevalence of depressive disorders among Americans (Bloom, 2004; Simon, Fleck, Bushnell, & Group, 2004) may reflect a problematic lifestyle that has become the norm. If more people regularly engaged in altruistic social interest behaviors, would the prevalence of depression decrease?

I believe that this line of research has substantial implications for how we understand the concept of “community,” what it provides to people, and what the most effective therapeutic strategies might be for improving subjective well-being. When one engages in altruistic social interest behaviors, one is reaching out beyond one's limited microcosm and weaving a connection to other microcosms and eventually to a larger world. As this behavior pattern goes on, the helper finds him- or herself touching more people in a way that is at the same time personally significant (i.e., providing help that is targeted to others' very personal needs) and nonspecific (i.e., motivated by a general orientation of benevolence or generosity of spirit). Over time, this reaching out and weaving of benevolent connections will likely lead to a sense of a benevolent net that links the helpers to a broader cosmos extending beyond themselves, their families, or even their known friends. This net catches the needy and protects or buffers them from isolation and harm. It is a continually expanding community as we saw in the case of Brian. In thinking about this concept of community that is nurtured and enhanced by altruistic social interest behaviors, it seems akin to a powerful benevolent force. It is thus a spiritual sense of community.

A Word of Caution . . . and Hope

Although I would like to believe that altruism is to be encouraged and nurtured in our society and encouraged and nurtured in therapy, I also think that some caveats must be considered. The first comes from the previously mentioned Presbyterian study that showed there was a significant and enduring relationship between providing support to others and better mental health. Nonetheless, it also showed that the benefits were mitigated when caregivers felt overwhelmed by the needs of others. Therapists may need to assess whether there is a point to which caregiving is beneficial for an individual client and whether there is a point beyond which it is overwhelming or stressful. When setting tasks of altruism, therapists need to ensure that the assignment is balanced by a recognition of the client's capacities and needs.

The second caveat builds on Jungian concepts addressed and developed by Dr. Carol Pearson (1998) in her book *The Hero Within*. Pearson describes six different archetypes—the Innocent, the Orphan, the Wanderer, the Altruist, the Warrior, and the Magician—that exist within all of us to various degrees and can be useful for solving difficult problems and transforming our lives. Although each person may embody each of these six archetypes and may reflect both positive and negative qualities of each, it is likely that some of these archetypes are more dominant than others within an individual's psyche. It is also likely that

some of these archetypes are more consistent with some environments than with others, such as one's family of origin or one's work environment. Imagine if one is focusing on developing and nurturing the Altruist archetype in a Warrior work environment. Is it likely to be successful or even encouraged? I believe that in such an environment, altruistic social interest behaviors will result in harm to the Altruist, whether the harm is related to pragmatic, real concerns or solely to the individual's sense of trust in the world as he or she knows it. This is an important caveat because the frustration of altruistic behaviors can lead to a sense of loss and betrayal that prevent future engagement in social interest behaviors. I struggle with how to solve this dilemma. It does not seem realistic or feasible to try to combat Warrior environments with continued unaltered Altruism.

Nonetheless, reaching out to help others can fill an inner void in substantial and remarkable ways. Although some caveats have been discussed, on the whole I would say that altruistic behaviors hold great promise as interventions for all people and can be offered as simply as Brian's therapist did: "Find somebody who's worse off than you are, and see if you can help them."

Putting It into Practice

From the research, we know that helping others can help oneself. From the conceptual model presented and inspiring cases such as those of Brian, we can see a process by which acts of altruism enhance one's quality of life. How can that knowledge and wisdom be used in therapy?

1. Utilize the catalyst.

A catalyst may be an event or series of events that challenge a person's perceived quality of life. Often this is when most people seek therapy or counseling. If the therapist sees this as a positive opportunity for clients to reassess their life directions and values, clients are more likely to view it positively as well.

2. Explore clients' antecedents and mechanisms.

What are the precatalyst, stable characteristics that have helped your clients cope with life's challenges to this point? What are their cognitive, affective, or behavioral coping mechanisms that can be employed now? What are their interests, strengths, and resources? Knowing these may help in directing them toward maximally rewarding altruistic activities.

3. Encourage projecting out.

Set therapeutic assignments that help your clients look beyond the self, see the needs of others, and offer a helping hand. This is where knowing clients' antecedents and mechanisms can help. Brian had long-held interests and strengths in farming, along with an involvement in the farming community. Offering assistance to those he knew and understood utilized his strengths and gave him a sense of optimal functioning. Similarly, someone

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with computer skills could employ those skills to help rebuild old computers for the needy. Someone with a love of animals could be encouraged to volunteer at an animal refuge. Someone who enjoys cooking could bake a casserole for a sick neighbor.

4. Validate disengagement from self-reference.

Disengagement from negative self-reference is likely to flow naturally from acts of altruism. Help your clients see the benefits, both for self and others, as they reap the rewards of their helping activities. Invite them to acknowledge their acts of kindness because this is likely to promote more kindness and more happiness.

5. Support openness to change.

As Brian experienced, doing something he thought he could not do (finding and helping someone worse off than himself) opened up new ideas and new opportunities for positive changes. Encourage your clients to broaden their horizons and explore new possibilities.

6. Validate the perceived quality of life.

You can validate clients' improved quality of life with such questions as: How have your actions benefited those you have been helping? What differences has it made to your life in the ways you are thinking, feeling, and doing things? How has it improved your relationships with those around you? How has it enhanced your own appreciation of life?

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CHAPTER 14

Doing Nothing, Changing Profoundly

The Paradox of Mindfulness in a Case of Anxiety

Craig Hassed

MEET THE CONTRIBUTOR

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Having told her story in some detail at the first consultation, Sophie turned to me and asked expectantly, “Well, what can I do to get rid of these panic attacks? They’re destroying my life.” I found myself saying these words in response. “Perhaps you don’t need to do anything about those feelings of panic.” Sophie wrinkled her brow and looked at me with an expression that communicated more of a state of bemused curiosity than anger. Her mind had come to an unexpected and sudden stop because my statement seemed diametrically opposed to what she expected to hear. She was suddenly open to unexpected and previously unrecognized possibilities. It was as if she had been living in a solitary and bleak

prison cell for a number of years and a mysterious window of opportunity had opened in front of her. Hitherto it had been barred by the solid and fixed assumptions she had made about the cause and cure for her condition.

Interested and open inquiry is always the gateway to opportunity and growth. We sat in silence for a few moments before she added, “Then am I meant to just lie there and accept them?”

“Possibly. It might be an experiment worth trying. Is it possible that by trying to do something to get rid of the panic attacks you may have actually been heightening them?”

“That hadn’t occurred to me before,” she replied.

Life is full of paradoxes. A paradox, according to the *Oxford English Dictionary*, is a “statement contrary to accepted opinion; seemingly absurd though perhaps actually well founded statement; person or thing conflicting with preconceived notions of what is reasonable or possible.” Sophie’s situation had all the hallmarks of a paradox. In fact, the pursuit of peace, happiness, meaning, or fulfillment is a paradox for us all. The more anxious we feel about being at peace or happy, the more elusive it seems. It is just the extent of our misunderstanding and unawareness that varies.

It is a central precept of mindfulness, and indeed of all the great wisdom traditions, that awareness is a prerequisite for understanding just as light is a prerequisite for sight. And just as we have a fear of the dark, awareness and understanding are prerequisites for the alleviation of fear and agitation. The most important thing we can understand is ourselves, and if we have a few basic misunderstandings in relation to self-knowledge, then it will not be surprising that many secondary assumptions about happiness and freedom will also be misplaced. If, however, we come to understand ourselves, then perhaps a lot of other things will fall into place, and this was the theme that Sophie and I explored.

THE PARADOX OF MINDFULNESS

Mindfulness presents us with many paradoxes, some of which I will explore through the case of Sophie. This chapter illustrates some of the principles of applying mindfulness meditation and mindfulness-based cognitive strategies and explores possible neurological, psychological, and philosophical mechanisms to explain them. Some discussion is dedicated to the overlap and contrasts between the tenets of positive psychology and mindfulness-based interventions.

Two main themes of research have accelerated the rapid growth of interest in mindfulness-based therapies. The first, in relation to the prevention of depression relapse, is mindfulness-based stress reduction, an approach developed by Jon Kabat-Zinn (1990). From this, Segal, Williams, and Teasdale (2002) developed mindfulness-based cognitive therapy (Ma & Teasdale, 2004). The second main stimulus has been the rapid growth of the neurosciences, particularly in the fields of neuroplasticity and neurogenesis. It is likely that a number of mechanisms are responsible for why the practice of mindfulness has its therapeutic effects. It has long been known that the amygdala is the brain structure for mobilizing the fear response, but it has now been shown that upbringing and temperament (Whittle et al., 2008) as well as exposure to inescapable stress (McEwen, 2004) can influence the size and activity of the amygdala in the developing brain. It is also now known that these changes are, to a significant extent, reversible.

Mindfulness practice has been demonstrated to produce changes especially in the prefrontal cortex of the brain (Lazar et al., 2005; Pagnoni & Cekic, 2007), a region that

is particularly important for emotional regulation, executive functioning, reasoning, and impulse control. The prefrontal cortex seems to be monopolized by default mental activity like rumination. The neurological changes associated with mindfulness may not be due only to a slowing of cell loss but also to stimulating cell growth and strengthening neural pathways between the frontal cortex and the limbic system responsible for emotions. This may also be part of the reason as to why there is such an overlap between mindfulness and emotional intelligence with its domains of self-awareness, self-regulation, empathy, deep motivation, and social skills (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006).

THE BACKGROUND

Sophie was in her mid-20s. She was a capable and intelligent young woman who had been working in an administrative role for a small family business. She was good at whatever she turned her hand to and liked to set very high standards for herself. While her upbringing was sometimes unsettled and confusing, it was not necessarily unhappy. A cardiologist had referred Sophie to me because he believed the palpitations she had presented to him with were stress related. Over the last two years, her background anxiety had progressively escalated to her experiencing occasional panic attacks. Over time, however, their frequency and intensity increased to the point where she was either experiencing them or anticipating them nearly all day long. By the time she presented to the cardiologist with the physical effects of constant sympathetic nervous system activation, leading to the physiological exhaustion known as allostastic load (McEwen, 2004), Sophie had become almost totally disabled. She found it difficult to leave the house, had given up work, her social life was almost nonexistent, and her family was extremely concerned. Although she had some support from her parents—she was living at home—Sophie did not feel that she had anyone she could really speak to about her problems.

Despite her situation, Sophie remained resilient, motivated, and optimistic about her ability to deal with the problem. She was obviously concerned but was not experiencing major depression.

By now Sophie clearly recognized that her symptoms were stress related but did not want to depend on medications. She wanted to employ psychological strategies and had an interest in meditation although she had no experience with it. Thus, she was referred to me. Mindfulness-based interventions have been used for anxiety and panic disorders for some years with good success (Kabat-Zinn et al., 1992).

THE MINDFULNESS INTERVENTION

We had reached a point in the initial consultation where we were ready to dip our toes into the first of the mindfulness practices. At the prospect, Sophie immediately and emphatically stated, “I’m not closing my eyes.”

The introduction to any therapy is an important stage for a number of reasons. First, I was aware that despite her eagerness, there was a fear of stepping into the unknown, particularly if doing something new might trigger another panic attack. I felt that it was therefore important to let her set her own pace and to maintain control over her journey.

With her background, if she was resistant to mindfulness, I would certainly not push her to go where she was not ready to go. Rather than try to impose my usual way of introducing the mindfulness exercise—eyes closed and the first practice taking seven to eight minutes—I invited her to leave her eyes open and we would practice for only one or two minutes. In this time, we initially paid attention to the body through the sense of touch—such as feeling the posture, weight, touch of the clothes—then moved on to the senses of hearing and, as the eyes were open, sight. Any changing states of mind or emotion were simply observed as mental events without any need to process them or take up an attitude about them, thus cultivating an attitude of acceptance. The longer form of this exercise would have used the same principles but extended the length of time spent on each step.

Second, mindfulness is primarily about awareness and, contrary to popular belief, not essentially a relaxation exercise. However, regular practice of the relaxation response can switch off the overactivity of stress genes (Dusek et al., 2008) although, from a mindfulness perspective, the relaxation response would be seen as a side effect—albeit a common and welcome one—of being focused in the present moment. As Sophie’s case illustrates, one can practice mindfulness even during a panic attack, rather like learning to be at rest in the eye of the hurricane. It is the hypervigilance and hyperreactivity to unpleasant states and experiences—whether pain, panic, or mood—that sensitizes the neural pathways in the brain, making them more and more reactive to less and less stimulus (Eriksen & Ursin, 2004; Ursin & Eriksen, 2001). Furthermore, the activation of the brain’s cytokine system—a part of the biology of the stress response—can sensitize the brain for the later development of depression and mobilize the sickness response, which may explain many of the symptoms associated with depression (Dunn, Swiergiel, & de Beaurepaire, 2005).

As a result of her mindfulness practice, Sophie had felt peaceful and content, but it was equally possible that she would experience a heightened awareness of physical sensations as well as her background anxiety and apprehension of having an attack. She therefore needed to understand right at the outset that there was no requirement for her to have what she might perceive as a positive experience (such as feeling relaxed or content) and, equally, there was no requirement for her to try to avoid a so-called negative experience (such as physical discomfort or feelings of anxiety). The aim of this simple exercise was to spend a couple of minutes being aware of the present moment through a connection with the senses. This included awareness of her internal state as much as it included the external environment. If anxiety or unpleasant thoughts arose, Sophie was simply encouraged to practice being accepting of them. Thus, mindfulness is not just about paying attention, it is about paying attention with a particular attitude—with a quiet compassion for self, acceptance, and nonjudgmentality (Kabat-Zinn, 1990). For example, during the mindfulness exercise or during her daily life, every time she observed a state of body, mind, or emotion—whether it was pleasant or unpleasant—she practiced observing it without having to change it, get rid of it, hold on to it, or judge it as good or bad. As Shakespeare reminds us, “There is nothing either good or bad, but thinking makes it so.” Indeed, it has been shown that people adept at mindfulness are much more able to generate compassion (Lutz, Slagter, Dunne, & Davidson, 2008).

Sophie was asked to practice for up to five minutes twice a day and return one week later for review. I tend to prescribe a small starting dose and then increase it according to the person’s motivation and progress. She was also asked to notice how mindful or unmindful she tended to be in day-to-day life. This raises another crucial point that I wanted Sophie to explore. Mindfulness meditation is a form of mental training; that is, the

aim of the practice is not to achieve some kind of exalted state while sitting in the chair (state mindfulness) but rather to use the practice as the foundation to be able to get out of the chair and be more mindful in daily life (trait mindfulness). A tendency to be mindful in daily life is a far greater predictor of progress and psychological well-being than achieving exalted states in meditation but still remaining distracted and unaware in daily life (Baer, 2003). In mindfulness we are interested in the full 24 hours a day, not just two daily periods of a few minutes each.

Sophie asked if I had a CD with the practice on it, which I did, and she said that she would like to use it. The CD contained 1 hour of introduction, discussion, and mindfulness practices that were an extended form of what we practiced and discussed in the consulting room, and what is summarized in “Putting It into Practice” at the end of this chapter. Although ultimately I like people to be independent of external props in their mindfulness practice, CDs can be useful, much like training wheels on a bicycle helping to keep us balanced. Having a trusted practitioner’s voice guide the person through the practice not only helps to build a familiarity with the steps involved, but the tone of the practitioner’s voice also helps to reinforce the attitude of acceptance and gentleness.

A MINDFULNESS METAPHOR

There was no need for Sophie to try to keep certain thoughts and sensations away (Teasdale et al., 2000). They were likely to come in whether she wanted them to or not, so the only choice we could cultivate was to practice being less reactive to them—being less moved by them.

I explained to Sophie that they were, metaphorically, like trains of thought. We do not have to fight with the trains, we simply have to learn to watch them come and go without getting on them. I find the train metaphor a useful one, and it relates very readily to a client’s experience for three reasons.

1. We soon see that trains of thought come to the station whether we want them to or not.
2. We often find ourselves getting on the train without realizing.
3. We try to stop the trains we do not like by fighting with them or getting down on the tracks, but experience teaches us that this merely increases the impact of the train enormously.

We can deal mindfully with unwanted thoughts and sensations by realizing that we can practice observing their coming and going without having to do anything about them. The train may still move through our awareness, but we do not have to be moved by it.

In psychological language, this is called meta-cognitive awareness (Segal, Williams, & Teasdale, 2002), but I prefer to use metaphors rather than psychological jargon because they help both practitioner and participant to understand the process and how to work with it. In my experience, clients readily understand metaphors or stories in a direct way that hours of complex psychological theory will never provide (Burns 2001, 2007; Burns, Chapter 26, this volume; and Garnier & Yapko, Chapter 12, this volume). A depth of understanding in mindfulness is reflected in simplicity, not complexity.

This brings us to consider one of the paradoxes involved with mindfulness-based therapies: It is not by trying to hold back a train intent on moving in its own direction that we become free of unwanted thoughts. This only binds us to them more tightly. Freedom will come about through equanimity and impartiality, through nonreactivity to them.

THE MINDFULNESS APPROACH OF PARADOX AND INQUIRY

A central aspect of the mindfulness approach is inquiry. *Education* comes from a Latin word meaning “to draw out”; thus mindfulness-based therapies are truly educative in that the facilitator is there to draw out insights (wisdom) from the client through a Socratic style of questioning. The Socratic method is not about telling people what to think or how to see things. Instead, through questioning and following a line of thought under the guidance of reason, the counselor helps people to see things and come to realizations for themselves. In some ways, we could describe Socrates as the first real cognitive therapist. To be able to work in this way requires therapists to be mindful of their habitual desire to give answers and explanations and modify their style to questioning in such a way that the answer is obvious and comes from the clients themselves. When it comes out of a person’s own mouth, an answer has a lot more validity. As I hope you will see in the next section, I always try to ensure that the questions are initiated by the person’s actual experience rather than by a theory about how things might be or ought to be.

When Sophie returned the following week, I was surprised to find she had practiced (with the CD) for one hour twice a day.

“What is happening when you are practicing?” I inquired.

“I’m trying to do what you said: just watch the feelings without trying to fight them. I have always taken the attitude that I wanted them to go away, but I have noticed the more I want them to go away, the worse they get. Initially I got frustrated with them because I was trying to accept them, but they still wouldn’t go.”

The Paradox of Acceptance

Many people will assume or expect, as Sophie initially did, that they should experience a positive and pleasant experience while practicing mindfulness. Although many do, it is not a given. One could have pleasant or unpleasant experiences, or to put it another way, one could be observing differing states of mind or body during the practice. The aim is therefore to observe these changing states with acceptance and nonattachment, with a compassionate, attentive, but objective embrace of our moment-by-moment experience. “So your experience teaches you that nonacceptance gets us caught up in and preoccupied about the thing we are trying to escape from?” I asked.

“Yes. Although I can’t say that the feeling of panic is coming less often, I have noticed that if I don’t fight with it, it comes and goes a little more easily.”

“I suspect it hasn’t been easy for you to sit with those kinds of thoughts and feelings.”

“That’s the understatement of the week.”

The Paradox of Being Nonjudgmental

“What have you noticed about your level of mindfulness in day-to-day life?” I explored.

“It’s hopeless. I can’t keep my mind on what I’m doing at all. I was feeling okay the other day when I was making a cup of tea and then I started to think about how stupid I was for letting myself get into the mess I am in. Before I knew it, I was feeling panicky. I spilled milk all over the bench. Then I started to criticize myself for that and I was literally crying over spilled milk. I think I’m no good at this.”

Another paradox arises in mindfulness-based approaches. Sophie was encouraged to be nonjudgmental about her experiences, not judging them as good or bad but just seeing them as they are: a rich and ever-changing series of experiences arising and falling in her awareness. Her original response to her panic attacks was, understandably, that she hated them, feared them, and desperately wanted them to go. She was encouraged not to judge them in this way but to look on them with an impartial eye. There is, indeed, a difference between a quiet, attentive, impartial, and wise *discernment* and an agitated, distracted, partial, and oftentimes unwise *reactivity* to events. People who have practiced mindfulness over time will tend to find that their ability grows to wisely discern between what is relevant, useful, or appropriate from what is not while their tendency to be judgmental diminishes. Various wisdom traditions speak at length about the differences between the judgments born of wisdom and those born of the ego. Mindfulness strengthens the first and helps to abate the second.

“You’re doing extremely well,” I offered supportively, “but I suspect that you are being a little hard on yourself. Would you mind if we took the focus off trying to get things right and put the focus more on what your experience is teaching you?”

“What do you mean?”

“Well, you have discovered, first, that these judgmental thoughts and feelings come into your awareness whether you want them to or not; second, that your attention goes off and you become unmindful of the present moment without even realizing it; and third, that being distracted is associated with making mistakes.”

“No argument about that.”

“And have you also noticed that criticism makes it worse?”

“Ten times worse.”

“Well, it seems to me that what you are interpreting as a failure is in reality a gold mine of discoveries. If we gain a valuable insight from what appears to be a mistake, then we are better off than we were before. If we acknowledge and learn the lesson, then the mistake is a good thing, not a bad thing.”

Sophie felt relieved that it was okay to not get things right and that something good could come from making mistakes. It took a lot of the pressure off.

The Paradox of Doing Nothing

Within two weeks, Sophie had noticed that not only were the waves of panic less big but they were also coming less often. She was losing her fear of them. Now she viewed them as a succession of changing states of body and mind. Previously she had feared that they would not go, and felt that she had needed to do something about them. Now she was realizing that the less she did about them, the easier they passed of their own accord. Through “nondoing” things were changing. As far as perception was concerned, she also started to notice how often she built small things into large problems, particularly in interpersonal and family interactions. This included being quick to jump to conclusions about what others thought when, in reality, she really did not have a clue what others thought. Realizing this while it was happening had the effect of suspending her hasty judgments and also helped her to keep things in perspective.

After four weeks of solid practice, Sophie made an interesting remark. “You know, I’ve been a bit disappointed this week. I lie down to do my practice and wait for the feelings of panic to arise. I look forward to them coming so that I can practice accepting them, being less reactive to them. But the more I look forward to them, the less they come. Now I just find myself lying there feeling peaceful with nothing to do.”

“Well, this is another important discovery,” I commented. “Can I ask, do you need to control the unpleasant sensations, thoughts, and feelings you have experienced—whether it is anxiety, fear, depression, or anger—or is it a matter of learning not to be controlled *by* them?”

“That’s right. It is about not being pushed and pulled by them. I had been trying to maintain my balance by trying to control these experiences, but now I see that it was really just a form of suppressing what I was feeling.”

“Yes, it’s a bit like trying to keep balance while holding onto a train that is moving off in its own direction. Does one maintain balance by holding on or letting go?”

“Letting go, definitely.”

“And what of the tendency to be distracted and unmindful in your day-to-day life?”

“I’m not doing that nearly so much anymore, and that includes not thinking about having my next panic attack. My mind is a lot quieter now without me trying to quieten it.”

SCIENCE, WISDOM, AND PRACTICE

Sophie’s case illustrates how science, wisdom, and practice can come together to enhance an individual’s well-being. Through the paradox of mindfulness, she discovered a significant reduction of default mental activity that we might otherwise call thinking but also goes by other names, such as rumination, worry, daydreaming, and distraction (Buckner et al., 2005). Most default mental activity has to do with a preoccupation about self (Gusnard, Akbudak, Shulman, & Raichle, 2001) and so attention regulation through mindfulness helps to gently turn the attention out again thus diminishing this self-preoccupation and hypervigilance.

These and other discoveries were powerful realizations for Sophie, realizations that she would not be able to forget easily. They were most powerful because they came from her, not from me, not from a book, not from someone else.

Sophie continued to come weekly over the following four weeks. The panic attacks were soon a thing of the past. We reviewed her weekly experiences and insights, practiced the mindfulness exercise together, and looked at cognitive tasks such as letting go, acceptance, presence of mind, and listening (Hassed, 2002). After this time, Sophie felt self-reliant enough to continue by herself. She had been back to work for three weeks by this stage and was enjoying a renewed social life and new interests, including developing relationships that helped to foster her ongoing growth while leaving behind those that sabotaged it. In other words, she was a lot more mindful about the relationships and environments she put herself into and wanted to choose the ones that brought out the best in her.

In every culture and wisdom tradition, we can find accounts of the kinds of insights that Sophie had made. Although these wisdom traditions did not have sophisticated brain scanning techniques or randomized controlled trials to guide their search for knowledge, they encouraged an inquiring and open mind, a spirit of discovery, highly developed powers of observation, patience, and courage. These are exactly the qualities that Sophie needed to grow through adversity and to come to understand herself better. Although in modern

psychological terms it could be said that this was a young woman trying to manage an anxiety disorder, in a larger perspective this was a struggle as old as humanity itself: the search for deep and abiding happiness and the transcendence of suffering.

MINDFULNESS AND POSITIVE PSYCHOLOGY

There is much overlap between mindfulness-based approaches and the positive psychology movement, but there are differences also. From a mindfulness perspective, “true happiness” is natural and unchangeable whereas stress and depression have become “second nature.” To go beyond normal potential requires a major awakening. Ultimately, circumstances—internal and external—are of secondary importance, although they can be useful or detrimental in cultivating character. It is our attitude and relationship to our circumstances that matters more than the circumstances themselves. Voluntary variables—such as optimism, positive emotions, strengths—can be cultivated. In fact, we will be cultivating variables, for better or for worse, whether we are aware of it or not. Unfortunately, when unmindful, this tends to be unconscious and without discernment—particularly in relation to the negative variables.

From a mindfulness perspective, there are perhaps three levels of psychology.

1. *Common psychology* based on the common beliefs and attitudes predominant in the society regardless of their merit—perhaps the life of “quiet desperation” without flourishing
2. *Positive psychology*, the conscious cultivation of positive traits and strengths to help us flourish
3. *Enlightenment psychology*, the possibility for transcendence beyond the relativity of time, place, and experience and the duality of positive and negative

From the perspective of common psychology, the precepts of positive psychology are valid and of practical use. From the perspective of enlightenment psychology, positive psychology is also valid but as a stepping-stone rather than a final end point.

Whether Sophie felt that she was on a path to enlightenment or not was up to her. She never put her search in those terms, but she certainly did gain insight into some unfounded but unexamined assumptions that were causing her much grief. Indeed, it could be said that Sophie had made some profound changes by “just lying there, doing nothing.”

Putting It into Practice

Mindfulness Exercise

It is helpful, wherever possible, to have a quiet place to practice without interruption. Nonetheless, mindfulness can be practiced anywhere, any time—indeed, it is important for the practice to be as portable as possible, whether the environment is

active and noisy or not. As it helps to have an idea of how long you will be practicing for, a clock within easy view can help to reduce anxiety about time. Simply open your eyes to check the time if need be.

1. Position.

The sitting position is generally preferred with the back and neck straight and balanced, requiring a minimum of effort or tension to maintain the position. Lying down can be useful if deep physical relaxation is the main aim, or if the body is tired, in pain, or ill. Falling asleep may not be desirable unless it is late at night. Having settled into the preferred position, let the eyes gently close. Meditation can also be practiced with open eyes cast gently down, resting on a point a yard or two in front of the body.

One can use the sense of touch focused on the body (body scan), or breath or another sense, such as the hearing, or a combination of these. The important thing about the body and the senses is that they are always in the present moment so they help to bring the mind into the present moment. Contact with any of the senses will automatically draw the attention away from the mental distractions that otherwise monopolize our attention.

2. Body scan.

Initially, be conscious of the whole body and let it settle. Now progressively become aware of each individual part of the body, starting with the feet and then moving to the legs, stomach, back, hands, arms, shoulders, neck, and face. Take your time with each part. The object of this practice is to let the attention *rest* with each part, simply noticing what is happening there, what sensations are taking place, moment by moment. Practice cultivating an attitude of impartial awareness, by not having to judge the experiences as good or bad, right or wrong. Simply accept them as they are. There is no need to change your experience from one state to another or to make something happen. Let yourself observe how the mind might judge, criticize, or become distracted. These are simply mental experiences to be aware of, nonjudgmentally, as they come and go. As attention wanders from an awareness of the body, simply notice where the attention has gone and *gently* bring it back to an awareness of the body. It is not a problem that thoughts come in or the mind becomes distracted. They become a problem only if we view them as a problem.

3. Breathing.

The attention can focus on the breath, right where the air enters and leaves through the nose, or where the stomach rises and falls with the breath. No force is required, and in mindfulness there is no need to try to regulate the breath; let the body do that for you. If distracting thoughts and feelings come to your awareness, there is no need to try to stop them, or force them out. Notice how trying to force thoughts and feelings out just feeds them with attention, makes them stronger, and increases their impact. We are simply practicing being less reactive to them, even if

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the thought is about the meditation practice and how well or poorly we think it might be doing.

4. Listening.

Here we are simply practicing being conscious of the sounds in the environment, both near and far. As we listen, we let the sounds come and go while letting any thoughts about the sounds—or anything else, for that matter—also come and go. Keep gently bringing the attention back to the present when it wanders. The value of listening in the moment is that the attention is not feeding our usual mental commentary, commonly so full of the habitual and unconscious rumination that constantly reinforces ideas about ourselves and the world.

5. Finishing.

After practicing for the allotted time, gently come back to an awareness of the whole body and then slowly allow the eyes to open. After remaining settled for a few moments, move into the activities of the day that need your attention.

Source: Summarized from Hassed, 2008.

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CHAPTER 15

Laying Out in Anxiety

Acceptance and Commitment Therapy for Values-Based Living

Robyn D. Walser and Maggie Chartier

MEET THE CONTRIBUTORS

Robyn D. Walser, PhD, is director of trauma and life consultation services and works at the National Center for Post Traumatic Stress Disorder. As a licensed psychologist, she maintains an international training and consulting business and a therapy practice. Robyn is an expert in acceptance and commitment therapy (ACT) and has coauthored three books on ACT, including one on learning ACT. She has been doing ACT workshops since 1998, training in multiple formats and for multiple client problems. She is active in research and has presented her findings and papers at international and national conferences, universities, and hospital settings. She is invested in developing innovative ways to translate science into practice and continues to do research and education on dissemination of ACT and other therapies.

Maggie Chartier, MPH, MS, is currently a doctoral student in clinical psychology and intern at the University of San Francisco, California Clinical Psychology Training Program. She received her master's of public health in epidemiology and international health at the University of Washington, Seattle. Maggie's primary areas of interest include examining new ways to approach risk behavior and treatment issues among multiproblem clients and people living with HIV with a particular focus on methamphetamine addiction, trauma, and mindfulness. She has been learning and teaching acceptance and commitment therapy and mindfulness for the past two years. One of Maggie's primary goals as a psychologist is to bring empirically supported treatment interventions into community settings, helping communities be a meaningful part of both research and dissemination.

Susan presented to therapy with extreme anxiety and depression. Her key problems involved her work as a nurse for the past 20 years. What if she got the paperwork wrong? What if she delivered the wrong medication to the wrong client? What if she should lose her job? She felt “zoned out,” “forgetful,” and “unable to think.” Her key desire was to manage her anxiety so that it did not interfere with her work and ability to make friends.

A 48-year-old white female, Susan was single and lived alone. Her early family life was filled with turmoil; her parents were volatile, and her mother an alcoholic. They fought regularly, often physically. From time to time, Susan would either get involved in the fights or would hide in a neighbor’s garage until it was over—times of desperate loneliness. When her parents divorced, her mother’s drinking increased and has continued to this day. Not surprisingly, Susan felt fearful and anxious, had few friends, and did not go on dates.

During her college years, she went on her first date—an event that was to tragically shape the rest of her life. She was date raped, became pregnant, and had a complicated abortion. It was at this time that she made a decision not to trust men and, when coming to see me some 30 years later, had still not been on another date. Like her mother, she had a history of intense alcohol abuse but had been sober for the last 17 years. Susan’s main goals for therapy were to be able to manage her anxiety and work-life better and perhaps one day have a meaningful relationship.

The two main therapeutic goals for Susan, from an acceptance and commitment therapy (ACT) perspective, were:

1. Help Susan see how maladaptive avoidance of internal experiences was associated with many problems in life functioning, and then move toward acceptance of internal experience.
2. Bring Susan into contact with her personal values and encourage her to take specific actions in relation to those values as a means to bring vitality back to her life.

Dr. Walser was the therapist for the case. Maggie Chartier edited and worked on parts of the chapter that did not directly involve the client.

HOW ACCEPTANCE AND COMMITMENT THERAPY FITS WITHIN A POSITIVE PSYCHOLOGY PARADIGM

ACT (pronounced “act”), developed by Steven Hayes, PhD (Hayes, Strosahl, & Wilson, 1999), focuses on *acceptance* of internal experiences while promoting *commitment* to taking action in accordance with personally held values. Its theoretical and philosophical origins are derived from relational frame theory (Hayes, Barnes-Holmes, & Roche, 2001; www.contextualpsychology.org).

A growing body of evidence supports the efficacy of ACT for many psychological problems (see Hayes, Louma, Bond, Masuda, & Lillis, 2006, for a review). ACT holds the view that human beings are whole and acceptable as they currently are, with all of their emotions, thoughts, and historical experience, both those that are evaluated as good and those that are evaluated as bad. The key is for an individual to compassionately observe their own experiences while also making flexible life choices that are consistent with a personal life path.

ACT and positive psychology share common ground in that both are dedicated to helping people live more meaningful and fulfilling lives and both philosophically believe that social issues can be addressed on an individual and community level. However, they can differ in their means of attaining these goals. While some of the major approaches in positive psychology focus on increasing positive emotions, thoughts, and experiences through an emphasis on personal strength, capacity, and an innate desire to have a more meaningful life, ACT focuses on living well and experiencing what is there to be experienced (i.e., thoughts, emotions, body sensations, and memories). The underlying premise of ACT is to fully experience *all* that there is to experience—whatever and whenever it arises. It is about increasing the richness of living through the acceptance of all internal experience. As such, full engagement in values may, at times, bring feelings that are not necessarily positive. Whereas positive psychology at times emphasizes the creation of the positive to undo the negative (Fredrickson, 2008), ACT takes the stance that whatever you experience is fully acceptable.

ACT and positive psychology both hold to the notion that people want to live more *meaningful lives* and can attain this through enhancing the *experience* of love, work, and play. Both have the goal of enhancing subjective well-being in a broad sense, and both aim to promote valued living. Both approaches share the idea of engaging in activities that have the potential to be uplifting while also focusing on bringing vitality to concepts such as compassion, creativity, integrity, and love.

AN OVERVIEW OF ACT

The theoretical underpinnings of ACT guide the intervention and are key in understanding the implementation of the therapy. One of the main premises that ACT relies on in the therapeutic process is in drawing the distinction between mind and experience. Humans often come to know themselves and the world *through* their “mind.” They become fused with their mind as if they are a being who *is* a mind rather than a being who *has* a mind. What is lost in this fusion is the client’s experiential sense of knowing the self and world. An important therapeutic process in ACT then is to help the client contact experiential knowledge.

This can be demonstrated simply by one of Susan’s struggles. She often complained that she could not “stand the anxiety another moment,” and then, in her course of believing what her mind had just said about her experience, she would choose to drink alcohol as a means to escape the anxiety. Her mind’s way of knowing the self in this circumstance included an evaluation about a feeling and an implication about the outcome of experiencing that feeling (can’t stand it = bad outcome). If this verbal sense of knowing the feeling is held to be literally true, it seems that immediate action must be taken or some awful event will follow. Her very attempt to avoid it also became problematic (e.g., alcohol use).

Experiential knowing, however, has a very different quality and potential for outcome. Let us take Susan’s scenario. She says to herself, “I can’t stand this anxiety another moment” and, rather than buy the thought, she lets her experience inform her. Experiential knowledge will tell her that in fact she *can* stand the feeling for another moment, as the next moment will pass. What we learn from experience is that emotions and thoughts are more like a flowing river—constantly in motion, ever changing, even if subtly so. Learning to observe thinking and feeling as ongoing processes rather than as immovable outcomes creates a place where

openness to experience is available and willingness to feel and think whatever one feels and thinks is more likely. Once the client is able to contact this sense of self as experiencer, she can observe the experienced events and make choices that are outside of these events. The client is more flexible. That is, Susan can notice the thought that she cannot stand it and feel the sensations of anxiety while making a choice in her life that is not driven by those things but rather is driven by her values.

GETTING STARTED

Informed Consent

Before Susan and I started therapy, it was important to consider the informed consent process. In addition to typical written consent, time is also given to the ACT intervention in particular. A verbal consent can be helpful.

ROBYN: I wanted to introduce you to acceptance and commitment therapy or ACT. It will most likely be different from other therapies you may have tried or from what you may have heard about how therapy works. Largely, what happens is contained in its name. We are going to be working on acceptance of emotions and thoughts, and commitment to a quality life. In this therapy we don't work to make you think differently; instead we help you to "see" your thoughts in such a way that they don't continue to have a negative impact on you. We also don't try to change emotions; rather we focus on acceptance of emotion, but not in a just-give-up fashion. Rather, we do it in a way that helps you notice that you have emotion, that you can "carry" emotion with you, and that you can still work to live the kind of life you want to live. We will be exploring your relationship to your emotions and, as we progress, you will know if this is working for you.

Commitment to a Course

Because ACT can raise fairly fundamental issues, it is wise to get the client to commit to a course of treatment and agree not to measure progress impulsively.

ROBYN: It is best to carve out space for this treatment. We may end up stirring up some old stuff. Sometimes you may feel like we are not moving forward and, at other times, things might be painful. It is like exercise; sometimes you feel pain even though you are in the process of getting healthy. I do think that you should hold me accountable. If we are not moving ahead after several sessions, you will know and we will both see it in your life. Let's check after four to five sessions. If at that time things don't seem to be improving then let's talk about options. If you are moving forward, great, we will press on. Does this sound like a plan you can live with?

An additional point to emphasize is:

ROBYN: I will also be asking you to do things outside of therapy. It will be important to begin to implement activities and goals that are linked to what you want to see happen in here. This may be hard, as making and keeping commitments can be

challenging. What kinds of things might get in your way when being asked to do activities outside of session?

You and the client should discuss what comes of this question and agree to work on it as it arises.

Clinical Assessment Interview

The overall goal of assessment in ACT is to determine what of the client's behavior is consistent with an ACT formulation of problem avoidance and fusion while also defining behavioral inaction with respect to personal functioning (see Hayes, Strosahl, Luoma, Varra, & Wilson, 2004).

In the interview, we worked to clarify where overt behavioral avoidance had become problematic and checked for areas of Susan's life that she had stepped away from in some significant way. For Susan, it was clear that her avoidance of dating and of speaking to colleagues had become stifling. These kinds of behavioral avoidance issues had negatively impacted her life in that she experienced intense loneliness and regular problems on the job, including low performance ratings and poor relationships.

We also assessed for Susan's use of external and internal emotional control strategies by exploring the answers to this question: "What do you do to escape, run away, or to hide from your emotions?" Typical external avoidance strategies include drinking, using drugs, leaving social situations, isolating, and the like. Susan's external avoidance strategies largely involved isolation. She would also sleep for long periods of time (14–16 hours on the weekend) as a way to escape life.

Typical internal strategies include distraction, numbing, and telling yourself to "get over it." Susan consistently used distraction. For instance, she would watch television for three to four hours every night and then go to bed. She would also try to whip herself into shape by being internally critical, often saying things to herself such as, "Don't be so stupid, you idiot!"

ACT WITH SUSAN

Whereas rigidity and inflexibility are the "enemies" of psychological health, the essential therapeutic goals are to create psychological and behavioral flexibility. Given this aim, let us briefly return to Susan's two specific therapeutic goals:

1. Promote Susan's acceptance of self by helping her establish a willingness to experience thought and emotion through the use of defusion, mindfulness, present moment, and self-as-context techniques.
2. Promote valued living as Susan personally defined it by exploring personal values (e.g., connection) and working on specific goals/behaviors related to those values (e.g., talking to coworkers in a kind manner).

It is also important to note that we wanted to draw on Susan's strengths during the therapy, and these were key factors in her progress. One of Susan's most valuable strengths was persistence. Although she encountered several setbacks during treatment, she continued

to engage. For instance, after quitting several jobs, she still continued to pursue her nursing career and was determined to find a job that better fitted her value of living a more balanced life. Susan's other main strength was her ability to make and keep commitments. She continued to meet multiple interim goals, such as regularly exercising, opening an online dating account, and attending singles' events. These strengths were all defined in terms of values.

IMPLEMENTING THE SIX CORE COMPONENTS

ACT clients are taught to hold all internal experiences with compassion while also taking steps to create meaning in their lives. This is done with six core ACT processes: Acceptance, defusion, contact with the present moment, self-as-context, valued living, and committed action. Let us work through these processes with Susan.

Acceptance

The acceptance process involves undermining emotional control and avoidance by creating a space for acceptance and willingness of internal experience. In the initial stages of ACT, the therapist works with the client to undermine the dominance of excessive and misapplied verbal control. This can be a bit tricky to do as it involves using language to attack language—or using one's mind to explore the problem of being “glued” to the mind. The use of metaphor can be helpful in getting around this problem (Burns, 2007; Hildebrandt, Fletcher, & Hayes, 2007). Clients are asked to clarify what thoughts, emotions, sensations, and memories are causing problems. Additionally, clients are asked to extensively describe all of the strategies, both good (e.g., seek therapy) and bad (e.g., drink alcohol), they have used to deal with and/or eliminate the internal experiences that are interfering with their lives.

ROBYN: Susan, tell me about your struggles. What is it that is causing you so much difficulty?

SUSAN (tearing up a bit): I get angry at people, they are just so stupid.

ROBYN: Okay, what else?

SUSAN: I hate my family, especially my mom. She makes me angry with all of her drinking. She just doesn't get it.

ROBYN: Okay, sounds like two of your struggles have to do with anger and memories related to your family and mom. Is that right?

SUSAN: Yes, and anger at other people.

ROBYN: Okay, anything else? One of the things you told me is that you felt sad and anxious. Does this cause you struggle?

SUSAN: Yes, I just hate that I feel that way. It's so stupid.

ROBYN: All right, so you struggle with anger, bad memories, anxiety, and sadness. And would it be fair to say “stupidity”?

SUSAN (chuckling): Yes.

ROBYN: So now we know why you are here to see me. You want to fix this stuff.

SUSAN: Yes.

ROBYN: Okay, before we head there, I would like you tell me all of the things that you have tried in the past to change, fix, eliminate, or be done with these struggles. Let me know both the good and the bad.

At this point Susan listed about 30 or 40 different strategies, ranging in nature from just ignoring it, to distraction (watching television), to escape (sleeping, taking extra medication, drinking alcohol, smoking, anger at her family, etc.). Once we had an extensive list, we explored the utility of these strategies.

ROBYN: So here we are with this big list of things that you have tried to fix these problems. Let me ask you, which one of these strategies worked? Which one of these strategies took these problems away?

SUSAN (nervously laughing): None. I wouldn't be here if it had worked.

ROBYN: One thing we can say is that it wasn't lack of effort, right?

SUSAN: No, you can say that again.

ROBYN: So it's not that you haven't tried.

At this time I used the quicksand metaphor to help Susan begin to see the problem (Walser & Westrup, 2007, pp. 73–74):

ROBYN: What does your mind tell you to do when you fall into quicksand?

SUSAN: It tells you to get out, to swim fast.

ROBYN: Right. "Hurry up! Save yourself!" But what happens when you do that?

SUSAN: You sink.

ROBYN: Right. What if this problem, trying not to feel what you feel and think what you think is like that? The harder you try to get out, the more you sink. What do you need to do to stay afloat in quicksand?

SUSAN: Stop moving.

ROBYN: Right. You lay out in it. You put as much surface area of your body as possible in touch with the quicksand, get in contact with it, without effort to struggle. Paradoxically, the more you fight against it the more entrapped you become.

SUSAN (puzzled again): You mean I've got to lay out in my anxiety?

ROBYN: By laying out in anxiety, I am suggesting you give up the struggle. As with the quicksand, it is the struggle to extract yourself from it that causes you to sink deeper into it. By floating, being still, laying out in it, you have a better chance of survival. It is not about giving into the anxiety but about giving up on the struggle, about trying a different approach from what your experience shows has not been working for you. If it meant that you stopped sinking, might you be willing to give it a try?

It is also very important for the therapist to be compassionate at this stage in therapy. The goal is not to point out how the client has failed but rather to point to the strategy—control of private events—as the problem. It is noted that attempts at control actually may prolong the experience or paradoxically cause the experience to grow in intensity. During these parts of the therapy, it is important that the therapist appeal to the client's own experience and not try to convince the client that the strategies of "fixing" or elimination do not work. The client will be able to tell the therapist the "truth" of these matters.

Defusion

The defusion process involves undermining fusion with the mind by deconstructing how our use of language and learning promotes fusion, unhelpful evaluation, and needless reason giving. The main goal is to help the client "de-fuse" from their mind. In Susan's case, it was

learned that she was holding her thoughts to be literal truth and she was responding to her constructions of the world as if they *were* the world. For example, Susan would fuse with the idea that she was “stupid,” and she would respond accordingly—being quiet when it would have been helpful for her to speak, stepping back from important decisions, questioning herself, and physically “freezing.” These behaviors would then lead to mistakes on the job. “Defusing” from her construction “I am stupid” involved seeing the words for what they were—a set of words put together in a particular way—and then choosing to respond in a way that was more workable.

ROBYN: Tell me more about the thought “I am stupid.”

SUSAN: Well, I am. If I weren’t, then these things wouldn’t happen to me.

ROBYN: How old does this thought feel?

SUSAN (reflecting): I have had it as long as I can remember . . . back to when I was a child.

ROBYN: Wow, it’s been around awhile. What do you think the likelihood is, given how old it is, that it is going to go away?

SUSAN: I have no idea, but if I could just stop thinking it then I could do better at work.

ROBYN: Okay, so it seems like the thing to do is just stop thinking “I am stupid” and some of your problem will be solved, right? What if “just stopping” can’t work? What if it is like this . . . I don’t want you to think about the last word that is going to come at the end of the sentence that I am about to say. I want you to just say stop and see if you can prevent yourself from thinking about this last word. Ready? Mary had a little . . .

SUSAN (sighing): . . . lamb.

ROBYN: Did you say “stop”?

SUSAN: Yes, in my own head.

ROBYN: And what happened?

SUSAN: Something funny . . . it was like . . . stop, lamb, stop, lamb, stop, lamb.

ROBYN: Well, as you said this thought is old and just like Mary had a little . . . , there are times in your life when a button gets pushed and a thought pops into your head . . . “I am . . . ”

SUSAN: Stupid.

ROBYN: Right, it’s just like Mary had a little lamb. I am stupid. What if you could stand back and see this for what it is: words that you have learned and come together in a particular way when a certain button is pushed? I am asking you to see it for what it is—thinking.

SUSAN (unsure): Okay.

ROBYN: I am going to ask you to close your eyes and think something. (Susan closes her eyes.) I want you to think about the chair you are sitting in. Can you picture it in your mind and see the word *chair*?

SUSAN: Yes.

ROBYN: Are you the chair?

SUSAN: No.

ROBYN: Okay, let’s make it a little more challenging. I want you to see the color red. Got it? (Susan nods.)

ROBYN: Are you the color red?

SUSAN (starting to get it): No.

ROBYN: Now I want you to think the thought “stupid.” (pause) Are you the thought “stupid”?

SUSAN: No.

ROBYN: Right! All I am asking you to do here is stand back a little from these automatic thoughts and see that you have them and yet you are not them.

In this scene, Susan and I worked to help her defuse from her thought, to see it for what it is: thinking. Notice here that defusion is not about changing the thought “I am stupid” to some other thought. There is no need to exchange this thought for a thought that is “better” (e.g., “I am really not stupid, the evidence doesn’t bear that out”). Rather, the thought is just that. Susan and I used other techniques to continue to build her ability to defuse from her thoughts. As Susan was able to defuse from her mind, she was more readily able just to notice her thoughts. We began to talk in session about *Susan* living her life instead of *Susan’s thoughts* living her life.

Contact with the Present Moment

In this process, you can use mindfulness to begin to help clients live more fully in the present moment, contacting the ongoing flow of experience as it occurs. Susan’s struggles involved dwelling on her family history and worrying about the future. In addition to asking Susan to practice mindfulness exercises at home on a regular basis, we also worked on being in the present in session. Here is an example of one of our initial in-the-moment exercises.

ROBYN: It seems like you get stuck a bit when you worry about what is happening tomorrow and when you think about what happened when you were a kid.

SUSAN: Yeah. I can spend hours thinking about those things.

ROBYN: It seems like your mind does a real number on you, dragging you around the future and the past. (Susan agrees.) Let’s try something. I am going to ask you to do a few things and see if you can just let yourself do that and nothing else.

SUSAN: Okay.

ROBYN: I would like you to notice what it feels like to sit in the chair . . . feel the pressure of your legs and back as they press against the furniture. (Pause.) Now notice the sensation of your feet on the floor. (Pause.) Shift your focus to your chest and feel the sensation of your lungs as they rise and fall with each breathe. (We continued in this fashion for several minutes.) Did you notice how from moment to moment you were just paying attention to the next thing I asked you to observe?

SUSAN: Yes.

ROBYN: Were you thinking about your work or family?

SUSAN: No, not at all.

ROBYN: See what our mind does—it does good stuff, that’s for sure, but it also does this thing where it drags us back through our history or pushes into our future. Neither of those is found in the right here and now.

Susan liked the idea of being more mindful and understood the premise. Nonetheless, she initially had difficulty doing mindfulness exercises. She persisted and found them to be useful in helping her to sleep and in slowing down at work just enough to make decisions that were more helpful to her job performance. It was made clear that this kind of activity would be lifelong. Mindfulness is not an outcome but a process.

Self-as-Context

In this process of self-as-context, you are working with clients to create experiential contact with a sense of self that is larger than the content of one's life. For instance, one may have a feeling that lasts for a period of time, but it soon passes, and another experience is there to be noticed and felt. The quality that is being created here is one of being able to observe mind and body as ongoing presence rather than discrete, to-be-believed instances of thinking or feeling. Once the client is able to observe and contact experience, rather than *be* that experience, then new and more flexible ways of responding can develop.

ROBYN: Are you willing to do a short eyes-closed exercise with me to help you connect to what I am talking about here? (Hayes et al., 1999, pp. 192–196)

SUSAN: Yes (and closes eyes).

ROBYN: Okay, I would like you to start by simply noticing your breathing for a few moments. (Pause.) Now I want you to think back to something you did this morning and notice what it was that you were doing. (Pause.) Notice the sights and sounds of this memory. And as you notice this memory, notice who is noticing. Now go back to a memory from a week ago. Take a look around that memory, what were its sights and sounds. (Pause.) Now as you look at the memory, see who's looking. There is a *you* there that is observing this memory. The same you that observed the memory from this morning, the same you that is sitting here now. (Pause.) Now go back even further and choose a memory from your childhood, the first one that comes to mind, and take a look around that memory. What are the sights and sounds of this memory? And as you notice the memory, notice the noticer. (Pause.) Notice that you are observing this memory. And also notice that it is the same you that observed one from last week, and from this morning . . . the same you that is sitting here now. (This exercise continues with asking Susan to notice the different roles that she plays, how her body has changed and yet she remains, her emotions and all that she has felt plus her thoughts and how they are without number. She has been there through it all.) Now as we wind down, notice that there is a you there that has these experiences and yet is not these experiences, you are larger than them. You hold and contact them and there is space to hold and contact more. Notice this observer sense of you—a you that is the context for your experience, not the experiences themselves. Now gently return to the room (Susan slowly opens her eyes).

SUSAN: Wow, that was interesting.

ROBYN: Were you able to contact that sense of you that is larger than your thoughts and feelings?

SUSAN: Yes.

Susan connected well to this process and began to see herself as larger than her thoughts and feelings. She worked from this perspective frequently as she began to take actions in her life that were about what she truly wanted to matter.

Valued Living

Identifying and clarifying personally held values dignifies the therapeutic process and provides direction for the client. Clarifying values in multiple life areas helps to orient the client to a meaningful life. The value of connection (e.g., friendship, dating) for Susan

was by far the strongest that she held and far outweighed her desire to stop feeling anxious or sad. Susan decided that a more fulfilling life would result if she could bring connection into her experience, even if anxiety continued to occur.

ROBYN (with respect): What if today was the last day of your life and you had the chance to say what would be written on your headstone, what would it say?

SUSAN: This is weird, I don't like to think about my own death.

ROBYN: Understandable. But are you willing to just come along with me for a minute and see where we land?

SUSAN: Sure (with a wry smile).

ROBYN: Imagine that today is the day . . . what if your headstone said something like this: "Susan's life was about making sure that she didn't feel anxiety." What do you think?

SUSAN (pausing): Well, it would be accurate but not the best headstone.

ROBYN (compassionately): I agree, that is a tough thing to have it read. Now what if it is the same day and the headstone reads: "Susan was about making connection to friends." What do you think about that one?

SUSAN: I would much rather have that one!

ROBYN: What if you can? Starting today? Remember you have feelings of anxiety and you have the thought that you are stupid. These are experiences that come and go . . . and with this knowledge, would you be willing to feel and think them if it meant you could have headstone number two?

This discussion led Susan and me directly into a conversation about committed action, which is where we turn next. Values can be clarified in a number of ways, and having the client work on value clarification throughout therapy is important. Interestingly enough, when you turn toward your values and let go of the struggle with internal experience, one by-product tends to be a lessening of symptoms.

Committed Action

This process of ACT is about encouraging clients to build larger and larger patterns of committed action that are consistent with chosen values. Here the work is about taking very specific behavioral steps that are linked to personal values. We pick up here from the last conversation.

ROBYN: Do you think it is possible to pick the second headstone starting today? I mean, what if it is available to you now? Is there one thing you could do today that would be about making connection?

SUSAN: I don't know. It might make me anxious.

ROBYN: Okay, let me ask you a simple thing. If you had two drinks sitting in front of you, let's say water and soda, and you were going to pick one, which would you pick?

SUSAN: I would pick water.

ROBYN: Why?

SUSAN: Water is better for you.

ROBYN: Good, why else?

SUSAN: Water feeds your body and doesn't have any calories.

ROBYN: Okay, you now have several good reasons to pick water. It's good for you, it feeds you, it has no calories, etc. These are excellent and powerful reasons, right?

SUSAN: Yes.

ROBYN: With all of your good reasons to take the water, could you also take the soda and drink it?

SUSAN (pauses): Yes, I could. And I could call a friend.

This exemplifies the kind of work Susan and I did together on making choices even though you “don’t know” or feel “anxious”: We started with small goals and worked our way toward larger goals. We returned to the notion of choice as freely held regardless of what her mind or feelings had to say about it. Her values were hers to live. Over time, she engaged her values more by accomplishing small goals on a regular basis—she worked on living values as a lifelong process.

SUSAN’S LIFE

Susan made great strides in therapy. We believe that this was because therapy was not about stopping either her anxiety or her thoughts of being stupid. Neither was it specifically aimed at replacing unwanted feelings and thoughts with happier emotions or cognitions; rather, therapy was about the acceptance of whatever she experienced—whether these experiences were perceived as good or bad, positive or negative. The promotion of acceptance, psychological flexibility, and commitment to living a values-based life, we believe, is the promotion of those qualities essential for a person to live a psychologically healthy existence.

Susan eventually found a job that allowed her to practice nursing in a small, friendly setting and thus to substantially improve the quality of her work life. She was able to make choices about fixing mistakes if they were made and about being more open with her colleagues. She also made some important strides with her family. Her value was to be loving with her family. Although she still struggled with her mother’s drinking, she planned, and spent, several vacations with her mother. Susan also joined a yachting club and an online dating service for women only. At last word, she was actively engaging these activities . . . and still laying out in her anxiety.

Putting It into Practice

After attaining informed consent and a commitment to the course of therapy, ACT has six core therapeutic components.

Target Problem	Core Therapeutic Goal	Therapeutic Intervention
Experiential avoidance; whatever a client is doing to get away from experiencing emotions, thoughts, sensations, or memories	Acceptance	Undermining emotional control and avoidance by creating a space for acceptance and willingness of internal

(Continued)

(Continued)

Fusion with the mind, believing thoughts about self and experience; arguing with mind	Defusion	<p>experience. This was communicated to Susan through the quicksand metaphor.</p> <p>Undermining fusion with the mind by deconstructing how our use of language and learning promotes fusion, unhelpful evaluation, and needless reasoning. Susan believed her thoughts to be the truth—and responded as if they were. Defusion is not about changing thoughts, such as “I am stupid,” to other thoughts but about living life independent of unhelpful cognitions.</p>
Getting stuck on living in the past or worrying about the future; getting caught up in those stories	Contact with the present moment	Using mindfulness to begin to live more fully in the present moment, with more contact with the ongoing flow of experience as it occurs. For Susan, being in the present helped free her from past and future worries.
Excessive attachment to a sense of conceptualized self	Self-as-context	Creating experiential contact with the self-as-context (the context in which internal experience is happening) instead of the conceptualized self (self as the content of what internal experience and mind dictate). Once Susan was able to observe and contact experience rather than <i>be</i> that experience, then new and more flexible ways of responding developed.
A life focused on the elimination of emotion, thought, memory, sensation, history, or experience; symptom reduction	Valued living	Identification and clarification of personally held values that can ground and motivate us to confront previously avoided psychological experience. The value of connection (e.g., friendship, dating) for Susan was by far the strongest that she held. She decided that a more fulfilling life would result if she could bring connection to her

Remaining stuck in a place of
inaction

Committed
action

experience—even if anxiety continued to occur.
Encouraging and helping clients to build increasing patterns of committed action consistent with chosen values. Here the work is about taking very specific behavioral steps that are linked to personal values, such as calling a friend, joining a club, or connecting with a dating service.

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CHAPTER 16

Playing with the Moment

A Frame Theory for Positive Outcomes in Anxiety Treatment

Reid Wilson

MEET THE CONTRIBUTOR

Reid Wilson, PhD, directs the Anxiety Disorders Treatment Center in Chapel Hill, North Carolina, and is associate clinical professor of psychiatry, University of North Carolina School of Medicine. He is a member of the vanguard (first) class of certified graduates of Dr. Martin Seligman's Authentic Happiness Coaching Program. His interest is in utilizing the principles of flow during times of struggle. Reid is an international expert in the treatment of anxiety disorders, with books translated into nine languages. He designed and served as lead

psychologist for American Airlines' first national program for the fearful flier. He served on the board of directors of the Anxiety Disorders Association of America for 12 years and was program chair of the National Conferences on Anxiety Disorders from 1988 to 1991. His free self-help web site—anxieties.com—serves 385,000 visitors (16 million hits) per year. Reid lives and works in his home in the woods, road bikes and rows for fun, and is a perpetual student of anxiety, worry, and flow.

As we sit down, her sweet smile is at odds with the tautness in her face and the shake in her hands. Renée's nervousness is palpable. In addition to suffering from panic disorder with agoraphobia and on top of arriving without her number-one support person, we are now seated in front of a British audience of 30 therapists and two cameras. You would think I would go easy on her, but I do not. Instead, within the first several minutes, I make five comments that undermine her sense of safety. See if you can find them. (I will put a number in brackets after them, in case you miss one.) This may appear to be cruel and unusual

punishment toward this terribly anxious woman. But I have 45 minutes to conduct this treatment session, and Renée wants to make a difference in her life. I have decided that the best way to support change is to charge directly into her belief system and its moment-by-moment representatives. Here is how we start:

REID: Hi, Thanks for coming!

RENÉE: You're welcome.

REID: Are you nervous?

RENÉE: I'm extremely nervous, yes.

REID: On a scale of zero to 10 . . .

RENÉE: About 8.5.

REID: 8.5? Impressive! I like people to come in with high anxiety because then we have something to work with. [1] (Renée gives a nervous laugh. She's trying to act appropriately, but she seems so anxious; she is barely getting the words out right now.) What does an 8.5 feel like?

RENÉE: It feels like my heart is thumping a lot—pulsing a lot—and (as she gestures) I've got a knot in my throat. And I've got pins and needles in my hands and feet right now.

REID: So, what's the worst that's going to happen to *you* here, what do you worry most about here?

RENÉE: I think the worry is more about . . . when it happens, I'm concentrating more on the symptoms than the situation itself. As soon as my heart starts beating a bit too fast, then it's like *Ooh, I mustn't lose control*. And from that it just gets worse, like *Oh, God, I'm losing control* and, *Oh, God, my hands are starting*, and *Oh, my legs feel jelly*.

REID: And what ultimately will happen—what are you afraid is going to happen? Just that the symptoms will get worse, or is there some big thing that's going to happen? The world explodes? (She shakes her head.) The world doesn't explode?

RENÉE: No, I'm not afraid of that, no, I'm just afraid that I won't be in control of the symptoms and it's going to accumulate and . . .

REID: Well, you're not in control of them now, are you? [2]

RENÉE: Not really, but just by talking to you, you see (smiles), I don't think about my heart pounding so much (laughs a bit), so my heart doesn't pound so much.

REID: Ah. Maybe we should pay more attention to your heart then! [3]

Here we are a few minutes later.

RENÉE: Altogether, I think it's the heart pounding, it's the legs getting jelly; it's the pins and needles. It's anything that just makes me think *Right now I'm anxious, and I'm scared about being anxious because what if the panic attack makes me so like that* (squeezing her fists, pulling her arms into her chest, and lifting her shoulders into a tense state) *that I can't even move and I feel trapped*. It's the feeling trapped.

REID: So, since I've never met you before, tell me about last time when you just couldn't even move because the anxiety was so great?

RENÉE: It was a few years ago.

REID: A few years ago? Well, you're due for another one; it's been a long time! [4]

RENÉE: That is kind of in here (pointing to her temple). As soon as it starts I'm thinking that's the way it could get.

REID: But why haven't you had any in the last few years? What's happened?

RENÉE: Because to start with, I stick with people. My husband followed me everywhere, then my parents . . . But he's not here now! (Her voice rises when she says this, and she tosses her head back and forth with nervous laughter.)

REID: He's not here now? Well, then, this is a dangerous situation, isn't it? [5]

This is a brief provocative treatment model. I am going to disrupt her current rigid belief system, which is based on two pessimistic views: tomorrow will be just like yesterday, and I do not have what it takes to change.

THE GOAL: CHANGE THE FRAME OF REFERENCE

Let us assume that actions are dictated, in part, by beliefs about the world, cause and effect, how one gets one's needs met, fairness, and so on. The word *belief* has several synonyms, such as cognitive set or schema, point of view or orientation, values, standards, attitude, perspective or stance, frame of reference or frame of mind. Let us create a shorthand term—frame—that represents such a frame of reference that is triggered in the moment and tends to direct our next action. Here are the frames that appear to be guiding Renée right now:

- Feeling safe and in control is my highest priority.
- I need to maintain my current rituals to stay safe and in control.
- Physical discomfort is synonymous with losing control.
- Paying attention to physical sensations is dangerous.
- Distracting myself is an excellent way to stay in control.
- If I panic I may become paralyzed and trapped, and that is bad.

If she can challenge these perspectives, then she has the option to choose an entirely new set of actions that support her valued goals. Often clients have adopted such a fearful, limited frame of reference that they will not even be *aware* of their valued goals until they develop a sense of self-efficacy.

In anxiety treatment, long-term change becomes stable to the degree that clients adopt an optimistic frame of reference. Here are the types of frames that are a priority:

- I am courageous.
- I want to approach what frightens me.
- I can handle what happens.
- I am moving toward the activities that I value.

My job this session is to initiate Renée's movement toward these frames. But you cannot grab a new frame of reference until you loosen your grip on your current one. Accessing courage will be our first task.

BRING RESOURCES FORWARD

Her most powerful frame at the moment is *I must keep anxiety at bay*. If we are going to confront that frame in a way that makes a difference *right now*, then we need to pull her fear

forward, into the room. That is the method in my madness as the session opens: I am implying that her typical defenses may not protect her here.

She is going to need some powerful resources to challenge her automatic frame that tells her to back away and brace for the hit, and I need to be mindfully watching out for those resources. Fortunately, she gives me an opening to access one of the best. She begins telling me how she has been climbing back into her life for the past several years, even though she had no professional help until recently and had no learned coping skills. I take this opportunity to reinforce her strength. Notice that she will dismiss the attribution at first. But I am not changing topics until she takes ownership of an inner resource that we need *right now*.

REID: You had no skills back then. And you had no idea what was going on. You've worked hard to get where you are! And it wasn't a quick thing; it was slow.

RENÉE: It was very slow.

REID: So, you have a lot of courage.

RENÉE (she shakes that suggestion off with her head, smiles a little, and hesitates before she speaks): Maybe.

REID: Well, I define courage as being scared and doing it anyway.

RENÉE: Mm-hmm.

REID: That, to me, sounds like you have a lot of courage. Would you agree?

RENÉE: Yes.

REID: So I wonder if we could find some ways to help you be even *stronger*. Would that be okay with you?

RENÉE: That would be fine.

Now we have an accessible, competing frame—*I am courageous*—that can play an important role in the session. She has, first, acknowledged a positive resource or strength and, second, agreed to work it.

Let us move to 18 minutes into the session. I have been suggesting what we might accomplish. I want her to know that her fear of runaway panic is normal. But this is a mental game, and she has given up ground to the anxiety disorder (Wilson, 2006). To take territory back, she will have to develop a strategy that is not directed by fear. I am going to reinforce two principles:

1. Change takes place in each present moment.
2. She needs to attend to her *reaction* to anxiety, not to the anxiety itself. She is not in control of anxiety showing up; she is only in control of her response.

REID: Another thing that could go on our list is your thought about whether you would have a panic attack and how bad that attack would be. I think that's working against you. Do you think that might be true?

RENÉE (nods): Yes, I'm sure it's true.

REID: Because you're thinking, I'm calm now, and maybe I can be at a 5. (I'm alluding to a 10-point scale of calmness to panic.) I hope I don't get to a 6. It would be bad if I was at a 7. If I got to an 8, that would be awful! But I think I can do a 5. But how do I know it's going to stay a 5?

RENÉE: That's the thing.

REID: You're like everybody else around that. So I think we have to do something about changing your relationship *in the moment* of the anxiety. Does that make sense to you?

RENÉE: Yes, it does.

REID: Do you think we could fool around with that idea just sitting here with each other? Do you think we could explore how we might do that?

RENÉE: Yep.

If I want her to consider a change to the system that has protected her for years, then I had better be clever about it. So I imply something brief and something light.

REID: Could we just fool around for a bit here? Just explore how we *might* do it?

RENÉE: Because my anxiety . . . I associate it with being alone. In fact, I just want to be able to be alone.

There! She is telling us her valued goal: to be able to be alone. We know a lot about goals and how they can be a motivating resource (see Street, Chapter 4, and Cheavens & Gum, Chapter 5, this volume). But Renée has a frame that contaminates that resource: *Anxiety is keeping me from being alone; the only way I can be alone is to first get rid of anxiety*. Therefore, I say:

REID: So let's figure out how to be alone with your anxiety. (I can tell she's rather skeptical about the idea.) That sounds kind of crazy, I know. (She laughs.) But part of what happens with you, as with everyone else, is you're saying *I need to get rid of it in order to feel okay*. And I understand that you mean that. But the way to get rid of it is to be okay with it. Because as soon as it shows up, you go *Uh-oh!* And then what happens?

RENÉE: What I've noticed is that the more I try to fight it—and I mean fight it; not be rational—the worse it gets.

INTRODUCING PARADOX

At this moment, we are on the same page. Since she believes that she cannot tolerate anxiety, she resists it when it appears. Her *I-can't-handle-this* frame signals the autonomic nervous system to secrete more epinephrine, causing an increase in her uncomfortable sensations. I am going to introduce the paradoxical strategy in a direct challenge to her frame (Ghadban, 1995). She, of course, will think I am insane. But since the cameras are rolling, she is polite about it.

REID: Okay. So what would be the opposite of fighting it?

RENÉE: It would be to go with the flow, if I can say that.

REID: To be okay with it?

RENÉE: Yes. Relax.

REID: That would be kind of the opposite. What do you think would be the *really* opposite of fighting something?

RENÉE (with a little laugh): Not fighting it?

REID: So you're trying to get rid of it, right?

RENÉE (nods): Mm-hmm.

REID: What would be the opposite of trying to get rid of it?

RENÉE: I don't know.

REID: Trying to keep it *with you*. That would be the opposite, wouldn't it?

She pauses, tilts her head, and furrows her brow. This makes absolutely no sense to her.

RENÉE: That would be terrible, wouldn't it?

REID: What do you mean?

RENÉE: Well, if I'm anxious when it's there and if I keep it, then I think I'm going to get even *more* anxious, aren't I?

Her frame is totally logical . . . but completely wrong.

REID: Oh, no, let's back the tape up. I think what you said was "*The worst problem I have is: when it shows up, I fight it.*"

RENÉE: Yes.

REID: Did you say that?

RENÉE: Yes.

REID: Okay, and so now I say, "*Well, let's do the opposite and not fight it,*" and you say, "*That would be the worst thing, to not fight it.*" Well, you can't have both ways, right? So if the worst thing is to fight it, let's see if we can figure out . . . (I'm working on her frame now, offering her the possibility of another option.) It's not about the anxiety; it's about your *relationship* with it.

RENÉE: Yes.

REID: So, if you and I can add *one single thing, one single thing* today, what I would want to add—don't know if it's even possible; maybe we can find out—I would add: You changing your relationship, *like a game*, with the anxiety.

I have such faith in the power of altering the frame toward one of *this is a game*, I am going to push that single strategy repeatedly. Psychologist Mihaly Csikszentmihalyi defined *flow* as the state in which we have deep, effortless involvement, are fully absorbed in activity, lose our sense of time, and have feelings of great satisfaction (1990). His research into flow clearly points to the benefits of perceiving any challenge as a game that you have the possibility of winning. When we apply a paradoxical strategy to anxiety, our clients boost their own likelihood of "winning." The ability to *increase* discomfort or uncertainty or doubt, although threatening, is more within clients' perception of their skill set than reducing those elements. I reinforce this experiment with playing by keeping this session light. I joke with her and say a few silly things; I want to intersperse our conversation with smiles and laughter. Her *problems* are serious, but our *task* is to play a game, and serious interventions often can be communicated in a playful yet powerful way.

THE COGNITIVE GAME: TALKING TO ANXIETY

We are 24 minutes in, and I have been describing the permissive approach to treatment to Renée: acceptance of the moment, support of breathing skills, and a sense of self-efficacy that says *I can handle these feelings*. Now I am going to disavow that approach and push the provocative one.

REID: I've got a way for us that works better. It's hard, but it's simple. The other way to go is *Boy, my heart rate must be 120 beats per minute. I wonder if I can get it to 140.* (Her eyes seem to double in size.) Why are your eyes bulging like that?

RENÉE (laughing hard enough for her shoulders to shake): Because that's a very scary thought to me.

REID: To have your heart beat 140 beats a minute?

RENÉE: Any faster than it's already beating . . .

REID: I have *no interest* in having your heart beat any faster than it's already beating. What I want you to do is to request *anxiety* to make it beat faster. I don't want you to imagine yourself having a panic attack. I don't want you to imagine yourself tied to a railroad track with a train coming. I don't want you to overbreathe and hyperventilate to make your heart beat faster. I want you to say—and we're going to try it in a minute, okay?—*Anxiety, thanks for showing up. You know . . . gosh . . .* (I pause, look nervous, put my fingers on my wrist to take my pulse) *90 beats a minute; that's so fast. I feel scared about that. Could you get my heart rate to go up to, like, 100 beats a minute, please?* You're talking to your anxiety. This sound crazy yet?

RENÉE: No, but it sounds scary.

REID: Crazy, scary—same thing. (Again she's laughing.)

We have arrived at the core of the protocol. This is a cognitive game. We are going to personify and externalize the anxiety disorder, get it outside the self. We will make a request that is opposite of what anxiety expects. If resistance fuels anxiety, then the opposite is *not to accept* the experience. Acceptance is too soft, too neutral. Besides, getting someone to move directly from resisting a potentially terrifying experience to accepting it is too difficult. We need finesse.

The opposite of not wanting something is *wanting* it. Why want it? Think about the principles of habituation, the gradual adaptation to a feared object. In behavioral treatment, the road to recovery is paved with frequency (the number of times a behavior or symptom like anxiety occurs), intensity (the severity with which it occurs), and duration (the length of time it occurs for). You need to face your distress and doubt often enough, with strong enough distress each time (at least a 50 on a subjective units of distress scale), for long enough each time. If you *want* to get better, and *this* is how you get better, then it is logical that you should *want what it takes* to get better. In this case, you want frequency, intensity, and duration.

The most important principle here is that when you stop resisting, you get better. In other words, it is not what you do, it's what you *stop* doing. No matter how clumsy Renée is at attempting to talk to her anxiety, to the degree she will *attend to* mastering that technique, she will dissociate from her tendency to resist. Let us see what happens.

I now ask her which of her two strongest sensations is the worst at this moment: the shaking or the knot in her throat. She says it is the knot. Which sensation do you think we should use for our first practice? If we are doing a typical hierarchy for approaches like systematic desensitization or exposure therapy, we would pick the shaking. But I go for the knot instead. Why? Let us take on the biggest bully. If we do not succeed, that is okay, because, after all, we were taking on the bully; who would expect we would win against the bully on our first attempt? But if we succeed, then we beat the bully! We can get a lot of mileage with that win.

REID: Okay, so I wonder if you could just *play*. This is like Acting 101. And here's what we are doing. This is a mental game, right?

RENÉE (nods): Mm-hmm.

REID: So we're just getting you to do something the opposite of what you always say. You say *Uh-oh*. We're not going to stop you from saying *Uh-oh*. We're just going to add: *Boy, anxiety, would you please make my knot get stronger?* I'm not asking you to close your eyes and imagine it getting stronger, right? I just want you to talk in your mind about it. Okay?

Let me clarify the strategy. When clients find themselves being pulled in by their fear, they are to take three steps:

1. *Notice the uncomfortable sensation or fearful doubt.* This puts them momentarily in an observer role instead of being 100 percent the actor in the drama.
2. *Request the absolute opposite of what they would typically request.* "Please make me more (uncomfortable, confused, uncertain, embarrassed). And stick around longer, please." They can justify this move in two ways.
 - a. They actually *do* want frequency, intensity, and duration, because that is how they get better.
 - b. In this cognitive game, they are refocusing their attention toward an exaggerated, opposite position of what anxiety needs in order to control them. This generates a dissociation from their natural urge to resist.
3. *Then turn attention to the task at hand.* They are not to take any action to generate doubt. They are not to monitor their body or thoughts to see how the intervention is working. They get back to studying, or crossing the soccer field, or opening the can of soup.

If their sense of threat takes a dominant place in their mind again (which might occur 8 seconds later), they return to step 1. Their job is *not* to change their anxiety or doubt; it is to change their reaction.

DIRECTLY CHALLENGE THE AVOIDANT FRAME THROUGH ACTION

Let us get back to Renée. I have just asked her to practice encouraging anxiety to increase the knot in her throat.

REID: Now, what are you predicting is going to happen? You're going to stay the same, get worse, or get better?

RENÉE: Umm, that I will either stay the same or get worse. I can hardly see it getting better by me telling it to get worse.

Perfect! This is exactly what I want. If she is going to change her avoidant frame, that frame needs to come front and center, making itself available to be influenced. We are about to conduct an experiment that Renée frames up as either keeping her the same—feeling anxious enough to generate a knot in her throat—or making her worse. As you can imagine, this is going to be a pretty tough assignment for her. But she is going to do it anyway, because

she has courage! As you will read next, I am going to help her out by offering some options. She can pick her own way to talk to anxiety; here are six choices: encourage, tease, dare, beg, demand, or plead. What I *do not* offer her is a choice of refusing to do the task.

REID: Let's do it out loud, okay? What I'd like to do is just imagine anxiety is sitting here with us. I want you to instruct it to get your knot larger than it is. You can encourage strongly. You can tease it. You can dare it to get stronger. You can beg it to get stronger. How would you like to do it? Do you want to beg it? Do you want to tease it? Do you want to demand it? Do you want to plead with it to get stronger? Which would you like?

RENÉE: Umm, I will beg it to get stronger.

REID: Okay, so try it out. Let me hear. I'll coach you along the way. So just stay with it for about a minute. Say as much as you can that would have to do with begging anxiety to make your knot stronger, bigger.

RENÉE (quietly, with her eyes on the floor in front of her): Anxiety, I beg you to make that knot stronger (pregnant pause). Anxiety, I beg you to make that knot stronger.

REID: Now let me give you another example of how you can do it.

RENÉE: Uh-huh.

REID: Anxiety, I beg you make this knot stronger. I want it to be *so* large; I want it to be as big as a marble. I want it to be . . . how about a golf ball? Could you make it a golf ball? I would like it to be so large that people in the audience start to see my neck protrude with this big ball in there. I want you to make it so big that to swallow, it would have to go all the way around this lump and then through my throat (gesturing to show the path my saliva would travel around this bulging throat). If you would do that, it would make me so happy. It's so important. I do so many things for you. I avoid things for you, I don't go to lunch with my husband, I don't stay by myself. All these years I've done so much for you! Now I'm getting mad. I'm asking you one simple thing: to make my lump larger, my knot bigger. Please do this one thing for me. Gosh, I sound like my mother for a little bit.

She is chuckling, of course. I am being ridiculous here. Absurd. I have no expectation of her following my lead. What I want is to play such an extreme role that it moves her to be even one-tenth as strong as I am sounding.

REID: So could you try your own version of that? Just stay with it and really try . . . like you're auditioning for a role, and this is your job, and if you don't do this persuasively you don't get the part, and you've wanted this part for *so long*! Are you willing to try this again? Is that all right?

RENÉE: Yes. *Anxiety, I beg you to make that knot much, much bigger* (pauses, small laugh). It just seems so unreal. *Make it as big as you can* (pregnant pause, then she points to her throat). But it's not there (laughs heartily).

REID: Excuse me?

RENÉE: It's not there anymore. (She continues laughing, and gives a broad gesture with her arm, like the knot just flew out of her throat.)

REID: What do you mean, it's not there?

RENÉE: Well, it's not there. (She repeats her gesture.)

REID: It's gone?

RENÉE: Well, yes (smiling).

REID: Well, let's try the shaking. Ask *anxiety* to make your legs shake more than they are now.

I am not stopping her to say “See? See how well this works?” She is in the middle of her learning process, and I’m remaining in my ally role.

RENÉE: *Anxiety, I beg you to make my legs shake 10 times more than now* (pauses). But, you see, it’s not happening (laughing again).

REID: But try again. Maybe you can persuade it. Come on.

RENÉE: C’mon anxiety, do make my legs shake much more *now*. Order!

REID: I like that demanding part. See if you can get the lump back. Ask it to come back. Tell anxiety to bring it back, please.

RENÉE: *Anxiety, bring it* (interrupts her sentence with laughter) *bring that lump back NOW!*

Did you notice the subtle change in her orientation? She started out pleading with anxiety. Now, less than 10 seconds after she last begged, she is spontaneously in a dominating, demanding role.

REID (as a lighthearted challenge): If you laugh in this role, we’re not going to give you the part; so, c’mon. I’m teasing you when I say that. You’re doing fine. You’re doing great. So go ahead see if you can get it back. Beg it.

RENÉE: *Go on, I order you right now to come back, to get very, very, very big* (momentary pause). But, it’s not happening.

Even when I suggest, in this last exchange, that she return to begging, it is too late. *She* is in control of the game now, and she is going to demand the biggest knot this side of the North Sea.

As we have less than 15 minutes left in the session, I continue to charge ahead, because the more ground we cover, the more she will solidify this lesson. So I teach her how to hyperventilate. She is scared, so we take only one deep breath together and exhale quickly. Then we try three deep breaths and give a quick, hard exhale each time. We compare notes on our symptoms. My hands are sweating, and I am seeing stars. We do 10 deep breaths together, and then she asks anxiety to *please* make those sensations stronger. Again it is too late; Renée is now dominating this game.

SUMMARY AND FOLLOW-UP

I respect that my anxious clients’ pessimistic frames of reference build a powerful fortress that they believe keeps them safe. I challenge those frames immediately; I take on the bullies. My primary therapeutic objective is to help them adopt positive frames that direct their actions as they face threats. The most important frames are not specific to any one circumstance but apply to the broadest range of threats. They are self-efficacy—“My actions count”—and resilience—“I can cope with whatever happens.”

I want clients to view this as a mental game. In flow theory, when you perceive a difficult task as a game, there are distinct advantages. You can follow built-in rules, with clear goals and boundaries. You can create tasks that give you immediate feedback about your efforts. You can focus your attention, sense that you have some control, and believe you have a chance to win. By attending to small, moment-by-moment tasks, you can more easily maintain an inner-directed purpose by taking on challenges that are within reach of your skill set.

With its aim of enhancing well-being and the quality of life, a positive approach to therapy seeks to build those frames and skills that will help clients not just eliminate a current set of problems but learn to better deal with any future challenges that life will invariably send their way. This is the most important and also most difficult task in anxiety disorder treatment: *to help clients generalize their learning across all contexts*. By emphasizing strategies that promote the perspective of self-efficacy and resilience, we contribute to this goal of generalization.

How Renée employed her new frames for her ongoing well-being is illustrated in an unsolicited e-mail I received from her about eight months later. Here are a few snippets. Notice how many of her comments (I have italicized them) reflect a frame that directs her actions. This is what we are looking for, since beliefs stabilize the gains of habituation over time.

Some months have passed since we met, and a few things have changed, or should I say I have changed a few things, in my life. (She has left an unsatisfying but secure job and tolerated the threat of being home alone.) I took the plunge, and it was worth it. . . . *Every single day on my own gives me a chance to challenge myself and my thoughts*. I have put your method of “encouraging my symptoms to get stronger” into practice, but it is not an easy one as a quarter of myself is all for it and the other three quarters are going: “Yeah. Right!!! In your dreams.” Still, *I will carry on trying as I want to live my life to the fullest again*.

[She obtained a new, more satisfying job.] To start with, my husband used to give me a lift to work and pick me up, as the thought of driving there, of getting stuck in the rush-hour traffic, terrified me. The longest I drove on my own for the past 8 years was 3.5 miles to my parents-in-law. But one evening of October I told my husband that I was going to *drive myself to work, and see what happens*. . . . I have decided to do it again, and again, and again. I am still fairly anxious, and I wouldn’t call it a nice journey (only 25 minutes), but it allows me *to challenge myself and to put some of your methods in practice*. The new job requires a lot of difficult mental tasks. For me, *it is like climbing Mount Everest. And I will conquer it*.

Putting It into Practice

1. Assess the clients’ frames of reference.

Consider that, for anxious clients, most actions are directed by faulty beliefs, or frames. Renée’s frames included that anxiety meant losing control and was dangerous; that she should avoid all threat; and that she had to stay close to her parents and husband to be safe. Understanding them is essential to challenging them. What are your clients’ frames about their issues?

2. Bring resources and motivating goals forward.

Before challenging the avoidant frames, it is helpful for the client—and therapist—to be aware of the resources that can facilitate such challenges. Renée had courage and strength. Her valued goal—to have time alone—was a motivating resource. What resources do your clients have to assist their progress in therapy and in life? How can you explore your clients’ valued goals, and how might you use them to motivate the therapeutic process?

3. Alter the frame toward one of *this is a game*.

Addressing serious problems as a cognitive game permits clients to practice essential new skills and frames in less threatening ways. Games have built-in rules, clear and reachable goals, immediate feedback, and offer the possibility of control. In a game, clients can design a winning strategy.

4. Personify and externalize the anxiety disorder.

Placing the problem outside of the self enables clients to see it more dispassionately, as observers. Doing this allowed Renée to talk with her anxiety and, in turn, come to dominate the game.

5. Encourage clients to request the absolute opposite of what they would typically request of anxiety.

Within the frame structure of a game, clients can seek out to increase the frequency, intensity, and duration of the symptom or of their worry and doubt. This paradoxical strategy pulls their attention away from resisting. When they stop resisting, they change their relationship with anxiety away from one of struggle.

6. Directly challenge the avoidant frame through action.

Look for ways your clients can directly face threats. Renée played a game that lasted only a few minutes, a period she felt she could manage. Within that structure, she dropped her resistance and encouraged anxiety to do what she was most afraid of: to get stronger. In that manner, she activated the principles of the treatment protocol and learned a core principle: I can win by going *toward* fear.

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CHAPTER 17

Can You Be Happy in Pain?

Applying Positive Psychology, Mindfulness, and Hypnosis to Chronic Pain Management

George W. Burns

MEET THE CONTRIBUTOR

George's Meet the Contributor details are provided at the beginning of Chapter 1.

Ernest assisted his 72-year-old wife, Yolanda, to her feet and helped her down the corridor to my office. She moved toward the wall on her left side and, as she put her left arm out for support, I noticed that arm was shorter than her right, her hand contorted and atrophied. Her husband supported her on the right in a progress that appeared labored, deliberate, and uncomfortable.

The letter from her referring physician said:

She has an issue with chronic lumbar back pain and left-sided sciatica related to spinal stenosis and has had multiple interventions including five laminectomies as well as treatment by pain specialists. Unfortunately, this has been with general lack of benefit and she remains on analgesics. Other health problems include a level of mood depression, related to chronic pain and Parkinson's disease. Thank you for reviewing her with view to hypnotherapy.

Yolanda added that she also suffered with osteoarthritis, osteoporosis, diabetes, hypothyroidism, congenital left-sided hemiplegia, medically controlled epilepsy, and hypertension. Due to the pain, she experienced significant sleep disturbances and had ceased activities such as walking and gardening. As a result, she put on weight, setting up a vicious cycle: The heavier she became, the greater the pain when she moved, so she exercised less, put on more weight, and experienced greater pain.

Embarrassed by her weight and in pain when she walked, she mainly stayed at home reading the newspaper and watching television. Her husband, if anything, was perhaps overly solicitous, taking over all the household tasks, such as cooking and cleaning, while Yolanda felt bad that she no longer did the things she saw as her duty.

With the congenital hemiplegia, she had known health problems all her life, but the chronic lumbar pain had begun only in the last decade. Commenting on all the surgical, pharmacological, and psychological interventions she had received (including a two-week residential course at a cognitive-behavior therapy clinic), she said, “None have been successful.” At this point, I must admit there are times when I wonder: *Where do we go from here?* Especially when the client has already received such a variety of well-established, evidence-based interventions without gain.

If Yolanda had been in severe pain for the better part of a decade, and if all interventions to that point had been unsuccessful in achieving any freedom from pain, then maybe the goal of being pain-free was not the best direction for her to be heading. In terms of the old adage, I thought, if something was not working, then it was time to try something different. If it was unlikely that her pain would suddenly disappear (as she most heartily wished), what else might be helpful? Could she live with it more comfortably, or even more happily? Indeed, was it possible for a person to be happy in pain? And might the improvement of her mood also help bring about some reduction of the pain?

A THERAPEUTIC GOAL OF NEUTRALITY

Most treatment models in the pain management area, whether surgical, pharmacological, or psychosocial, have been directed to what might be described as a goal of neutrality. That is, they aim at the elimination, removal, or management of the pain, seeking to return the client to a painless, neutral state. If pain has weighted the scales of a person’s life in a negative direction, most treatments have aimed to restore the equilibrium rather than to weight the scales more toward positive experiences. While pain elimination is, of course, the ultimate or most desirable goal for the client, there may be some circumstances in which chronic pain cannot be removed and, indeed, some where the removal would be unwise if it heightens the risk of physical damage for the person. Earlier approaches to the hypnotic treatment of pain were, perhaps simplistically, directed toward total pain removal, assuming that if it was possible to control some forms of acute pain with hypnosis, then it was possible to control chronic pain with similar direct suggestions (Hartland, 1971). Later approaches have sought to help clients eliminate, diminish, or manage the pain through hypnotically induced analgesia, anesthesia, amnesia, dissociation, distraction, time distortion, and other such techniques (Barber, 1996; Hammond, 1990; Yapko, 2003).

Aiming for a goal of neutrality, no matter what the field of psychotherapeutic endeavor, can be problematic in four ways.

1. If the client has had a long history of pain and a long history of unsuccessful interventions, it is unlikely that he or she is going to hold any great hope or belief that yet another intervention will suddenly bring about a miracle—even though it may be desired, and desired strongly.
2. There is no such thing as emotional or experiential neutrality. We are never devoid of feeling, psychologically or physically. Feelings are constantly present and

- constantly varying, even when we feel “normal.” Therefore, to make the absence of feeling, whether physical or emotional, the sole therapeutic goal is destined to failure from the beginning.
3. Not only is a goal of neutrality unattainable, but it may also be detrimental for the client. There is good evidence that setting unattainable, unworkable, and inappropriate goals leads to frustration, disappointment, and even depression (Emmons, 1999; Street, Chapter 4, this volume).
 4. Just as anxiety and depression can serve as coping mechanisms at times, so pain can also serve a functional purpose. Pain’s core function is as a signal, alerting a person to potential danger that could cause or exacerbate physical injury. Pain may have various meanings in the life of a client and can have impact on various aspects of a person’s life. It can become closely related to an individual’s functioning in personal, social, familial, and professional areas (Ginandes, 2002; Zeig & Geary, 2001). To suggest that one might remove a symptom that has such function or association with so many aspects of a person’s life can be both frightening and scary for that person. Based on the little I knew about Yolanda, it seemed obvious that removal of her pain would result in significant changes in her relationship with her husband as well as in the day-to-day functioning of the household.

If the removal of the negative had not been, and was unlikely to be, successful for Yolanda, then, I found myself wondering, would it be possible for her to create more positive experiences, emotions, and sensations that could have an “undoing effect” on the negative, as suggested by Fredrickson (2005, 2008) in her broaden-and-build model? Could we aim for a goal of more positive experiences, or even happiness?

CAN YOU BE HAPPY IN PAIN?

Curious to explore this question, I asked the audience of a radio program on which I have been a regular monthly talk-back guest for the past 25 years. With about 50,000 listeners, it seemed like a good sample of the general public from which to inquire.

“Can you be happy in pain?” I asked on air. “If you live with significant chronic pain and still feel that you lead and enjoy a happy life, how do you do this? Please phone in and let us know as it may be helpful for others to learn from what you do.”

The individual callers spoke of horrific accidents and long-term pain dating back 20 years or more, but their anecdotal accounts of how they maintained happiness tied in closely with what we have learned from research into happiness and well-being. “I love my family” was the most common reason mentioned for happiness. “I love life,” said others with one being grateful for the “big picture image of the positives” rather than focusing on the specific, unavoidable experiences of pain. Finding direction, hope, and purpose in hobbies, relationships, or undertaking new occupational training appeared to be strong factors, along with engaging in altruistic behaviors (see Schwartz, Chapter 13, this volume) and having spiritual faith.

If others could be happy while experiencing significant chronic pain, was it also possible for Yolanda to experience greater levels of happiness? With this question in mind, I asked her, “What do you find *least helpful* for your pain?” My inquiry was deliberately crafted.

1. By asking *what do you find*, I wanted to invite her to explore what was in her control. To this point she had felt—and with some reason—that the pain was totally in control of her.
2. The phrase *least helpful* was an invitation to look toward concepts of helpfulness rather than helplessness.
3. I hoped the term *least* would introduce an idea of a gradient of experiences, of shades of gray, rather than being too global or black and white.
4. Asking what was *least helpful* then allowed me to next ask what was *most helpful* and, thus, leave these questions on the most positive note.

“Walking is worst,” she said. “I can’t.”

Her answer reflected the global, absolute style of thinking that is often a characteristic of depression. She had, in just a couple of words of this cognitive style, totally ruled out walking in all forms. I made a mental note to inquire later about specific possibilities. Was it possible to walk very short distances? Was it better on some surfaces than others? Was it easier with a cane or walker? Had she tried walking in a swimming pool with the support of the water?

“What do you find the *most helpful*?” I then asked.

“Taking a hot shower or having hot packs on my back,” she replied.

Seeking to explore what past positive experiences or activities she had had in her life, I inquired, “What do you do for fun?”

“I used to love gardening but I haven’t done it for years,” she answered, relegating fun to the past tense. In addition, her comment again reflected the global cognitive style of depression in which it seemed like a black-and-white issue that she either could garden or could not garden.

“If the garden has been a pleasure, how might you get back into it, gently, self-caringly, and practically?” I questioned. “Could you take some time to simply sit outside in the garden and enjoy the various sights and smells? If bending is a problem, could you get a garden stool to kneel on to tend your flowers, or ask your husband to put the pots on a table so that you can look after them without having to bend?” In other words, we began to explore possibilities for how she *could* resume enjoyable activities rather than globally rule them out as impossible.

THE ROLE OF HYPNOSIS

Given her request for hypnosis, I introduced Yolanda to this on the first consultation. Generally, in the therapeutic context, hypnosis is a procedure in which the therapist offers suggestions and therapeutic interventions to facilitate changes in a client’s sensations, perceptions, thoughts, or behaviors. In the area of pain management, hypnotic analgesia commonly is presented with suggestions for the reduction of the pain sensations and the increment of feelings of comfort. Clients often are taught self-hypnotic skills to help modify the perception and experience of pain.

Molton, Graham, Stoelb, and Jensen (2007), reviewing recent articles published on psychological approaches to chronic pain management, consider self-hypnosis training to be among the most empirically validated treatments along with cognitive-behavior therapy and operant behavioral therapy. Another review—of 19 methodologically

rigorous studies of the effects of pain therapy on chronic pain across various pain populations—concluded that hypnotic treatment resulted in significantly more pain reduction than did no treatment (Jensen & Patterson, 2006). However, even when pain intensity was not substantially lowered, about 80 percent of study participants reported increased relaxation and well-being, and continued to practice their self-hypnotic skills (Jensen et al., 2006, 2008). Feldman (2009), also following a review of the literature, noted that, depending on the nature of suggestions, hypnosis can modulate the affective and sensory dimensions of pain. Citing Milton Erickson’s advice to practitioners in a teaching seminar to “discover their [clients’] patterns of happiness,” Feldman asserts: “The potential exists for more effectively modulating pain affect and subjective distress by activating individual specific ‘patterns of happiness’” (p. 243).

As well as helping to build effective strategies in relaxing and, it was hoped, ease the pain, I presented hypnosis to Yolanda during the initial consultation as a basis to introduce interventions that would access her specific patterns of happiness, build more positive experiences, and enhance a greater sense of well-being. These interventions also may have been offered with meditation, mindfulness, or relaxation approaches. Hypnosis was chosen as the client seemed motivated toward it and because it provides a quick, deep, and effective basis for the presentation of therapeutic interventions. It is an approach clients can readily learn to work with themselves and has a long history of beneficial clinical applications. While space here does not permit a detailed explanation of hypnosis, I recommend *Trance-work* (Yapko, 2003) to readers interested in discovering more about what hypnosis is, how to induce it, and how to work with it therapeutically.

Three interventions will be discussed here in the context of hypnosis: nature-based mindfulness, recalling past positive experiences, and rebuilding relationships. These are offered as examples; I do not mean to suggest they are the only ways for fostering greater well-being in clients with chronic, severe pain. Indeed, many of the interventions described throughout this book provide other possibilities.

NATURE-BASED MINDFULNESS

During the second session, Yolanda said in a mildly excited voice, “I had a very good night’s sleep following the hypnosis and generally slept better through the rest of the week.” However, her greatest joy was in her announcement: “And I’ve not had to take as many painkillers.”

In addition, she said, “I’ve enjoyed some brief time in the garden almost every day.” She explained that her husband had built shelves under their backyard pergola and arranged her potted plants in accessible positions for her to tend—just a little at a time. I was delightfully surprised by how quickly she had applied some of the suggested therapeutic initiatives. Wanting to seize the opportunity, I reached over to the coffee table, picked up a potted plant, and asked her to hold it. I spoke briefly about the principles and benefits of mindfulness practice (see Hased, Chapter 14, this volume), then invited her to look at the flowers and mindfully observe them through each of her senses. Mindfulness has long been shown to benefit the management of pain even at a four-year follow-up (Kabat-Zinn, Lipworth, Burney, & Sellers, 1986) while meditation on and in nature can have healing and restorative benefits (Kaplan, 2001).

Let yourself take a few moments to quietly look at the flowers. What do you see? What are the shapes . . . the colors . . . the shades? What do you see as you shift your gaze to the stems? The shapes . . . the colors . . . the angles? What do you observe as you look at the leaves? What do you notice about their shapes . . . the variations in color . . . the differences in how the light falls on them? If you lift the pot closer to your nose, what do you notice about the fragrance? Does it vary from flower to flower? What are the differences? Do the leaves have their own fragrance? If so, what is that like? You might want to touch a leaf and be aware of how it feels to run your finger gently over it, or hold it between a finger and thumb. Is that tactile experience different from touching the stem? What do you notice in softness or firmness . . . in smoothness or roughness? How does it feel to touch a petal? What are those sensations of smoothness . . . softness . . . pliability? You could pluck a petal and put it to your lips if you want. What are the tactile sensations against your lips? How does it feel if you place it on your tongue . . . or chew it with your teeth? What is the taste like? What is the flavor? Where do you notice it most: on your palate . . . on your tongue . . . or elsewhere?

The mindfulness exercise contained pauses between each sentence and phrase to allow Yolanda to associate with and experience each sensation along the way. It stepped her through her senses of sight, smell, touch, and taste. Sound was not included as there were no observable sounds from a potted plant in a psychologist's office. When asking her to practice this at home, I also asked that she be aware of sound sensations: the breeze rustling the leaves of her plants, the buzz of insects in the garden, the call of a bird, or whatever other auditory experiences she might observe.

At the end, I inquired, "What did you experience as we were doing that exercise?"

"I have always loved my garden and flowers," she replied with a smile on her face, "but I have never, ever appreciated a flower so much and, strangely, the pain wasn't there as I was doing it. I am not sure if it had gone or if I just wasn't aware of it."

Although it may be of academic interest, therapeutically it did not matter whether the pain had gone or if she simply was not aware of it. It was enough for Yolanda to know that relief was possible, and that by practicing such a nature-based mindfulness exercise, it could be replicable. Although the therapeutic aim here had been the creation of the positive, that creation also resulted in the added benefit of a reduced awareness of pain.

The hypnosis literature talks of distraction as a technique in pain management areas (Hammond, 1990; Yapko, 2003), but often it is difficult for clients to try to distract themselves from something as intense as pain. I prefer to think of it in terms of a selectivity of attention: that we have some level of choice about what we attend to and what we do not. Selectively choosing to mindfully attend to the positive sensations present in the flower meant that Yolanda paid less attention to the pain sensations. To have that choice was an empowering experience for her in (1) creating greater sensations of well-being and (2) diminishing sensations of pain.

RECALLING PAST POSITIVE EXPERIENCES

In that second session, I also taught Yolanda a self-hypnotic relaxation technique of being mindfully aware of her respiration and her muscles. In addition, I asked her to quietly recall past positive experiences with particular, mindful focus on the specific thoughts, feelings, and behaviors associated with those experiences. As with the mindfulness exercise on the flower, I asked her questions during the hypnosis, allowing her time between each question to quietly consider the associations she made to them.

- When have you felt at your happiest?
- What have been the times in the past when you have felt the most content or at peace with yourself?
- What were you *thinking* at the time that helped contribute to that well-being?
- How were you *feeling*?
- What were the things you were *doing* that helped create and maintain those more positive thoughts and feelings?
- What might be possible for you to do now to re-create some of those thoughts, feelings, and activities again?

As a homework exercise, I gave her the Sensory Awareness Inventory (Burns, 1998, 2005, 2009), which invites clients to list the things they get pleasure, comfort, or enjoyment from in the five sensory areas of sight, sound, smell, taste, and touch, as well as a sixth category for activities or things that the person enjoys doing (see Burns, Chapter 20, this volume).

Yolanda had barely entered the office door for the third session when she announced that she had not only been practicing her self-hypnosis but that she had actually applied it at times when the pain became intense and severe. As a result she said, “I’ve cut down the painkillers a hell of a lot and have slept so much better.” Then she added, “My husband’s been feeling a bit stressed, so I have taught him how to relax as well.” To me this seemed a significant step. Yolanda had moved away from thinking about her own pain and discomfort to being aware of what her husband was experiencing and started to offer him some of the practical support that he had been offering her for so long. Helping others often is helpful for oneself (see Schwartz, Chapter 13, this volume).

Yolanda had struggled to find many items to list on the Sensory Awareness Inventory, which reflected her current, significant lack of joy and pleasure in life.

“What have you enjoyed in the past in each of those sensory areas,” I asked, “or what might you see yourself enjoying in the future?” If clients do not identify any, or many, current pleasures, they may be able to source them from the past or anticipate them in the future.

In response, she began to reassociate with a number of past positive sensory experiences, describing favorite sights: watching the river that flows through our city, the sandy beaches on the coast, sunrises and sunsets, a lightning storm across the ocean, and, of course, the roses and flowers in her garden. Enjoyable auditory experiences included listening to relaxing CDs as well as the sound of children laughing. High on pleasurable smells were flowers, cakes cooking in the oven, a sweet curry on the stove, rain on the ground, and newborn babies. In mentioning the latter, she announced that her granddaughter was expecting Yolanda’s first great-grandchild. Enjoyment of taste brought mention of roasts, curries, and Chinese food, while pleasant tactile sensations included hot showers and fresh sheets. Under things she enjoyed doing she listed pruning her roses and getting out more.

“If these are things that bring you pleasure, how can you start to do more of them?” I asked, hoping to explore ways she could now put her awareness of pleasant sensory experiences into practice.

“Perhaps my husband and I can stop at a riverside café for lunch on the way home,” she replied. “We haven’t been out for ages because I haven’t been able to sit in a restaurant chair for long with the pain, but I think I am ready to give it a go for a short time.”

During the hypnosis in that session, I reinforced her progress and, on the basis of the Sensory Awareness Inventory, invited her to imagine creating situations that provided for

maximum sensory satisfaction, such as going out for lunch by the river while, at the same time, providing due self-care through things like checking if the café had comfortable seats, getting up and stretching if she needed, or asking the staff for prompt service as she currently had a problem sitting.

REBUILDING RELATIONSHIPS

The earlier announcement of the impending birth of her first great-grandchild gave me the opportunity to ask about her family and perhaps tap into some positive expectations and anticipations about the future. Good family networks are positively correlated with well-being, and looking forward to the arrival of a great-grandchild, watching its development, and anticipating the pleasure of interactions with a young child have a positive, future orientation.

“Are you looking forward to your first great-grandchild?” I asked.

“Well, I haven’t seen as much of the family as I would like for a while. We used to have family dinner at our place every Sunday night, but I couldn’t cook and it fell by the wayside. And as traveling in the car is painful, I can’t get to see them.”

Often many factors come into play for the families and close friends of people in chronic pain. While they may love their spouse, mother, grandmother, or close friend and genuinely want that person to feel better, seeing the constant suffering of that beloved person leaves them feeling helpless and powerless that they cannot assist or relieve the pain. Yolanda’s previous pain focus and depressed mood probably were not pleasant for others to be around. One way we have of dealing with situations or people that repetitively have us feeling powerless, helpless, inadequate, or depressed is to avoid them. In many ways, it is an understandable choice: If we want to be happy, it is sensible to keep away from what we know makes us unhappy. This is exactly what Yolanda’s family and former friends appeared to have done.

“Then if you would like to see more of the family,” I said, “and look forward to seeing—and smelling—this first great-grandchild, how can you start to rebuild the connections?” This again led us into a conversation about possibilities. If seeing the family was important for her and doing the cooking was not possible, could they meet on a riverbank near her home for a picnic? Could she ask them to each bring some food and take the responsibility off her? Could she invite them around to a brunch that involved minimal preparation, or meet at a nearby café? If she thought these were too much just yet, could she simply phone them a little more often to keep in touch with what was happening in their lives rather than waiting for them to call her?

A WORD OF CAUTION

Pain is a complex and multifunctional condition that can have various meanings in the life of a client, can impact many aspects of a person’s life, and can be closely related to functioning in personal, social, familial, and professional areas (Ginandes, 2002; Zeig & Geary, 2001). Above all, it is important to bear in mind that pain is a warning signal, alerting a person to current and potential physical damage and, as such, needs to be attended

to carefully and appropriately. It is not appropriate, helpful, practical, or ethical simply to point a person along the path of improved affect without a full assessment and understanding of the medical causes and implications of the pain. And just as pain can be multifunctional, so therapy needs to combine multiple disciplines (Molton et al., 2007). “Appropriate medical evaluation and treatment,” Yapko (2003) emphasizes, “are not only encouraged, they are *demand*ed. . . . *Delaying or discouraging appropriate medical care is tantamount to malpractice*” (p. 360).

THE OUTCOME

In three sessions of therapy, Yolanda had been introduced to self-hypnosis training along with some mindfulness practices. She had been assisted to access past positive experiences, in part through the use of the Sensory Awareness Inventory, and to explore how they might be reintroduced into her life. As a result, she got out of the house into more stimulating environments, such as her garden and the riverside. She developed a greater orientation toward the future, planning activities to help rebuild family and social relationships. She also reduced her use of painkilling medication. This she did with the assistance of therapeutic strategies designed to enhance positive well-being rather than through more traditional interventions aimed at stopping or managing the pain.

A positive psychology approach to enhancing well-being has the advantage of avoiding the trap of trying to get rid of pain. It also avoids the problems associated with a therapeutic goal of neutrality and may lead to pain reduction as a secondary product of building the positive.

What if Yolanda’s pain had not diminished as it did?

- She would have been no worse off in regard to the pain she had so commonly experienced for the past decade.
- She still would have had the skills she acquired in building more positive experiences and the associated benefits of greater well-being.

Does this mean that such positive psychology interventions should be the treatment of choice for everyone in pain? Not necessarily, but it does mean three things:

1. Positive psychology has a rightful application in this area as part of an overall multidisciplinary approach.
2. It may be possible for a person to be happy even while experiencing chronic pain.
3. Pain reduction may result from the application of positive therapy.

As it has been long established that relaxation can undo anxiety (Wolpe, 1958) and positive emotions can undo negative emotions (Fredrickson, 2005, 2008), it would seem logical that negative experiences associated with pain can also be “undone” through the creation of positive experiences such as joy, interest, contentment, happiness, and well-being.

Winter had truly arrived by the time I saw Yolanda for her fourth session two weeks after the third. “Cold weather usually makes the pain worse,” she began, “but I have been

keeping up my self-hypnosis and still haven't gone back to taking as many painkillers. I haven't been experiencing as much pressure on my back and my legs and, consequently, I have been able to walk a little more and get out into the garden between the rain showers. In fact, I have been really enjoying the smell of dampness in the soil."

Her mood had lifted and, with her husband, she had been out twice for light lunches at former favorite cafés. They had arranged to meet their children and grandchildren for an afternoon tea by the river, and her husband had taken along a comfortable chair for her to sit in. Arranging the meeting had meant more phone contact with the family, and they, in turn, had promised to resume visiting her.

Her husband observed, "Her pain has diminished by two-thirds and our life is starting to get back to what it used to be."

FOLLOW-UP

Yolanda was followed up by phone eight months after her four sessions of therapy. "I have been meaning to send you a card to say thank you," she began, "but life has been so busy." I was pleased to hear her life was busy in comparison to the lonely life she had described on our first meeting, when she was doing nothing more than sitting at home reading newspapers and watching television. In the background were family noises. "My granddaughter is here with my new great-granddaughter," she explained with joy in her voice.

While her pain levels had been lower for several months, she said there had been a recent exacerbation. Her physician had changed her medication, and this appeared to help but she proudly announced she was still "not taking as many [painkillers] as before." She was continuing to practice her self-hypnosis, although she confessed she was not doing it as much as she thought she should and that she was finding it difficult to do when in intense pain.

"How are you feeling in yourself?" I inquired.

"There things are much better," she answered. "I hadn't realized how much I had let the pain get on top of me before and how I had gradually given up on life. I must have driven Ernest around the bend, poor fellow. Now we go out for drives and lunches at least once or twice a week. The family are phoning and visiting more. In fact, we have reestablished our Sunday dinners again. Everyone brings something they have prepared along and they all help with the washing up. And that feels good. I also know that if things start to get on top of me, I always have the garden to go and meditate in. That really helps."

Yolanda was still experiencing pain. Unfortunately, it seemed unlikely it would remit completely. However, she was handling it better and living a happier, better quality of life. So, to return to our title question, *Can you be happy in pain?* I believe Yolanda, along with those listeners who phoned into my radio program, have illustrated that happiness in the face of pain is possible and that the enhancement of happiness should *always* be a considered therapeutic goal when working with clients in chronic pain.

After I had congratulated Yolanda on her progress and her continued application of the things that were working for her, she said, "I think I might need to come back for a refresher at some point." At the time of writing—some two years later—she still has not.

Putting It into Practice

1. Help build a positive therapeutic goal.

If your client, like Yolanda, faces unchangeable symptoms or problems, ask yourself and your client: What can be changed? What are the realistic and achievable goals to aim for? Avoid setting the traditional therapeutic goal of neutrality that aims at the elimination of symptoms without considering the possible gains.

2. Explore how your client can be happy in pain.

Are there already times when your client has had even just fleeting moments of well-being? If so, what are they, and how can they be developed? If not, the next four steps might offer pointers for their creation and development.

3. Consider nature-based mindfulness exercises.

Being mindful of each of her sense modalities in her experience of a potted flower enabled Yolanda to dissociate from the pain albeit temporarily. What are the important objects or experiences in the life of your client? How might you guide the client to be mindfully engaged through focusing into each sense?

4. Help recall past positive experiences.

If there is an absence of positive experiences and emotions in your client's life at the moment, it may help to ask what things in the past have contributed to his or her well-being or optimal experience. Ask:

- When have you felt at your happiest, most content, or most peaceful?
- What were your thoughts, feelings, and behaviors that helped create and maintain that?
- How can you re-create them again?

If a person cannot associate with past positive experiences, then you may ask about the future:

- When you are feeling happier, how do you envisage things will be different?
- What will you be thinking, feeling, and doing?

5. Use the Sensory Awareness Inventory.

Using this inventory allowed Yolanda to list items of well-being that she had not been able to verbalize previously. The act of thinking about and recording them can be a positive experience for a client in itself. The responses also provide both therapist and client with resources that can be used to build exercises for enhanced well-being.

6. Assist the client in rebuilding relationships.

Close positive relationships are important to our levels of happiness and, as the callers to my radio program affirmed, to our happiness when in pain.

Rebuilding family relationships proved a beneficial exercise for Yolanda. Consider who are the important people in the life of your client. What are the qualities of those relationships? How might those relationships be enhanced?

7. Tread with caution and within your area of expertise.

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CHAPTER 18

Charting a Course to New Beginnings

Decoding Signals of Persistent Traumatic Stress Reactions in a Shipwreck Survivor

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MEET THE CONTRIBUTOR

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Imagine you are cruising on a passenger liner in the North Atlantic, enjoying a long-desired and planned for vacation. Then disaster strikes. The vessel is holed. Water floods the engine room, power fails, the ship lists over and begins to sink. You hurry to the side railings and hang on as the vessel slides into a dark, deep, and freezing sea. In the pervasive blackness of night, waves wash over you. You cough and splutter. The wet and cold evokes uncontrollable shivers. You watch as fellow passengers perish around you. Time seems

* Vignettes in this chapter are a composite of impressions from work with two clients that best illustrate key components of my approach to therapy.

endlessly suspended. A slow-motion horror picture unfolds. If rescue is to serve any purpose, it must come quickly. A few more minutes and you too will be swallowed up by the sea. You hear a rescue helicopter approaching and realize survival is possible if its searchlights spot you.

A CRY FOR HELP PROMPTS IMMEDIATE ASSISTANCE

An urgent request from a physician gave details of a client who had recently survived a shipwreck in the North Atlantic. Although physically uninjured, he had been unable to settle into any routine of daily living since returning home. He reported persistently intrusive flashbacks and dreams of the life-threatening incident and a range of further posttraumatic stress reactions. Most disruptive were unceasing hyperarousal, vigilance, agitation, and withdrawal from family and friends. He had at first considered these evoked reactions to be normal and as expected. But their persistence, intensity, and adverse impact on adjustment were rendering his life intolerable. His reactions had precipitated a spiraling free fall of desperation and crisis. Assistance was requested in the acute management of reactions evoked by this trauma. For the purposes of this case, I have given this man the Norwegian name Terje, chosen from Henrik Ibsen's epic poem "TerjeViken," which tells of seafaring trauma, loss, forgiving, redemption, and growth.

INITIAL IMPRESSIONS AT INTERVIEW

An interview took place within 24 hours. At the moment of first encounter with Terje, I was struck by his evident state of agitation, hyperarousal, and panic-driven vigilance. Quickly ensconced in a comfortable chair, chosen as it was next to the consulting room exit, he tried, with limited success, to string together a coherent sentence to explain what had happened. The narrative reflected perfectly the agitation of his physical presence. He could not sit still beyond a few seconds. The eruptive energy on display lacked direction and purpose. He was physically and psychologically exhausted.

He said, "I am at the end of my wits. I have lost all control over myself, my life, and my relationships. It is getting worse. What can I do?"

Unable to modulate his reactions and demonstrate a modicum of order, he was in utter despair. Energy for day-to-day tasks was depleted through not sleeping, except for brief spells. Had the clinical imperative been to formulate a diagnosis, I would have suggested acute panic disorder or acute stress disorder (American Psychiatric Association, 1994). From a perspective of positive psychotherapy, skepticism has to be expressed about the clinical value of describing personal crises after trauma in diagnostic terms. Caution should be shown if diagnosis is used for therapy focused on problem formulations, care planning, and clinical prescriptions. When interviewing this survivor, I was reminded that his presentation carried powerful witness to the limitations of labels based on acute symptoms (McFarlane, 2003). Diagnosis was the least pressing consideration at this point. Before me was a man so frightened he lived with unrelenting panic. He was exhausted, in crisis, in despair, and in danger of metaphorically drowning in a perfect storm of chaos. All I felt I could do in the immediate term was to throw him a lifebuoy and start drawing him toward a place of safety. My construction of the clinical challenge was informed by the details explained next.

EXPLAINING SIGNAL FUNCTION, CODING, AND DECODING

The tradition of construing reactions evoked by trauma as negative symptoms of disorder probably does a massive disservice to survivors. Immediate reactions should be construed in different ways that resonate readily for practitioners of positive psychotherapy. Trauma survivors' distress is not in question. There is no doubt that acute trauma reactions compound difficulties in dealing with day-to-day living. What I question is whether evoked reactions are symptoms. An alternative construction is that reactions evoked by trauma may be adaptive in that they serve the cause of individual and group survival. The evidence base that prompts this reassessment is compelling (Shalev & Ursano, 2003) and recently has been used to develop a new approach to anxiety and depression in primary care (Ørner, Siriwardena, & Dyas, 2004).

By way of illustration, consider some typical reactions evoked by trauma: crying, despair, panic, agitation. Survivors who cry in despair and stay close to other survivors during the early aftermath of trauma are responding adaptively. They communicate their presence to others, thus increasing their chances of rescue and survival. This is true for individuals and groups. Being quiet and subdued is dangerous. So it is that those who cry are more likely to be heard by those who can help. Closeness and touch reassures. Intimacy heals with powerful effect.

This survivor had stayed in close proximity with another passenger throughout. Together they had given one another crucial encouragement by upbeat talk even when fellow passengers drowned. Together they held on to life when exposure to low temperature threatened shutdown of critical life functions. It seemed Terje found comfort in the presence of another while hoping for rescue.

As evidenced by this shipwreck survivor, evoked reactions signal with clarity and immediacy a need for help. Crying, fear, vigilance, and hyperarousal were adaptive to the extent that they mediate signals for others to respond to. Crying and calls for help are difficult to ignore because they engage primitive response mechanisms. Once the signal function of his presentation was recognized, its survival value became obvious. I take a grim view of symptom-focused treatment approaches that aim to suppress adaptive reactions.

Modern psychotherapies have lagged behind in their explorations of the possibility that recurrent and enduring responses may also serve adaptive functions. Terje illustrates how they can do so. Understanding the genesis of enduring trauma reactions requires an acknowledgment of the complex and dynamic processes that are involved. Through their influence, simple signals are transformed into coded communications. This transformation involves a subtle dovetailing of current and past memories in which pretrauma experiences engender idiosyncratic perceptions of the trauma itself and salient day-to-day features of life lived during the recovery phase. Persistent reactions therefore have to be decoded. The premise is that signals are expressed in clients' narratives. At least in part, these narratives are imbued with a natural resonance among the trauma, its enduring reactions, and aspects of life as lived at the moment of telling. Decoding involves cooperation between therapist and client. Through trial and error, they can reach a position of better understanding the signals mediated by enduring reactions and act to address the communicated need. This therapeutic approach marks a departure from those currently in vogue by not making symptom suppression its primary focus.

SIGNAL FUNCTIONS OF EARLY REEXPERIENCING EXEMPLIFIED

Terje's memory of the shipwreck will never be erased. Nor should it ever be forgotten. Vivid, intrusive, and persistent flashbacks that engaged all sensory modalities, as if it were happening again, ensured he remembered. While distressing, reexperiencing the memory signaled that his functioning was below par and that he needed help. Traumatic memories are encoded, stored, and retrieved in ways that differ from other recollections. While protected by home comforts, he would experience a return of the sensation of feeling intensely cold, wet, and shivering. This was exactly what had occurred while he was immersed in the freezing ocean.

The various manifestations of trauma-related reexperiencing still present psychotherapy with compelling challenges. I have argued for a shift away from construing memories as symptoms of psychopathology to an appreciation of their adaptive signal functions. Pursuing this approach inevitably involves a focus on person-specific communications. It necessitates a shift away from dogma and by-the-book procedures in therapy.

My approach to therapy starts with an exploration of the contexts that have given rise to and maintain particular recollections. An aspect of doing so is for psychotherapists to seek to decipher the subtle signals that link aspects of current circumstance to those aspects of the traumatic experience that are relieved. Deciphered signals point the way to effecting remedial changes in circumstance and move the focus away from eliminating evoked reactions.

A clarification of what is meant by signal decoding might be useful at this stage. Terje was close to dying of hypothermia when he was rescued. He was shivering with cold. But rescue workers knew this survivor was in a less critical state than those rescued from extreme cold or exposure who did not shiver or shake. This reflexive muscle activity is debilitating but is highly adaptive because heat is generated within the body and this maintains vital life functions. Rescue workers would have been misguided in construing his shaking and shivering as symptoms to be eliminated. Sensible practice comprised decoding evoked reactions as natural reactions to extreme cold with survival value. So understood, remedial action consisted of removing the victim from the exposure to cold, covering him in heat-preserving materials, and having him ingest warm drinks. Signal decoding saved his life.

Contrast this with how some psychotherapies construe reactions evoked by trauma. The National Institute for Clinical Excellence (2005) has published treatment guidelines for posttraumatic stress. These recommend graded exposure plus eye movement desensitization and reprocessing (Shapiro, 2006). Both approaches have some merit but derive from a tradition of symptom elimination. The notion that evoked reactions have a signal function does not feature in these perspectives.

BREAKING AWAY FROM ORTHODOXIES

The perspective I am advocating is a radical break with symptom-focused orthodoxy. It raises questions that are particularly pertinent to positive psychotherapy and may in time be crucial for future psychotherapeutic theory and practice. Most modern psychological therapies take as their premise that human emotions, such as fear and distress, can be used as a basis for clinical diagnoses. Once feelings are transformed into symptoms, the benchmark for treatment outcome is their elimination. I believe this to be misguided.

Experiencing distress, despair, fear, and the like is inconvenient, but none is a disorder. Our unwelcome emotions arise from, and signal to us, the existence of particular adversities. Is it therefore not better to address the adversities than the symptoms?

By-the-book therapies, so much in vogue at the moment, foster unrealistic expectations that diagnoses prescribe effective treatment of symptoms. So it has come to be that factual memories of traumatic events, with their associated feelings of distress that compromise day-to-day adjustment, are construed as evidence of faulty cognitive processing. Practitioners and academics try to explain trauma-related memory phenomena as arising from negative appraisals, catastrophizing, and making faulty use of past experience when trying to make sense of recent events (Ehlers & Clark, 2000). I consider this to be wrong.

CONSTRUING REACTIONS EVOKED BY TRAUMA AS ADAPTIVE SIGNALS

So, what is the merit in arguing that decoding Terje's evoked reactions helped promote improved adjustment? Leading on from the example of rescue personnel reading signs and symptoms of exposure correctly, it is now reasonable to ask how evoked psychological signs can be decoded with similar perspicacity. During our first interview, I listened to his narrative of the shipwreck and how he had been reexperiencing it ever since. His memories retained an exceptional freshness and impressive detail of recall. He relived moments of the collision through to eventual rescue. He felt himself teetering on the brink of death and being comforted by warmth and eventual reunion with his family. Although acute, these intrusive and persistent reminders caused intense distress.

Terje's narrative was extraordinarily helpful for the purposes of clinical assessment and care planning. At a most elementary clinical level, the adaptive communicative functions of acute recall are a valuable resource for therapists. Viewed as such, traumatic stress reactions lend a focus and intensity to clinical assessment that engages those who are in a position to help, support, and care. To turn away from those who are in distress is difficult. To be indifferent to accounts of trauma and their consequences for survivors is near impossible. I do not believe that this is primarily because of our learned professional responses. A high level of personal alertness and engagement probably is rooted in our most primitive response mechanisms. When a baby cries, we cannot help but hear it and provide some comfort. Those who know a baby well can differentiate the cries that communicate tiredness or cold or hunger or illness. A further indication of the power of evoked responses to suffering is found in the extraordinary recurrent phenomenon of the multitudes of "helpers" who insist on making themselves available to assist in mass casualty situations. Their lack of training and experience is of no seeming consequence.

Bringing this perspective to bear on Terje's narrative prompts the insight that his communications had been superbly effective in securing urgent professional help at a time of crisis. Continuing to act alone was no longer a realistic option. Somehow, his call for help had, with help from a family physician, expedited a referral to a specialist within two days despite the fact that the waiting time for most clients referred to the department was nine months.

Summing up the initial assessment interview, I offered Terje my views on his predicament. I said, "Above all else, you are a lucky survivor of a major life-threatening trauma.

Your experiences have evoked a set of fairly typical traumatic stress reactions. This is traumatization in the true psychological sense of the word. As events unfolded, memories were imprinted in exceptional ways, in your mind but also your body. This is why you feel cold when warm and have images of what happened flashing before you.” He commented that he felt the intensity of feelings during the event continue to influence what he experienced on a day-to-day basis.

Because of what had happened, I also suggested that there would probably be significant future changes in his life and self-image. He should therefore try to put aside any aspiration to return to being the person he was immediately prior to the shipwreck. I also said that his current state did not constitute a disorder. It was to be expected and he would probably feel intense fear and despair for some time. This was because recent threats to life had impacted to such a profound degree that he had become intensely aware of the risks that are a part of everyday life and how little control we have over some threats to our lives. No one, least of all himself, should argue the unreasonableness or irrationality of his fears.

Decoding his signals guided me to offer these suggestions:

Try not to resist these reactions. Be realistic. At the moment, you are in no fit state to respond to current or possible future adversities with a coherent set of planned actions. What matters most today and the next few days is for you to be specifically attentive to your own self-care. Make sure your practical day-to-day needs for food, water, heat, rest, and the company of others with whom you feel close are attended to and satisfied. You should try to get rest even if sleep is difficult. Seek out situations that you feel give you some sense of safety, security, and being cared for. You should also keep reminding yourself that although the distress you feel is inconvenient in the extreme and that it effects are debilitating, it is unlikely to persist into the longer term. Finally, and maybe most important of all, keep telling yourself: *My distress is not a disorder* (Ørner, 2003, p.146).

This is a reasonable response to reactions evoked by a recent trauma. The emphasis is communication of needs, a recognition that the message has been heard and is being responded to. No therapeutic intervention was attempted. The shipwreck had created a new reality for Terje. He was forewarned of the unlikelihood of his ever returning to being as he was prior to the incident. For the time being, waiting rather than treatment was indicated. No attempt was made to modulate, control, or eliminate evoked reactions.

DECODING ENDURING REACTIONS FOR THE LONGER TERM

My ambition so far has been to demonstrate how acute traumatic stress reactions serve important adaptive functions by improving chances of survival under exceptional circumstances. The case made so far extends from the short to the intermediate term.

The question arises as to whether long-term, persistent and intrusively recurrent reactions to trauma may also serve similar functions. If appropriately decoded, can these also identify a pathway toward effective remedial action? This is a matter that therapists and academics have failed to pursue with any vigor. I shall make a case for long-term and enduring reactions to trauma also being part of nature’s armamentarium of adaptive responses.

The typical development of posttraumatic stress disorder is a gradual resolution over time (National Institute for Clinical Excellence, 2005). This is what clinicians commonly observe. Instances when reactions persist are therefore exceptional and require explanation. In my opinion, psychotherapists do well to focus on the particular life circumstances of

trauma survivors that may have sustained reactions to the present. So construed, persistence might be an adaptive sign that some crucial aspects of a survivors' posttrauma adjustment situation should be addressed. What evokes is different from that which perpetuates.

Evidence shows that the aftermath of trauma is often a difficult time for survivors. Transition and change are typically called for. Of the many subtly complex challenges presented to survivors is the need to reexamine some basic existential assumptions about self, the world in which we live, and how the two interact (Janoff Bullman, 2006). As is known from clinical practice and research into positive adaptations after trauma, assumptive change helps bring about improved adjustment (Joseph, 2004).

POSITIVE PSYCHOTHERAPY AND ENDURING REACTIONS

Terje's state of unrelenting vigilance was not significantly appeased by the initial consultation. Evoked reactions had, however, proved amenable to some change by the time of his second appointment. He spoke of being no stranger to fear but had never experienced emotions over which he had no control and could not modulate at will.

Positive psychotherapy should make sense of persistent fears. Working from Terje's narrative, I decided to focus on two aspects of this experience. First, I would clarify what had originally evoked his intense fear. While the initial threat to his life had caused intense fears, their persistence and resilience required explanation, not least because he was now back in safety. My premise is that fear is nature's way of warning of ongoing threat to self and others. It is never felt without reason, although the source of danger may not be known. So it proved to be for Terje.

I put these points to him in a statement about possible ongoing threats, independent of the shipwreck. His association was to a recurrent dream. "It puzzles me what I dream about," he said. "It's not about drowning. Instead, I dream of situations where I lose control. I call for help but remain alone. I wake in a panic."

Trying to decode the signals in this recurrent dream, I thought the critical themes were of abandonment linked to loss of control. I incorporated this in a second interpretation. "This makes me wonder if something is going on in your life now that makes you frightened of being alone and being abandoned."

After some moments of reflection he said, "The last couple of years have been difficult. I often felt frightened about what was going on. First, a very close relative was seriously ill. Then my daughter had an accident at work. I feared it had killed her. Later I feared it would paralyze her for life. She is okay now, but the last few years have been awful. I saw my life coming apart. What you said made me realize how terrified I still am about all of this. Deep down I am frightened out of my wits. This is not to do with the shipwreck. We must talk more within my family about how we can support one another."

This vignette illustrates the process of decoding a ciphered signal in positive psychotherapy. It consists of acknowledging the troublesome consequences of enduring reactions. At an early stage, neither client nor helper knows what accounts for their chronicity. Suggesting that fears persist under conditions of ongoing threat engendered new insights. So decoded, fear is linked to actual contemporaneous threat. Terje required no encouragement to speak with close family members about being of greater support for one another. In the process, he reasserted control in his life and that of his family. As a result, he and they felt safer and the fears started to subside.

DECODING ADAPTIVE SIGNALS IN LONG-TERM THERAPY

Terje announced that he wished to speak about another recurrent dream. He said, “My dreams are not a replay of the shipwreck from beginning to end. Segments come to me at different times, some more often than others. One is a repetition of an incident within the whole event. I can still see and feel what I was going through when it happened. I wake up in a panic.”

His statement illustrates the often-intermittent nature of trauma-related dreams. While the roots of such dreams are in the traumatic event, they are also mediated by particular memory processes, both past and present. My impression is that recurrent dreams differ in their degree of resonance to survivors’ current life situations. These degrees of resonance are of central interest to long-term psychotherapy. When trying to decode dream signals, the key is found in the link between the past and the present.

I made a statement validating positive aspects of his experience: “Having dreams that are not exact replications of a trauma is common. Dreams are usually not a documentary recording of what happened. From a personal point of view the question to ask is why particular dream segments come back when they do. Neither you nor I know why this is so for you. We may find out if you can talk about the dream in more detail.”

He said, “It is just before the ship sank. With another passenger I was on the foredeck. The hull was holed at the back and along the side. Seawater quickly flooded the engine room and cut off all light and power. Evacuation plans we had rehearsed with the crew were useless. When the ship started to sink the bow section rose upward. While I hung on to the railings the deck rose upward before slipping into the sea. It was as if I were hanging in the air.”

“Why do you think this particular dream segment comes back so often?” I asked.

First he said he did not know. Then he elaborated, “To be left hanging up in the air. There I was hanging on. I was left high up in the air a long time. Eventually, I was dragged into the sea. I am puzzled. It is not even what upsets me most about what happened.”

When therapists are made party to such narratives, they should not presume any understanding of the personal processes that give rise to these recollections. The working hypothesis should be that a ciphered signal is incorporated in the manifest dream content. Its exploration will involve therapist and client collaboration. The recurrent dream probably springs from both past experience and some aspect of survivors’ current, day-to-day life situation. Progress with decoding requires flexible and unusual approaches to language, words, and communication. The language of dream signals is not the same as for ordinary prose narratives.

What followed illustrates how playfulness with language helps decipher dream signals. We examined how single words or expressions can have more than one meaning. I said, “In your account you make repeated reference to ‘being left hanging in the air.’ This frightens you as it did during the shipwreck. But think about it. The expression ‘being left hanging in the air’ has several meanings. One is as happened before the sinking. Another everyday expression goes, ‘I was left hanging in the air.’ It means waiting in uncertainty, when all is unclear and unfinished. I wonder if there are aspects of your life now that give you reason to feel that you are left hanging in the air.”

Terje looked surprised when asked the question. Then a look of amazement took hold. He said, “Well, my employer has left me hanging in the air. I am waiting to be told about my future career prospects. They have been unclear for some time. The company I work for is

being reorganized. I do not know what my future will be. I may become redundant. A year ago, I set up a meeting with senior directors to clarify my prospects. They said I would be advised in due course. I have heard nothing more.”

He continued, “I thought about this often before the shipwreck. Yes, the words I used to myself and my wife were that ‘I had been left hanging in the air.’ How very strange that the dream of the ship sinking captures something that is happening in another part of my life. How can that possibly be?”

I responded, “I do not know how this happens. It is to do with how the mind works to make sense of what goes on in our lives. Dreams send signals to us. Sometimes they are clear, at other times we have to play with words and speculate. I did not know about your work situation. But we speculated and you came up with a new insight about something that is of great concern to you. Your employer has left you hanging in the air. Having deciphered the message, it is important that you approach the directors again and insist they no longer leave you hanging in the air.”

Terje agreed and scheduled a meeting to discuss his future. He then started to plan for his future and, in so doing, reclaimed a sense of control over his life.

The importance of this dream episode derives from the insight it engendered. Memories from the trauma seemed to undermine his adjustment, but the form this took was determined by other current matters of critical personal importance. Decoding the signal, he realized he had relinquished control over matters that were a threat to his future. Nature’s plan was not to let him get away with such recklessness. After appropriate action was taken, the dream did not recur.

HAVING CHARTED A COURSE TO NEW BEGINNINGS

The skill of navigation and charting a course involves extensive use of coded signals. A chart represents geographical realities by signs and symbols the significance of which navigators have to interpret. This is an apt metaphor for a positive psychotherapy for survivors of trauma, be they of recent or more distant origin. Clients’ narratives furnish high-resolution charts of personal experiences, and those signs and symbols that are recurrently intrusive (as in dreams) invite deciphering. This might help trace a course to steer toward a destination from where new beginnings are possible.

I hope this case illustrates how Terje’s acute, intermediate, and longer-term reactions to trauma served adaptive ends. Left alone, he was caught in a fogbank of distress with no visibility. Without help, he might have remained in a state of deeply troubled obscurity. Worse still, he might have hit the rocks (again) from steering a blind course. Such outcomes were avoided through collaborative efforts. We explored ways of decoding the signals evoked by a trauma and discovered a new, richer personal evidence base. From Terje’s newly charted position, it became clear what he had to do to reclaim control of himself and his life.

Positive psychotherapy is empowered and enriched by a perspective that emphasizes the adaptive functions of evoked reactions. This chapter shows the relevance of such formulations to reactions evoked by a specific trauma. I venture to suggest it is equally informative to do the same with clients who endure distress but where the origins are less specific, as with anxiety (fear) or depression (distress) (Ørner et al., 2004).

Clinical experience tells me it is a mistake to claim that human suffering is, in itself, adaptive. Distress can be powerfully debilitating, but its origins should be explored when seeking resolution. When neither client nor therapist knows what has contributed to its generation, there is merit in taking the view that evoked reactions embody signs and signals that can guide us to the source of current adjustment difficulties. Treatment approaches that ignore this function of suffering, or seek to eliminate reactions to current adversity, are likely to be unhelpful or carry costs to clients. The latter accrue through continuing adjustment difficulties, poor self-esteem, no sense of personal well-being, and, eventually, poor physical health. A deciphered signal can act as a candle lit in the dark in our search for problem resolution, fulfilling adaptations, and sustained good health.

Being relatively unencumbered by a restrictive inheritance of theoretical and practical orthodoxies, I believe positive psychology and positive psychotherapy are ideal settings for exploring the adaptive signal functions of reactions evoked by trauma and general adversity. I hope to see a day when the psychotherapies reject the notion that symptoms define the problem and stop using symptom elimination as the primary criterion for evaluating outcome. A new psychotherapy will also accept that a client's account of evoked reactions is nature's way of signaling warnings about the extent of adversity and a need of help from others. The syntax and grammar of these signals is not the same as for ordinary spoken language. Some degree of decoding is therefore required, and this in turn calls for a review of the client-therapist working relationship. At the start, neither patients nor therapists know what may have evoked and sustained a reaction reported at first interview. Progress can be made through a high level of mutual engagement and shared purpose. In their encounters, both are experts. They differ only in respect of their areas of expertise. Therapy then becomes a process for empowering clients to assume a level of control in their lives that is conducive to their own well-being and that of their most significant others.

Above all else, therapy helped Terje plot a course from a near-fatal shipwreck to a safe port of call. From there he planned the next phase of his life. He has, as far as I know, continued to do so to the present. Significantly, the memory of what happened on the night of the shipwreck has never been eliminated. Nor have his recollections of the complications that arose in its aftermath. So at least in this sense, his symptoms persist. In my opinion, this is both a successful and a satisfactory outcome.

Putting It into Practice

1. Examine your own concepts of symptoms and evoked reactions.

The way a therapist perceives therapy will, to a large degree, influence both its process and its outcome. Consequently, it is important for us as therapists to examine the presumptions that inform our practice. For instance, do we construe acute and enduring reactions to trauma as problematic symptoms that should be eliminated or as adaptive responses to particular adversities? Your concepts will, in a fundamental way, steer the processes that unfold in therapy.

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2. Help clients reconceptualize evoked reactions as coded signals.

The ways clients construe and conceptualize their reactions and complaints will also, to some extent, determine the pathways of progress and outcome. It is good practice to invite clients to consider the possibility that their reactions are sustained by current circumstances and are like coded signals that might be decoded to better achieve and appreciate a more fulfilling life. You may ask clients: “If your reactions of fear, agitation, arousal, and panic have a message for you, what do you think it may be? What types of advice do you imagine this message gives you about what you can do to feel more in control of your life?”

3. Construe reactions evoked by trauma as adaptive signals.

The threat to Terje’s life had made him hypervigilant and acutely aware of all risks, whatever their source. These reactions were adaptive and functional responses that kept him alive in the sea and continued to warn him of possible future harm. Initially, it may help to inform and reassure clients that the function of their persistent and intrusive reactions is to warn of continuing risks at times of personal crisis.

4. Encourage clients to accept and utilize adaptive reactions.

Suggest that clients should not deny, suppress, or resist reactions that were evoked by particular events or ongoing circumstance. To do so is to deny an important message simply because it is inconvenient and difficult to understand. As with Terje, encourage clients to attend to basic self-caring and practical day-to-day needs for safety and security in the early aftermath of trauma.

5. Work with your clients to discover and implement action plans.

Once Terje had decoded his adaptive signals, he proceeded to plan courses of actions relevant to his own needs and those of his family. The actions he took coincided with his fears subsiding. Decoding is not only about understanding a message but also about translating that new knowledge into practical steps toward empowerment and control.

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CHAPTER 19

A Surprise Attack, A Surprise Result

Posttraumatic Growth through Expert Companionship

Richard G. Tedeschi and Lawrence G. Calhoun

MEET THE CONTRIBUTORS

Richard G. Tedeschi, PhD, is professor of psychology at the University of North Carolina at Charlotte, where he conducts research on trauma and posttraumatic growth, teaches personality and psychotherapy, and supervises graduate practica. He is a licensed psychologist specializing in bereavement and trauma, and leads support groups for bereaved parents for a nonprofit organization in Charlotte, where he also maintains his private practice. He has published, together with his colleague Lawrence Calhoun, several books on parental bereavement and on posttraumatic growth, including *Helping Bereaved Parents* (2004), and the *Handbook of Posttraumatic Growth* (2006). He has served as a consultant to the American Psychological Association in developing materials on trauma and resilience for use by psychologists and the public, and has provided workshops on trauma

and posttraumatic growth for groups such as police and the military and various universities and professional organizations.

Lawrence G. Calhoun is professor of psychology at the University of North Carolina at Charlotte and a licensed psychologist. Although his parents were North American, he was born and raised in Brazil. He is coauthor/coeditor of several books and of more than 90 articles published in professional journals. He teaches undergraduate and graduate students and is a recipient of the Bank of America Award for Teaching Excellence and of the University of North Carolina Board of Governors Award for Excellence in Teaching. His current scholarly activities are focused on the responses of persons encountering major life crises, particularly the phenomenon of posttraumatic growth. With his colleague,

*Note: A variety of elements of this case have been modified to ensure confidentiality and anonymity.

Richard Tedeschi, he has been studying this phenomenon since the early 1980s; they introduced the term *posttraumatic growth* in 1995 and published the *Post-traumatic Growth Inventory* in 1996. He welcomes the recent renewed interest in the positive elements of psychology.

A SURPRISE ATTACK

Jane was a 21-year-old customer service representative for an automobile rental firm, working to pay for her college education. During an otherwise unremarkable day at work, a man suddenly produced a knife, lunged across the counter where she was stationed, and stabbed her several times before others were able to wrestle him to the ground. There had been no warning whatsoever of this attack, and Jane had never seen the man before.

The emergency medical team arrived quickly and, although Jane had lost a good deal of blood, they determined that the attacker had just missed severing a large artery near her heart. She never lost consciousness and later remembered the details of this traumatic event very well. As she was treated at the scene and later at the hospital, she had a sense of detachment and was even joking with her fellow employees. Two weeks later, she presented (at the recommendation of her employee assistance program counselor) with symptoms of acute stress disorder, including recurrent images of the attack, nightmares, acute anxiety, and fear of being alone at home, of walking to her car in her parking lot, and of returning to work. In addition, she was left with physical scars from the stab wounds sustained in the attack.

The assessment of Jane was guided by the assumption that her responses to the attack were understandable and normal, even though her symptoms could meet the criteria of acute stress disorder. It was determined that she had no prior mental health history, was not a substance abuser, had been successful in her college coursework, was poised to graduate on time, had been employed by the automobile rental firm for two years, and had a good number of friends. This context suggested that she was a good candidate for a therapy that would follow established practice for trauma survivors, using psychoeducation about her physical and psychological responses, anxiety reduction procedures, an exposure component, and attention to her thinking in the aftermath, especially her sense of vulnerability, fears, and reconsideration of what she could do safely in terms of work, social life, and school.

Jane's history revealed other information that also guided the clinical work. She was engaged and living with her fiancé, Charles, on whom she relied to provide a sense of security in the aftermath of the attack. He accompanied her to places and checked parts of their apartment in order to allay her fears. In addition, Jane described a remarkable life history. Jane's father had left her and her mother when she was one year old. Her mother cared for her for two years before developing a severe drug abuse problem, beginning a period of drug treatment, relapses, and homelessness. Jane was removed from her custody at age 4. As her maternal grandparents had already died, and there were no close relatives who wished to care for her, Jane was placed in foster care, where she remained until the age of 17. In that time, she lived with approximately 20 different families. Finally, at 17, a foster family decided to keep her, and although they did not legally adopt her, she considered them her

parents, and had spent her holidays with them since she left home for college. She appeared to be a very resourceful person, who had managed to come out of a childhood that lacked any enduring love and support with a good sense of her worth, good coping capabilities, and a sense of optimism about her future.

Then the attack occurred, and Jane was now having trouble relying on the ability to cope that she had come to trust during all the years of instability in her life. She had never been so anxious before. She had never seen the world as so dangerous. She had never had feelings of such hatred for someone as she did for her attacker. She had thought of herself as strong for the past several years. She had taken pride in the fact that she had survived foster care, and thought of herself as a person who made herself—no parents made her. But now, in the aftermath of this attack, she was no longer sure of herself and her capabilities. It did not seem like her to be so afraid. The clinician had confidence that, given Jane's history, much of how she felt about herself before might be reclaimed with a fairly standard course of posttrauma treatment. Given work on posttraumatic growth, there might possibly be some valuable positive changes for Jane coming out of her struggle with this event. Of course, this event was not exactly over. There was more to come, in the form of a trial for her attacker. Treatment would also have to prepare her for this upcoming challenge.

PLAN FOR TREATMENT

We have written elsewhere about a perspective on clinical work with persons facing major crises that we call *expert companionship* (Tedeschi & Calhoun, 2004), which respects the client's ability to find a path to recovery, and perhaps, *posttraumatic growth* (Calhoun & Tedeschi, 1999, 2006; Tedeschi & Calhoun, 1995, 2004, 2006). This approach guides our clinical work, and it provided the orientation for the clinician working with Jane. In this expert companionship, we leave ourselves open to hearing the most difficult aspects of the client's story, seeing the possibilities for growth in their suffering and, ultimately, learning from the client. As extensive descriptions are available elsewhere (Calhoun & Tedeschi, 2006; Joseph & Linley, 2008; Tedeschi & Calhoun, 2004, 2006), here we provide a brief overview of posttraumatic growth and of the perspective for approaching treatment that we have called expert companionship.

Posttraumatic growth refers to the positive change that many people experience as the result of their struggle with highly stressful circumstances (Calhoun & Tedeschi, 1999). While this idea is ancient, it has also appeared as a theme in a few earlier studies as well as in the writings of several influential theorists and therapists of the twentieth century, before systematic research began in the 1990s (Calhoun & Tedeschi, 1989–90, 1999; Park, Cohen, & Murch, 1996; Tedeschi & Calhoun, 1995, 1996). The kinds of changes experienced can vary depending on the specific circumstances, but there does seem to be a common core of experiences (Morris, Shakespeare-Finch, Rieck, & Newbery, 2005; Tedeschi & Calhoun, 1996). Three types are noteworthy.

1. The spiritual and existential domain is one area in which posttraumatic growth is commonly reported. The positive changes here are not necessarily in the direction of greater belief or orthodoxy but in the direction of answers to existential questions that are more satisfying to the individual (Calhoun & Tedeschi, 2006).

2. Growth in interpersonal relationships is reported. Traumatic events certainly can disrupt and damage relationships with others, but it is also common for persons facing major life difficulties to report an increase of intimacy with significant others and a general increase in the sense of connectedness to others who also suffer.
3. Changes in self-perception also occur, with some people experiencing an increase in their own sense of personal strength, along with changed priorities, life paths, and an increase in the general appreciation for one's life and existence.

The somewhat paradoxical term *expert companion* is designed to convey the perspective that, when working with persons facing major crises, trained clinicians can indeed regard themselves as experts in some areas, such as the best approaches for treating symptoms of posttraumatic reactions. However, clinicians are *not* experts on the client's personal experiences, and if clinicians are fully present with clients and listen carefully to their stories about suffering, survival, and attempts to cope, clinicians may find themselves as the students, with the clients as the experts. Although clinicians can be experts on the general responses people have to highly stressful events and on the best practices for posttrauma psychological interventions, they are not experts on clients' experiences. Every particular set of circumstances is different, and clients know much more about their own experiences than therapists do. Clients are the experts on their lives and their tragedies, and clinicians can learn about this from their clients.

In some ways, the aftermath of trauma is a journey for the survivor. Clinicians may need to be companions to clients on this sometimes long journey, traveling along with clients when members of the clients' informal support networks have, in a sense, fallen by the wayside. Although these networks of family, friends, and other nonprofessional helpers can be very useful, members of the informal support system may not have the patience or the psychological stamina to provide unreciprocated support for weeks and months after a traumatic event. But clinicians, as expert companions, can provide professional support that can go on, even if intermittently, for years.

The expert companion perspective is not a new or separate school of therapy, nor is it a specific set of techniques. It is a particular clinical stance we recommend that clinicians take when they work with clients who are dealing with significant life crises. This expert companion viewpoint is also not independent of, but is integrated with, other aspects of trauma treatment that might be necessary in a particular case. With Jane, psychoeducation and relaxation training were useful at the start, so that she could regain her confidence in her ability to cope. It was not necessary to spend very much time talking about the attack itself. More time was spent trying to determine the degree to which her fears of other attacks were warranted, how she could continue to go to school and to work given her level of anxiety, and how she could ready herself to face her attacker in court. She was also distressed about feeling such hatred for the attacker, given that she had felt herself to be a peaceful person who did not wish harm on others.

POSTTRAUMATIC CLINICAL WORK WITH JANE

Therapy Sessions at Six Weeks

Treatment lasted about 10 months, until the case went to court for the final time. During the first 6 months, Jane felt a high level of anxiety but managed to go to her classes and return to

work after 3 weeks of therapy focused on psychoeducation, relaxation training, and use of her available resources, such as her fiancé and friends. But after approximately 6 weeks of therapy, 2 months after the attack, she reported this scenario.

JANE: It seems like Charles thinks I have it back together because I am going to work, and I'm back at school.

THERAPIST: But you aren't back together all the way.

JANE: I'm still nervous about things a lot. I still don't feel like myself at all. He doesn't seem to see this.

THERAPIST: I thought Charles was being really helpful.

JANE: Well, he has, but now he's gone back to his stupid video games. When I want to talk, he says he doesn't know what else to say, and he just goes back to the computer.

THERAPIST: Kind of hurtful.

JANE: Yes, he knows I'm still upset. He knows I still don't go down to the laundry room alone. He knows how upset I am about the coming court hearing.

THERAPIST: He said he doesn't know what else to say?

JANE: That's what he said.

THERAPIST: He didn't say he thought that you were okay now.

JANE: That's true—he just doesn't seem to know what to do.

THERAPIST: Have you told him what you need?

JANE: Maybe I'd better tell him again, but I told him he needs to just listen to me, and be around me, and not get so frustrated with me being like this.

THERAPIST: He's not used to you this way.

JANE: I've always been strong and independent.

THERAPIST: Not so much now?

JANE: I hope that comes back.

THERAPIST: You know, some people would never have the courage to return to that job.

JANE: I need the money.

THERAPIST: So it isn't courage, strength.

JANE: I guess. You do what you gotta do.

THERAPIST: I wonder if both you and Charles don't give yourself enough credit for what you have done in the past few weeks. You *are* doing what you gotta do. This attack hasn't prevented you from doing. You are able to put up with a lot of anxiety and keep moving. You are not paralyzed by this.

JANE: I guess I'm just used to it.

THERAPIST: All the stuff you've already been through.

JANE: Yeah. I've always figured I just need to keep going.

THERAPIST: On your own a lot.

JANE: Yeah, but I thought I had Charles with me this time.

THERAPIST: It was that way at first.

JANE: Now he's back to the computer games.

THERAPIST: He's always done this?

JANE: Oh, he's obsessed!

THERAPIST: How do you mean?

JANE: He'll spend hours and hours on it, while I'm there. You know, he's almost 30—you'd think he'd be over this kind of thing.

In this session, the clinician is subtly tackling several issues. He is checking out the degree to which Jane is able to see her own successes in the past as well as in the current situation and the degree to which she attributes these successes to herself. He is also trying to determine if Jane is getting the message across to Charles about what she needs or if she is getting frustrated with him prematurely. In addition, there is an implied instruction to the clinician from Jane: “Please give me what Charles is not, and please be patient with me.”

Therapy Sessions at Four Months

What followed for the next two months was additional frustration with Charles and with his focus on the computer rather than on her. The clinician suggested that she might wish to bring Charles to a session to discuss her need for support, given that she had not been able to make any headway with him herself. Charles refused to attend.

Soon there was the specter of the first court hearing for her attacker. Jane was concerned that she would cry and look weak. She had been treated well by the district attorney’s office in pursuing the case and keeping her informed. But she did not trust herself in the courtroom. In order to manage this, the clinician helped Jane to review the times she had been in court as a foster child in custody arrangements. This was building on strengths that clients can sometimes overlook (Furman & Ahola, 1992). When clinicians see such strength in their clients, it can be useful to point them out and find ways to use them. In the next exchange, the therapist is careful not to make it seem as if there is no difficulty here. The hard part has to be acknowledged so that Jane thinks that what is said about her strengths is credible.

THERAPIST: Court is more familiar to you, unfortunately, than it is to most people.

JANE: You’d think I was an habitual criminal!

THERAPIST: You’ve gotten pretty good at speaking up for yourself, even as a kid.

JANE: Yes, but this situation seems so different to me.

THERAPIST: Granted, it is in many ways. But *you* don’t have to be. You can be the you who has spoken up before. Remember her?

JANE: Sometimes it’s hard.

THERAPIST: What do you remember about that you?

JANE: Oh, I was just able to say things, because I figured I was the only one I could be sure would. I learned I had to count on myself.

THERAPIST: Did you ever fail yourself?

JANE: Not really. I mean, it didn’t always come out the way I wanted, but I always said what I needed to.

THERAPIST: Did you prepare?

JANE: Sure. I knew going in.

THERAPIST: That’s what we’ll do here, we’ll prepare. And since you haven’t failed yourself before, I believe it will work out the same way. We’ll need to incorporate some of what we’ve been working on to manage anxiety because you haven’t had to face someone like this before. But remember, this will be a very different setting than last time you saw him.

JANE: Right—I have to keep reminding myself.

THERAPIST: Your body seems to want to react differently. Remember how we talked about that self-protective, natural response?

JANE: Right, I have to keep that in mind. I’m safe now, I don’t need it.

The Therapy Sessions at Seven Months

The biggest surprises, for both client and therapist, came late in therapy, around the seventh month. Jane had managed to get through the first court appearance but was not called on to make any statement. She learned that her attacker would undergo a psychiatric evaluation. She was still angry with him but also said that she was not a vengeful person and did not want anything bad to happen to him. If he needed treatment, so be it, but he also should have to face consequences for what he did to her. A subsequent hearing was scheduled to consider the results of the psychiatric evaluation of her assailant.

The session after the appearance in court went like this:

JANE: I broke off my engagement to Charles.

THERAPIST: Really?

JANE: Yes, I just came to the conclusion that he wasn't supportive of me. He doesn't know how to talk to me. I told him I was getting frustrated, but he just didn't listen. Well, actually in the past week or two, he was doing better, but my heart wasn't in it anymore. I had detached from him or something. He was pretty upset. It was not good.

THERAPIST: What happened?

JANE: He just flew into a rage and said I couldn't do that. He grabbed me and wouldn't let me leave. I came back later with a friend, because I was kind of scared. Charles just acted crazy. He yelled at me and started throwing my things out the second-floor window. It was humiliating.

THERAPIST: How are you feeling about all this?

JANE: Well, it's sad it's come to this. But you know, I guess this attack and everything happened for a reason. I know that sounds stupid, but it showed me about Charles.

THERAPIST: You were able to see how he'd be in a crisis.

JANE: Right—he was good at first, but he just couldn't stick with me. He's just too self-absorbed or something. It's better I found out.

THERAPIST: It's better you found out before you got married.

JANE: Right. What if we got married and some bad things happen—you know they will sometime—and he just couldn't handle it? What a mess. I'd rather know now.

THERAPIST: What a way to learn it.

JANE: I'm left with these physical scars. I look in the mirror and hate that.

THERAPIST: And emotional scars?

JANE: I don't know. I think I did the right thing with Charles. Look what he did. Can you believe it?

THERAPIST: You *think* you did the right thing—are you saying you aren't sure?

JANE: Actually I am quite sure. I look at how my parents and friends stood by me. I would think Charles would do the same, and it wasn't even close. I want better than that.

THERAPIST: So, what are you thinking about the emotional scars after the attack?

JANE: I guess I might have a few, the anxiety I can still feel, but I have been going to places more, and getting more comfortable, like riding with my windows down in the car—remember how I wouldn't do that? And I am pretty good at work now.

THERAPIST: Yes, you certainly have made big strides.

JANE: I really am better.

THERAPIST: Yes, clearly you are getting there.

JANE: I mean I'm better—a better person.

THERAPIST: How so?

JANE: This is just something else that I have gone through in life that has taught me about people. I feel bad for people who have to deal with things like this, or anything. You don't know how hard people are struggling at times. I find myself thinking, sort of excusing in a way, or forgiving, maybe, you know, who knows what they're going through. Don't judge, you know? People didn't understand me, that I was so afraid sometimes, and some did, and I really appreciated that. That's the kind of person I want to be. You know, I am not going to spend my time with someone I can't count on, but I do see that it is important to have compassion for people, because you don't know what they may be facing.

THERAPIST: This is new thinking for you?

JANE: Well, new in a way. I knew it before, but not like this. I have a . . . a . . . I don't know the word exactly.

THERAPIST: You have a clearer view of this.

JANE: Very.

THERAPIST: Uh-huh.

JANE: Conviction—I have a conviction about it. I really know it. I will remember how it has been for me.

THERAPIST: I wonder how all those experiences in foster care informed you about such things. Or was this attack different in how it affected your thinking?

JANE: That foster care stuff made me strong, I think. I was able to get through it. This attack was different, though. I have never been so, so, unnerved, scared, shaken up. It just rattled me. It messed up my whole life! I wanted to tell the court, look, I lost my future husband!

THERAPIST: Actually, *you* decided he wasn't for you after all.

JANE: Yes, that's what I said. You know, I can look at it both ways. If it had not been for this attack, maybe Charles and I would be getting married. But I might be facing a bigger disaster if I did. Sometimes it is hard to figure what's good and what's bad.

THERAPIST: Maybe both.

JANE: That seems to be it.

THERAPIST: Certainly things look different to you.

JANE: Yes, I wouldn't say it was a good thing, but I do think I am better. All that bad stuff happened, but in the end, I think I'm better. (Long pause.) I hate those scars. I don't know, maybe I'll have plastic surgery. That's expensive. I don't know.

In this exchange, the therapist encourages the discussion of how Jane is seeing herself as a better person, by following her lead. Note that the mention of these changes are mixed in with negative things, such as her scars and losing her fiancé. This is the typical view of clients who have been traumatized but also see growth. They do not whitewash the experience, and they do not see it as purely positive. They acknowledge their struggle. It is important for therapists to do this as well while also valuing and accepting the positive changes.

WHAT THIS CASE TELLS US

The work with this client has taught us, once again, that in accompanying people on their struggle with trauma's aftermath, without acting as experts or trying to point out solutions

to the problems involved, some surprising results might be in store. When these results include posttraumatic growth, it is useful for clinicians to highlight these changes, so that the struggle can be meaningful rather than merely a struggle. Jane is integrating the experience into her life story as a turning point that is crucial, meaningful. Trauma of suffering a stabbing will not be associated solely with negative affect. Memories of the struggle with her misfortune will be infused with the positive aspects of her attempts to cope, the decisions she made, and the lessons she learned. The positive affect associated with this thinking may mitigate the negative effects of the trauma.

One of the other very important things this case can teach is that a general orientation of respect, empathy, and a nonjudgmental attitude toward the client are key elements of any good clinical intervention. The clinician repeatedly reflects and summarizes the client's experience, and the client responds positively to this stance by the therapist. And although it is something quite simple, the clinician says much less than the client does. Beginning clinicians in particular can learn that it is important not only to show the general qualities of good therapeutic practice but also to resist the temptation to talk too much (Marci, Ham, Moran, & Orr, 2007). As we have said elsewhere, the clinician should, and in this case does, "listen without necessarily trying to solve" (Calhoun & Tedeschi, 1999, p. 61).

Another important lesson from this case, particularly for clinicians who may be interested in the client's posttraumatic growth, is that the clinician never downplays the negative aspects of the client's experience. This case clearly illustrates that the presence of growth does not negate the very real array of highly distressing posttraumatic responses. Although there are rare, extremely resilient exceptions, most human beings exposed to very stressful events experience a variety of distressing emotions, and many experience a constellation of distressing posttraumatic clinical responses. It is important to remember, as this case clearly shows, that even in the midst of very difficult and psychologically distressing circumstances, clients can also experience significant positive changes. This clinician *is* prepared to listen for, and when appropriate acknowledge, the client's own articulation of potential posttraumatic growth. Without at least some understanding of the literature on posttraumatic growth, the clinician might not have noticed these articulations by the client. But the negative aspects of what has happened are never ignored or minimized.

It is also important to note that the clinician does not introduce the concept of growth without the client's articulation of these possibilities or, at the very least, the client's suggestion of the possibility that growth may be unfolding. Although it is still an open empirical question, we tend to be a bit leery of clinical approaches that simply introduce the topic of growth to clients and ask them to focus on it exclusively, when the clients themselves have never even intimated the possibility. This case does teach, however, that listening for themes of growth, and acknowledging them as appropriate, may allow clinicians to hear and attend to important elements of the client's narrative that otherwise might have been missed.

A SURPRISE RESULT

Jane was able to go to court and tell the story of her experience about being stabbed, the emotional struggles that she was still enduring, and how she was scarred. By the end of therapy, a court decision still had not been made about whether the attacker would go on to trial, but Jane was finding herself better able to accept the various outcomes that were

possible and even the fact that her attacker may be found to be incompetent due to mental illness.

As in most cases where clients report posttraumatic growth, there is an element of surprise to it. Jane did not set out to find the benefits she spoke of, such as greater compassion for others. In addition, she did not imagine that she would decide to leave Charles. All these things can be confusing to hold together at the same time—the bad and the benefits. She had lost Charles—but no, *she decided* she did not want him. It is sad not to be getting married to him—but no, it is better that she does not. She has the scars, but she also has the compassion. The attack was certainly an unexpected surprise . . . and so were the benefits arising from her important posttraumatic growth.

Putting It into Practice

1. Approach therapy from the perspective of expert companionship.

By acknowledging that we as therapists have expert knowledge in therapeutic strategies and that Jane had expert knowledge in her experiences related to the trauma, we were able to hear her story, see the possibilities for growth, and ultimately learn from her.
2. Be open to the possibility of posttraumatic growth.

Positive changes can result from a client's struggle with even the most highly stressful circumstances. These commonly occur in the spiritual, interpersonal, and self-perception domains. Jane provides an example of unexpected growth in the relationship area as well as in the personal qualities of strength, compassion, and life directions.
3. Assume an orientation of respect, empathy, and a nonjudgmental attitude toward the client.

We hope such an orientation can be observed in the conversations we have reported between the therapist and Jane at several stages in her therapy. This may involve:

 - a. Reflecting and summarizing the client's experience, such as when Jane complained about Charles going back to his video games and the therapist reflected, "Kind of hurtful."
 - b. Saying much less than the client does, as when Jane spoke at length about being a better person through the discovery of compassion and the therapist simply asked, "This is a new thinking for you?"
 - c. Listening without necessarily trying to solve (such as when Jane described breaking off the engagement) and rather than offering suggestions, the therapist asked, "How are you feeling about all this?"
4. Never downplay the negative aspects of the client's experience.

As Jane illustrates, her trauma was intense, shocking, and real. Not only did the story of her trauma need to be heard and acknowledged, but it was also the basis for her potential growth. Even in the midst of very difficult and psychologically distressing circumstances, clients like Jane can also experience significant positive changes.

(Continued)

(Continued)

5. Do not introduce the concept of growth without the client's articulation of the possibilities.

Instead, listen for the themes of growth, and acknowledge them as is appropriate. Doing this may allow you to hear and attend to important elements of the client's narrative that otherwise might have been missed. We did not, for example, have to introduce the idea that compassion might develop from her trauma. In fact, if we had done this, particularly early in therapy, Jane might have rejected the notion. By listening for such aspects of growth when articulated by her, we were able to acknowledge them in a way that reinforced her own discovery, growth, and empowerment.

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PART THREE

Enhancement

CHAPTER 20

Sunsets and Seashores

Nature-Guided Therapy in Positive Couple and Family Work

George W. Burns

MEET THE CONTRIBUTOR

George's Meet the Contributor details can be found at the beginning of Chapter 1.

Western psychology, since the time of its founding father, Sigmund Freud, has focused predominantly on the inner workings of the individual. In doing so, it has not only paid less attention to the relationships and systems in which that person exists but also has actively rejected the values of interacting with nature. In fact, Freud made his views on the ecology very clear when he declared, “Nature is eternally remote. She destroys us—coldly, cruelly, and relentlessly” (cited in Roszak, 1996, p. 22). This has resulted in a succession of psychotherapeutic models with a vast conceptual schism between person and planet. They have been based in the commonplace metaphor that locates the psyche “within” and the real world “outside.” With psychology’s growing interest in well-being, it seems timely to revisit these long-held assumptions and question whether interactions with nature can enhance our well-being. Can nature benefit us physically, psychologically, socially, and spiritually? If so, can nature be used to advance positive therapeutic outcomes and provide positive therapeutic interventions? To address these questions, I review aspects of the theory, research, and clinical data as well as incorporate some of the things I have learned about using nature-based approaches to clinical psychology over the last 35 years and show how they can be applied in therapy for a relationship problem of intense jealousy.

When I posed what I consider should be an almost obligatory question in couple’s therapy, “What brought you guys together in the first place?” (Contos, 1998), Joanne replied, “We met at a country music festival and got on so well that we decided to travel together for a few days after. We would sit alone on a beach watching the sunset and counting the stars as they emerged in the falling darkness.” If such contact with nature

helped Joanne and Peter establish their relationship in the first place, maybe it could help them maintain a positive relationship in the present and future.

CAN NATURE ENHANCE WELL-BEING?

A solid body of evidence, largely outside of the therapeutic literature, demonstrates how positive, nonthreatening interactions with nature can enhance various dimensions of well-being (for a more detailed review, see Burns, 2009a).

Physical Well-Being

In terms of our physical well-being, contact with nature promotes more health-oriented behaviors, increases pleasurable emotional states, and reduces the desire for people to engage in unhealthy behaviors, such as smoking and drinking (Greenway, 1995). Our bodies generally function more healthily in nature settings as measured by indices such as heart rate, skin conductance, blood pressure, and muscle tension (Ottosson & Grahn, 2005; Ulrich, Dimberg, & Driver, 1991). In fact, many researchers have found a strong link between human and ecological health (Burls & Caan, 2005; Maller, Townsend, Pryor, Brown, & St. Leger, 2006; Moore, Townsend, & Oldroyd, 2006). Nature has physically and emotionally “restorative” effects (Kaplan, 2001) and fosters psychological well-being that we know results in higher levels of physical well-being, less severe illnesses, better recovery rates from illness, and greater longevity (Danner, Snowdon, & Freisen, 2001; Maruta, Colligan, Malinchoc, & Offord, 2000; Ostir, Markides, Black, & Goodwin, 2000; Vaillant, 2004).

Psychological Well-Being

Over the last two to three decades, growing research evidence, particularly in the area of environmental psychology, has demonstrated the therapeutic benefits of nature contact. We have a preference to views of natural landscapes over human-constructed landscapes (van den Berg, Hartig, & Staats, 2007). We prefer to live and work in natural landscapes, and we tend to select nature as the environment in which we wish to vacation. Assumedly, we have these preferences because nature offers many enhancements to our well-being. Simple, brief interactions with the natural environment can reduce levels of stress (van den Berg et al., 2007), the suffering that results from crises (Ottosson & Grahn, 2008), and mental fatigue (Kaplan, 2001; Kuo & Sullivan, 2001). If you want to enhance self-concept, self-esteem, and self-confidence (Wright, 1983), facilitate treatment of the mentally ill (Pryor, Townsend, Maller, & Field, 2006) or improve family relationships (Kuo & Sullivan, 2001; Mulholland & Williams, 1998; Taylor, Wiley, Kuo, & Sullivan, 1998), then the research is clear: Assist your clients to engage in more nature-based interactions. Fredrickson (2000) states it simply when she says, “Certain nature scenes evoke contentment” (p. 11).

A CASE OF INTENSE JEALOUSY

“I believe my husband is having an affair with his best friend’s wife,” said Joanne. “There are times he has been secretive about his phone calls, times when there have been hang-up calls at

home. If he is not seeing her, they must at least be having phone sex. I know it's not logical but I can't get it out of my head, and it is destroying our relationship."

Both Joanne and Peter came to therapy together and vowed they loved each other.

Such intense jealousy, along with other emotions, may well have served a functional purpose in our evolutionary history (Nesse, 2005; Nesse & Williams, 1996). Men who feel jealous of and deter relationships with other suitors have a better chance of keeping their genes in the genetic pool. Women, however, have a guarantee that their genes are being reproduced, but nonetheless have other challenges that can predispose to jealousy. If a partner's affections wander, the wife and her children may have diminished access to life's basic necessities, such as food and shelter. There may also be a loss of intimacy, a greater risk of sexually transmitted diseases, and perhaps the waning of emotional support. Jealousy does not seem to take into account the biological time clock and can persist even after the childbearing and child rearing years have passed. Joanne was now in her early 50s, her two children had left home, it was a second marriage for both her and Peter, and it was falling apart because of jealousy. "However understandable jealousy may be," said Nesse and Williams (1996), "it has surely been responsible for a large part of the world's miseries" (p. 194). It certainly was for Joanne and Peter.

"You said it wasn't logical," I reflected on Joanne's comment.

"The other woman lives 2,500 miles away," she replied. "Peter would have to fly away for at least a day or more to see her, which he isn't. We work together in our building business. I know where he is every minute of the day and, at times, when he needs a spare pair of hands, I often help him on the job. On top of that, I had the phone company put a trace on his calls. Would he even agree to that if something were happening? But then as soon as I think that, I get suspicious that he could be using a public phone when he is out on the road or have set up a separate account.

"I even asked him to have a lie detector test, and he did. The report said he was telling the truth, but I'm convinced they didn't ask the right questions. You see, I believe that he is: 99.9%."

It has long been known, from ancient Greek philosophers through to modern cognitive researchers, that the beliefs we form about our world largely determine how we experience that world. A belief can influence our feelings, alter our physiology, determine our behavior, affect our relationships, and bias our interactions with the world around us. We are a species with a need to hold beliefs that explain the world in which we live, whether helpfully or unhelpfully. We might believe that the world is a wonderful place in which to live or that it is frightening and dangerous. We might optimistically believe that life is good or pessimistically believe that it is an unbearable challenge to be tolerated. These core beliefs, or style in which a person gives meaning to their world (explanatory style), determine whether people live an enjoyable, sociable, productive, and healthy life or whether they are prone to anxiety, misery, and depression (Peterson, 2000; Seligman, 1990, 2002; Yapko, 2001, 2006).

Was Peter having an affair? I did not know and did not see it as my role as a therapist to be a judge and jury on the matter. If Peter was having an affair and Joanne wanted to hang on to him, wouldn't her best course of action be to foster a positive relationship and thus diminish the likelihood of him straying? If he was not, wouldn't her best action again be to build positive experiences that he would want to maintain? From a therapeutic point of view, it seemed that helping them build a strong, positive, and loving relationship would be more beneficial than trying to eliminate Joanne's jealousy, of which she was reluctant to let go.

CAN NATURE ENHANCE RELATIONSHIP WELL-BEING?

When researchers take the top 10% of happy people and ask, “What are the key happiness factors in these ‘very happy’ people?” the single most important variable is having good social relationships with other people (Diener & Seligman, 2002). Emmons (2003) sees “the ability to engage in close intimate relationships based on trust and affection” as “the hallmark of psycho-social maturity and a key component in psychological growth” (p. 111). Reis and Gable (2003) clearly assert, “Relationships are an important, and perhaps the most important, source of life satisfaction and emotional well-being” (p. 129). If relationships are so important to our happiness, the next questions become:

- Does nature have a role in the facilitation of positive relationships?
- If so, what sort of influence does it have?
- And how can we make use of this in therapy?

While we are still in need of good, solid research on how nature can benefit relationships, we do have information based on case studies. Despite being the poor cousin in the domain of scientific data, case studies can highlight possibilities: If something is possible for one person, then it may also be possible for another. Case study material has shown nature to be of benefit in facilitating therapy for couples presenting with marital or relationship problems (Burns, 2000, 2009b). Couples like Joanne and Peter often begin their relationships in natural settings, courting under a full moon, watching a sunset across the ocean, or taking a drive in the countryside. As relationships develop, people commonly get caught up in the responsibilities of looking after the house, paying the mortgage, getting ahead at work, and tending to the children. Time spent in relationship-enhancing activities in nature tends to dwindle, and the relationship begins to flounder. Helping couples reconnect with nature can help the relationship flourish once again (Burns, 1998, 2000, 2009b).

When Joanne mentioned about forming their relationship while sitting on a beach watching the sunset and counting the stars, I asked, “How often do you do those sorts of things now?”

Her faced dropped. “We don’t. Peter is a workaholic. We are too tired at the end of the day, and on the weekends Peter is usually helping his mates with jobs they ask him to do. He doesn’t know how to say no. We also belong to a music club. He organizes the weekly gigs, and I’m on the committee doing the bookkeeping. We are like ships in the night. I feel low on his priority list. He denies I am but I feel it.”

As she told her story, it seemed there were many people and projects to which Peter willingly gave his time and attention. Maybe there were good reasons for her to feel she was not getting as much of this man as she wanted. If they both wanted to get back to what they had before, and if contact with nature (such as sitting on a beach watching the sunset) facilitated that quality of relationship, how could it be engaged therapeutically?

WHAT IS NATURE-GUIDED THERAPY?

Nature-guided therapy (Burns, 1998, 2005) is one of the broad range of ecotherapies (Buzzell & Chalquist, 2009). It draws much on solution-focused, outcome-oriented models of therapy and incorporates research from a variety of multidisciplinary fields, such as social

geography, architecture, anthropology, and ecology as well as positive psychology, environmental psychology, and ecopsychology (Burns, 1998, 2000, 2005, 2009b). Ecopsychology is a relative newcomer in the field of psychological disciplines. At its core, it attempts to understand human nature not so much as the inner workings of the psyche but more in the broader context of our relationship with the ecology. Ecotherapies attempt to translate this understanding into strategies for the enhancement of individual well-being, environmental well-being, and the well-being of the relationship between the two.

Nature holds a multitude of stimuli and is therefore an invaluable resource in increasing pleasurable input. The stimuli in natural environments are softer, more pleasing, and have a better “biological fit” than stimuli in human-made environments. Interacting with the magnitude and quality of natural stimuli makes it difficult to be depressed at the same time. In fact, it is proposed that natural environments can act as a reciprocal inhibitor of depression. Try to imagine how difficult it must be to feel down if, at the same time, you are watching a school of dolphins frolicking in the surf, gazing in awe at the kaleidoscopic display of a sunset, or cross-country skiing over cotton-wool snow that softly decorates trees and mountains.

FINDING NATURE-BASED RESOURCES

Gottman and colleagues have found that stable, happy, and lasting marriages are characterized by a 5-to-1 ratio of positive to negative emotions (Gottman, 1994; Gottman, Murray, Swanson, Tyson, & Swanson, 2005; Gottman, Swanson, & Swanson, 2002). To assist Joanne and Peter to increase their positivity ratio by creating more desirable experiences and spending less on the insoluble problems, they were asked, independently of each other, to complete the Sensory Awareness Inventory (SAI) (Burns, 1998, 2005). The SAI is an instrument that invites a client to list 10 to 20 items or activities under six headings from which they get pleasure, enjoyment, or comfort. The six headings are the five basic senses of sight, sound, smell, taste and touch, with a sixth category for activities or things the person enjoys doing. The SAI can form the basis for a therapeutic conversation that inquires about and discusses the six areas of pleasure, or it can be given as a homework assignment.

When Joanne and Peter returned to the third session with their completed SAIs, I asked how they *felt* as they filled them out. Joanne replied, “I was reliving the things I listed. I wasn’t worrying about those old thoughts.” Simply in doing the task, she had discovered an important skill, resource, and control to shift her cognitions from the negative to the positive.

For both Joanne and Peter, the process of completing the SAI offered enjoyment, put them in touch with enriching experiences, and confirmed positive feelings for each other. For couples caught in a cycle of conflict, it often comes as a relief that their therapeutic contact does not become embroiled in unresolved issues but directs them toward individual and relationship experiences of enjoyment. With the emphasis on pleasure and improved relationships, questions of motivation, resistance, or compliance are rarely encountered in administering the SAI.

For the sake of space, only the top five items under each heading on the SAI are reproduced in Tables 20.1 and 20.2. On the basis of these inventories, therapeutic interventions were designed to enhance positive experiences in their relationship while reducing the focus of attention on Joanne’s jealous beliefs.

Table 20.1 Joanne's Sensory Awareness Inventory

Under each heading, please list 10 to 20 items or activities from which you get pleasure, enjoyment, or comfort.

Sight	Sound	Smell	Taste	Touch	Activity
Flowers on landscape	Children's laughter	Fragrant flowers on a warm evening	Chocolate ice cream	Warm sun on my body	Bike riding
Sunrise/sunset	Ocean waves	Salty ocean air	Oysters	Wind in my face	Walking
Watching ocean	Most music	Newborn baby	Cheese	Walking on soft grass	Gardening
Grandchildren playing	Trickling water	Forest after rain	Pâté	My feet in the sand	Craft
The river flowing	Bird calls	Fresh-laundered linen	Fresh melons	Hugs from loved ones	Time with grandkids

HOW TO USE THE SENSORY AWARENESS INVENTORY

Once their individual SAIs had been completed, Joanne and Peter were invited to explore ways of using the inventories for their continuing well-being. If a client has listed between 10 and 20 items that provide pleasure, enjoyment, or comfort under each of the headings on the SAI, this means that he or she has a ready resource of some 60 to 120 potential experiences for changing thoughts, feelings, and behavior. From this extensive and comprehensive list, clients can be guided to change unwanted thoughts or experiences into more pleasurable states and thus increase the positive-to-negative ratio that predicts more stable, lasting, and happier relationships.

Table 20.2 Peter's Sensory Awareness Inventory

Under each heading, please list 10 to 20 items or activities from which you get pleasure, enjoyment, or comfort.

Sight	Sound	Smell	Taste	Touch	Activity
Waves	Running water	Sea air	Nice fruit	Cold bed sheets	Fishing
Grandkids	Waves on shore	Cut grass	Steak	Salt water	Playing with grandkids
Landscapes	Music	First rains after summer	Cheese	Cold wind on face	Bike riding
Sunsets	Rain on roof	BBQ cooking	Apple pie	Soft skin	Sex
Wife	Baby's first words	Vinegar	Seafood	Wife	Walking

Building Individual Pleasure

Looking at their individual SAIs, I inquired, “What did you *discover* in filling out your inventories?” Joanne replied, “I don’t do enough of the things I like.” Her response opened the opportunity to explore the things that she liked doing and how she might spend more time in these self-pleasuring and self-caring activities. In particular, I was interested in how she might be able to use the inventory if she found herself getting caught up in unwanted thoughts of jealousy. Could time gardening, looking at what was beautiful, or smelling a favorite flower shift the focus of thoughts and feelings in more helpful directions? If she were mindfully engaging in such activities, would she be ruminatively worrying about her thoughts of jealousy at the same time?

I asked Joanne, “From your list, what would be helpful for you to do to create a greater calmness of mind or tranquility of thought?”

Looking at her SAI, she replied, “Maybe to cycle along the oceanfront watching the waves roll into the shore, smelling the salty air, and feeling the wind in my face.”

If clients set such a task for themselves, it is important to ensure that it is attainable and realistic. Therefore, I asked, “Is that easily doable for you?”

“Oh, yes. We live near the beach and used to cycle together, but somehow it has slipped by the way and we don’t do it as much.”

Wanting her to commit to the task, I asked, “When can you start to do it again?” She decided on the next weekend. In a similar manner, self-pleasuring tasks were set for Peter.

Building Partner Pleasure

At the next session, I asked Joanne and Peter to swap their inventories, look at the things that their partner gained pleasure from, and begin to discuss ways that they may pleasure the other person. As well as being used to enhance one’s own well-being, the SAI can be employed to help pleasure one’s partner. I suggested that when they went home, they put their SAIs in a prominent place that would be visible for both themselves and their partner. They decided to stick them to the refrigerator door where they could review them and use them to do things to please their partner.

If Joanne wanted to do something caring for Peter, she could look at his SAI and use it as a basis from which to select satisfying experiences across several different sensory modalities. She might choose to prepare a barbecue (which he enjoyed the smell of), cook a steak (which he enjoyed the taste of), at sunset (which he enjoyed the sight of) with some of his favorite music (which he enjoyed the sound of) in the background. Similarly, he could buy her a chocolate ice cream (which she enjoyed the taste of) to eat while walking on the soft grassy bank (which she enjoyed the touch of) of a flowing river (which she enjoyed the sight of), listening to birdsong or trickling water (which she enjoyed the sound of).

Building Mutual Pleasure

The survival of a relationship depends to a large degree on the ability of each person to satisfy the needs of the other. When needs are not being met, when a relationship is not mutually satisfying, it falters or falls apart. When partners feel understood and appreciated, when they talk meaningfully, and when they share pleasant or fun activities, the relationship is likely to flourish (Reis, Sheldon, Gable, Roscoe, & Ryan, 2000). Relationships are built on shared

positive memories and move ahead with plans for, and anticipation of, future positive experiences. Would enhancing that individual and mutual satisfaction help Joanne feel more contented and more secure in the relationship? With this question in mind, I asked Joanne and Peter to participate in an exercise that had them looking ahead and planning future positive experiences.

“I want to ask that each night you look at each other’s SAI and plan a mutual activity for the following day.” Asking Joanne and Peter to plan future tasks, at a time when their conversations had become strained, was designed to help each of them feel understood and appreciated, communicate meaningfully, and anticipate shared pleasant, fun activities. It was designed to break the old pattern through the creation of more pleasurable processes.

“One thing we planned,” Joanne told me at the next session, “was to pack a picnic lunch on a day I would be helping Peter on the job. We agreed to put down our tools for an hour, find a local park, and share the time together having lunch. It was something we have not done before, but we both enjoyed sitting beside the lake, watching the ducks, and talking. And we are planning to take more such breaks together.

“We also planned to go for a sunset cycle along the beach front together. At first Peter was reluctant,” she said with a glance in his direction, “but I think he enjoyed it too.” He nodded agreement, and Joanne grabbed the opportunity to have him commit to it again.

Building Engagement through Nature-Guided Mindfulness

A life in which a person feels engaged, involved, and absorbed tends to be a life of greater happiness. If Joanne and Peter could find more engagement in their positive experiences and more positive engagement with each other, this was likely to help the relationship flourish. As mindfulness is one way to help a person be engaged in the moment and disengage from other factors, they were taught a nature-guided mindfulness exercise. This was done in imagery during one consultation, requesting they each imagine themselves in a favorite place then mindfully step through the experiences of each sensory modality in that place. It was suggested they practice this individually (so as to heighten individual engagement) when actually in pleasant natural environments and also to discuss their optimal experiences from the exercise with each other (so as to heighten relationship engagement). An example of a nature-guided mindfulness exercise is provided in Chapter 17 of this volume.

Building Meaning through Nature

Nature-guided therapy is largely about creating opportunities or possibilities for clients to experience something differently and allowing them to find metaphors or meaning in that experience (Burns, 2007). Joanne and Peter decided to practice their nature-guided mindfulness exercise while picnicking by the river and watching a sunset. Once clients have done something like this, the search for meaning can be enhanced by such questions as: “What did you discover in doing that?” In reply, Joanne related their conversation.

Peter had said, “Wow, what a stunning sunset. Did you bring the camera?”

“No,” Joanne answered. Then, looking at the scene as she might through the lens of her camera, she added, “The power lines ruin it anyway.”

Peter had been so absorbed in the sunset that he had not noticed the three thin wires that stretched from behind the trees on one side of the bank across the colorful sky to the other bank. “Are you going to let them ruin such a sky full of beauty?” he asked.

Then, she said, it dawned on her. Seeing the power lines and missing the beauty of the whole sky was what she was doing in their relationship. She had been looking at a small problem and neglecting the much bigger aspects of what was beautiful in their relationship. Seeing the doubts she had about Peter's fidelity was like seeing the power lines. Once aware of them, it was hard to stop being aware of them. She said, speaking in metaphor, "Did I let the power lines ruin the sunset, or did I look beyond them and focus on the immense beauty? When I asked myself that way, it was like there was no choice. What we have is too good to overlook."

CONCLUSIONS

Joanne and Peter were seen for a total of five sessions. Following their mindful sunset, Joanne's mood seemed markedly better and Peter appeared more relaxed. They felt confident they could continue with the positive initiatives they had begun.

"I have had a better, more positive week," commented Joanne. "I still believe he has had an affair 99.9% but I have come to the conclusion that if I can't change it, I might as well look for the big-picture stuff and get on with creating the good. I have stopped thinking of myself as a victim. I know he loves me and wants to be with me. Why else would he tolerate what I have put him through?"

As mentioned at the beginning of this chapter, the contexts in which many couples develop their relationships are often closely associated with nature: strolling hand in hand along the beach, picnicking by a stream, parking in a romantic spot under a full moon, or cycling at sunset along the coast. Such positive experiences can form the basis for romance and love. They are conducive to the *creation* of positive relationship experiences as well as the *maintenance* of continuing healthy relationships.

In offering clients assignments for reconnecting with the natural environment, all diligence and care needs to be taken for client safety and well-being as not all of nature is user friendly. Exposure to sunlight can have health benefits and also can cause skin cancer. In nature, there are wild bears, lions, and crocodiles that may be fascinating to view from a safe distance and that are only too willing to assert their dominance in the food chain if given half a chance. So, when I speak of the human-nature relationship, I have been referring to interactions with nonthreatening environments that have a positive emotional or aesthetic value.

Admittedly, human relationships are complex. To manage them effectively, participants need to master a range of skills, including problem solving, conflict resolution, effective communication, expression and acceptance of intimacy, as well as the affirmation of each other. Important on this list of skills is also the ability to have fun together, to share times of joy, and to create mutual happiness. Bringing beauty and positive sensory experiences into life makes it rewarding, happy, and healthy and may even facilitate feelings of love.

FOLLOW-UP

Several months after the five sessions I had with Joanne and Peter, I noticed her name in my appointment book again and immediately wondered if she or they had slipped back into the stresses resulting from her jealous thoughts. Joanne attended by herself, bright and cheerful,

telling me that Peter had stopped smoking and that she wanted some hypnosis to help her become free as well.

“Our relationship is going well,” she stated. “The jealous thoughts still come but are less frequent, and I am not dwelling on them as much. We continue to have our lunches from time to time and go cycling together. We have also booked to go on a Pacific cruise together to relax and enjoy our love of the ocean and sunsets.”

As Joanne and Peter show, the good news is that the natural resources for creating joyful, love-based, effective relationships are readily available. The items listed by clients on their SAI may be accessible at a neighborhood park, on a local beach, in their own backyard, or through a kitchen window. The pleasure of walking on soft grass beside a flowing stream may help soothe distressing thoughts. The feel of the sea breeze on your face as you cycle on the oceanfront may help spontaneously wash away anxiety through the emergence of tranquility. Depression can lift with the sensory stimulation of lunching by a duck pond in a local park. Sunsets and seashores can contribute to satisfying relationships.

Putting It into Practice

1. Look to build, not demolish.

Joanne had a story to tell, and it was important that it be heard respectfully. She had a belief that she, at least in part, did not want to relinquish. Therapy was aimed at helping her to build new positive alternatives for a happy and healthy relationship rather than at demolishing beliefs and emotions that may have had some functional, evolutionary relevance.

2. Look for past, positive nature experiences.

Joanne and Peter had established and built their relationship with the sea, sunsets, stars, and music as integral factors, but these had been lost in the busyness of day-to-day living. Ask your clients about their past positive experiences together: What brought you together in the first place? What are the contexts of these experiences? Has nature had a part to play? How might they reconnect with such past, positive nature experiences?

3. Use the Sensory Awareness Inventory.

The SAI is a simple, enjoyable exercise for clients to engage in. It provides an extensive range of positive, client-generated, therapeutically oriented resources that clients can use for improving mood, creating optimal experiences, and enhancing individual or relationship well-being.

4. Help broaden and build self-pleasuring activities.

Helping clients learn how to broaden and build positive emotions enhances states of flourishing. When I asked Joanne, on the basis of her SAI, what might help her move toward greater calmness of mind and tranquility of thought, she replied cycling along the beachfront, mindful of her various senses. Using your clients' SAIs, how can you work collaboratively with them to engage those sensory experiences that enhance states of well-being consistent with their therapeutic goals?

5. Assist clients to pleasure their partners.

As the survival of a relationship depends to a large degree on the ability of each person to satisfy the needs of the other, you might use the SAI as a basis to help clients rebuild this skill, which is often lost over the life of a relationship. To satisfy a number of Peter's pleasurable sensory experiences, Joanne could prepare a sunset barbecue for him, while Peter could take her for a riverside walk. Invite couples in therapy to explore their partner's SAI and how they can use it to promote the other's well-being.

6. Help clients find mutual pleasuring activities.

What can clients do to broaden and build mutual pleasurable experiences? The couple in this case took time during the working day to lunch in a local park and to cycle along the beach at sunset.

7. Build engagement through nature-guided mindfulness.

Using imagery or real nature contexts, show your clients how to mindfully step through the various experiences they have in each sensory modality. This may be practiced individually, and shared with each other, to heighten both personal and relationship engagement.

8. Move toward meaning.

When clients have completed a nature-guided activity, help them search for meaning in the experiences with such questions as: What did you discover in doing that?

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CHAPTER 21

A Dream of Creative Menopause

A New Neuroscience of Brief Psychotherapy for Solving Puzzles of Biology and Psychology

Kathryn Lane Rossi

MEET THE CONTRIBUTOR

Kathryn Lane Rossi, PhD, is a licensed clinical psychologist practicing in Los Osos, California. She received her post-doctoral training at the University of California–Los Angeles School of Medicine in couples therapy, where she was certified for advanced training in sex therapy in 1992. She is currently professor of psychology at The New Neuroscience Institute for Therapeutic Hypnosis, Psychotherapy, and Rehabilitation of Rome and San Lorenzo Magoria (Benevento), Italy. She teaches workshops training psychotherapists nationally and internationally. She serves on

the board of directors for the Milton H. Erickson Foundation Archives and Press, Phoenix, Arizona. She is a founding member of the Milton H. Erickson Institute of the California Central Coast.

Kathryn says, “My mother taught me that it takes fewer muscles to smile than to frown. Her positive nature and ‘can-do’ attitude permeates my very being. I am grateful for her example of embracing ‘change’ with the enthusiasm of seeing where it will take you next. She cheerfully expected fun and almost always found what she was looking for.”

Life changes
Attitude changes
Nothing remains quite the same
We cry, we puzzle but best of all—
If we couldn’t laugh, we’d go insane.
— *Kathryn Lane Rossi*

THE ASSESSMENT

Violet was a beautiful, well-dressed woman in her early 50s. She was athletic, quick-witted, and obviously very intelligent. Her bright blue eyes made good contact with mine as she shook my hand and said hello.

She presented because the emotional symptoms of menopause were troubling her even though her physical symptoms were slight. She felt her brain was slowing down. Her memory was “variable” at best. Often she had a difficult time recalling words. She had previously used psychotherapy to move through tough transitions and wondered whether it could help her get through menopause since most people believed it was an entirely biological process. She believed that “a series of very vivid menopausal dreams” could be saying something about her changing psychology.

It was clear to me that this woman was very high-functioning. Her psychosocial assessment indicated that she was happily married, successful with friends and work, and an accomplished musician. Other than the reported problems with her memory, the meaning of her vivid dreams, and the transitions of menopause, there were no major problems. We decided together that the goals of therapy would be exploring her dreams, her early-morning thoughts upon awakening, and her intuitions about what was happening to her. Together we embarked on a therapeutic journey to understand her psychological experience during this new life transition phase of menopause.

What goes on in the changing brain of a menopausal woman is remarkable. As her brain restructures itself, old patterns of thinking are challenged. Her passion is to understand *who* she is and *how* she is becoming. She is reintegrating with new insights, hopes, dreams, and aspirations about what ultimately makes her a happy, content, and forward-thinking human being. Menopause is a *psychobiological* process. The big question is: What are the psychobiological relationships between the psychology of her new insights, hopes, and dreams and the biology of menopause?

The meaning of dreams during profound life transitions has been the subject of speculation since biblical times. Think of Joseph interpreting the Pharaoh’s dream of seven fat years followed by seven lean years in ancient Egypt. Sigmund Freud (1900) called dreams the royal road to the unconscious while more recently Ribeiro, Simões, and Nicoletis (2008) have documented research about relationships among dreams, novelty, gene expression, and the growth of the brain known as brain plasticity.

GENE EXPRESSION AND BRAIN PLASTICITY

What is *gene expression* and *brain plasticity*? What do these terms mean for optimizing the creative process, psychotherapy, and menopause?

Modern neuroscience has profoundly updated our understanding of the genetics of life development. We now know that different patterns of genes are activated during different stages of life. Even our changing moods in everyday life are associated with different patterns of genes that are activated or “turned on” to make the proteins that generate our hormones and neurotransmitters that modulate our emotions, cognition, behavior, and health. We call this new perspective “Psychosocial Genomics” (Rossi, 2002, 2004a, b, 2007; Rossi & Rossi, 2008).

This is the basic insight of the new neuroscience of deep psychotherapy of menopause that we explore in this chapter. Major changes in gene expression during menopause

generate changes in the production of proteins in the connections (synapses) between neurons of our brain that are now called “brain plasticity.” These changes in brain plasticity can modulate mood, memory, and behavior that we experience as “symptoms of menopause.” Such symptoms also reflect a woman’s changing attitudes and new potentials during this life transition.

Erik Erikson (1994), the developmental psychologist, described menopause as a stage of life when women face the challenge of integrating the profound transitional issues of Integrity versus Despair. If we had a conscious choice, naturally we would all choose integrity (having it all together) rather than despair (being broken in many discordant pieces). The road to integrity is a life-long journey with many paths for success. This developmental process allows us to integrate our psychological mind with the growth of our physical brain at the level of gene expression and brain plasticity. This leads to new conscious choices and, ultimately, greater possibilities for happiness, fulfillment, and a life well lived.

In this chapter, I explore a new approach to understanding how psychological experiences of the menopausal woman may be related to the deepest levels of gene expression and brain plasticity in her brain. This chapter is a contribution to the emerging new neuroscience school of psychotherapy (Rossi, Iannotti, & Rossi, 2006; Rossi & Rossi, 2006; Rossi, Rossi, Cozzolino, & Iannotti, 2007; Rossi, Rossi, Yount, Cozzolino, & Iannotti, 2006).

INITIAL SESSION

Violet began her initial session with a panic of self-disparagement. “I feel like I’m becoming an idiot,” she said, wringing her hands gently and occasionally touching her left temple and her face. She looked distressed and anxious. “My memory is so bad. I’m actually avoiding people I know in the grocery store. I can’t remember their names sometimes, or important things, like the names of their spouses and children. I feel sometimes like I’m losing my mind. Is this what insanity looks like? I used to be so sharp witted. Is this the future for me? Am I going to my dotage? Is Alzheimer’s disease already hitting me? I’m only in my early 50s!”

An Immediate Psychotherapeutic Reframe via Neuroscience

“Not necessarily, Violet,” I said, wanting her to consider the positive alternatives. “Your so-called anxiety may actually be a mind-body transition seeking a creative outlet.”

“Really, do you think I could transform this hideous decline and maybe even halt it?”

“Yes,” I said. “It is possible. Your brain has the capacity to grow all of your life when you give it novel and interesting stimulation. The natural state of a growing brain is to develop and strengthen new brain connections. The brain can even make new cells and new neurons to help you adapt to life transitions like menopause.”

“I’ve never really understood my brain. You know, it’s always just been there for me. Now that I feel myself slipping into who knows what, I have a real need to understand what is going on. I need to have a road map of what to expect.”

“Well, believe it or not, we do have a mind-body road map. Look here at this picture,” I said, pointing to a copy of Figure 21.1 on my office wall. As pictures can often speak more than words, I draw clients’ attention to the posters I have around my office, thus offering visual as well as auditory information to enhance the potency of learning. “When we go through an important turning point in life, many people have very vivid dreams like you are

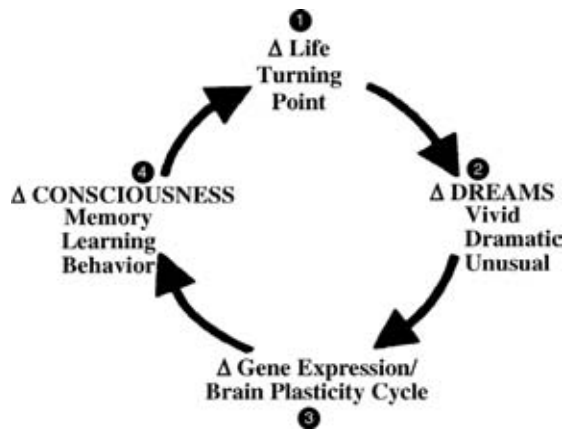


Figure 21.1 Neuroscience Update of Brief Psychotherapy Illustrating a Creative Psychobiological Cycle

having. It is now believed that genes are actually turned on in the neurons of your brain to form the proteins that make the new connections you experience as new memory, learning, and consciousness” (Ribeiro et al., 2008; Rossi, 2007).

Mind-Body Communication from Mind to Gene

“Menopause is a psychobiological, or mind-body, process,” I continued. “The changing balance of hormone levels, characteristic of menopause, affect gene expression, which then can affect the structure of the brain’s synapses. You remember that synapses are the connections between our neurons and our brains. Synapses are the travel agents of transformations.” I pointed to a prominent poster in my office (Figure 21.2) and said, “This is a picture of your brain when it engages a dialogue between the hippocampus and cerebral cortex in your vivid dreams about menopause.” My reasons behind choosing to explain a client’s problem and the creative process of therapy in the neuroscience model are that it can (as we have seen with Violet) help clients reframe distressing symptoms of change to positive signs of development and growth. Understanding the natural dialogue among the mind, brain, and body can assist a person normalize symptoms, see a pathway for progress, and grow through what otherwise could be an unsettling period. It can provide a tangible basis for understanding what might previously have been confusing and inexplicable to the client.

“This is how memory and new ideas and life changes are made,” I continued (Rossi et al., 2008). “When something new and exciting happens during the day, it is automatically replayed in a creative dialogue between the hippocampus and the cortex of your brain. Understanding this natural dialogue between the mind and brain during menopause is a new way of understanding your dreams and how your brain-mind and consciousness can change dramatically during profound life transitions. It could become an excellent way to help you cooperate with Mother Nature in creating a better life for yourself at this time.”

“But how does the mind get from the brain into the body?” Violet asks.

“One obvious answer is that the nerves carry messages among mind, brain, and body. A more subtle pathway is via hormones, growth factors, and so on, synthesized in the brain in

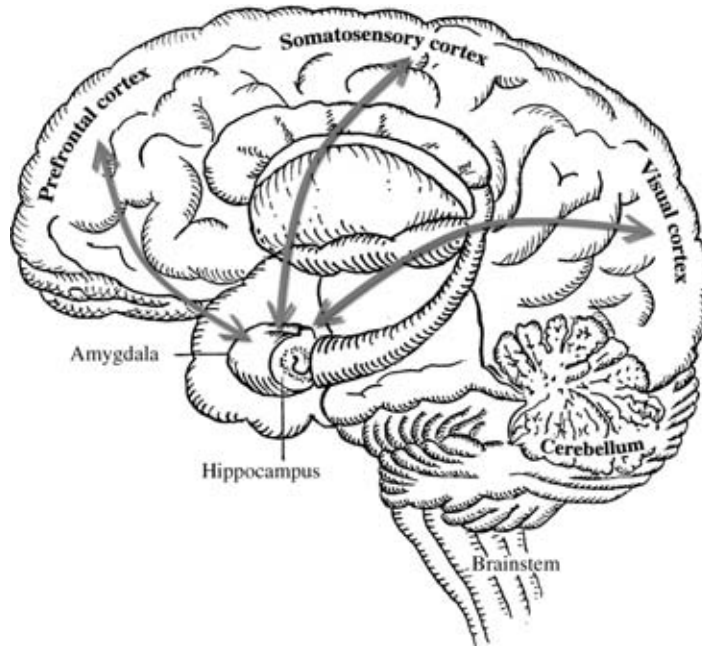


Figure 21.2 New Neuroscience Model of the Brain Consolidating Memory as a Result of Therapeutic Change during Psychotherapy

response to environmental signals and stress, which are then transmitted as molecular messengers through the bloodstream to potentially every organ, tissue, and cell of the body.”

“Transmitted as ‘molecular messengers’? Wow, this is getting really complicated,” Violet commented.

“It’s far less complicated than you might think. The current evidence of the degree of involvement of gene expression and brain plasticity in memory, learning, behavior, education, and psychotherapy is still controversial, but it is being strongly documented by many scientists. Gene expression and the growth of your brain is the natural basis of mind-healing in psychotherapy” (Kandel, 1998; Lichtenberg, Bachner-Melman, Gritsenko, & Ebstein, 2000; Lichtenberg, Bachner-Melman, Gritsenko, Ebstein, & Crawford, 2004; Lloyd & Rossi, 2008; Ribeiro et al., 2008; Rossi, 2002, 2004a, b, 2006–2007; Rossi et al., 2008).

Exploring Computerized Brain Fitness Programs in Psychotherapy

This immediate positive therapeutic reframe of Violet’s presenting problem in the first psychotherapy session was possible only because of her acute intelligence and curiosity. As we discuss the possibilities of using her creative energy, she wondered if computer brain and memory training programs she had recently read about could be of use to her. We agreed that, yes, she might enjoy exploring them. They could be very advantageous to enhancing memory and making her cognition faster. She made a commitment to complete the 40 one-hour sessions of *The Brain Fitness Program* (Merzenich, 2006–2007).

All went well during her *Brain Fitness Program* for the first 15 lessons. Then, in her words, she “hit a wall” of anxiety, fear, and headaches. How could she learn anything when

she could not even make out the words being said in *The Brain Fitness Program*? It was so hard and frustrating that it felt impossible. She wanted to quit but knew that quitting would not improve her memory and listening skills.

Sometimes, during periods of transition, the coping skills that people like Violet have relied on in the past may no longer work effectively for them. At such times, people are faced with the challenge of how to deal with the changing situation or process. Finding the solutions means they need to draw on novel or creative processes that have the brain searching for new neural pathways and mind-body links. For this reason, I want to help clients have a clear understanding of the processes of creativity and how to use those creative processes to enhance their adaptation. This is where utilizing the four-stage creative process in psychotherapy can be so helpful.

Concepts about the creative process have been around for a long time. In the 1500s, the Italian master Leonardo da Vinci described a seven-step creative process (Gelb, 1998). His creative principles are very interesting and are a precursor for the four-stage creative process utilized in psychotherapy. French mathematician Henri Poincaré described a four-stage creative process 200 years later. More recently, Ernest Rossi (2005) applied the process to psychotherapy, creative growth, gene expression, and brain plasticity.

It was at this point of her ambivalence about the *Brain Fitness Program* that Violet had a dream that clearly illustrates the four stages of the creative process (Rossi 1972/2000, 2002, 2004a, b, 2007; Rossi & Rossi, 2008).

THE FOUR STAGES OF THE CREATIVE PROCESS DURING A DREAM

Stage 1: Data Collection: Noticing Change in One's Self and Environment

In this initial stage of the process, clients are faced with the challenge of the transition, collecting the information about what they want, and assessing their potential opportunities. In the dream Violet describes, this was the stage of wanting to learn, go to college, and seek out the library.

I am a young, 23-year-old, foreign-born woman. I have a high school education and want to go to college but I have no money. I rent a room with other college students so at least I will have access to the university library.

I need to wash my clothes. I don't have very many and I don't feel like carrying them, so I put them all on and proceed to walk across the college campus for the first time. I know I will eventually find a place to wash my clothes and, more important, I will find the library.

The campus is *beautiful!* There are large expanses of perfectly groomed green grass with occasional ribbons of orange California poppies. The air is sweet from the rains of the previous day. Everything is very clean. In the first building I see students at their desks. It is enchanting to watch students scurrying to class, already late.

Stage 2: Incubation: The Often-Difficult Period of Transition between an Old and New Lifestyle

Here Violet is fully involved in the heart of her problems and, at times, may even seem to be at an impasse. However, we must be very careful with the older, traditional psychotherapeutic concept of *impasse*. An impasse traditionally suggests an end point,

whereas incubation is a natural transition of the creative process. Incubation is the thinking, feeling, and puzzling through a cognitive-emotional state of “I don’t know.” Violet was focused on the blackboard math problems. Which way does she go? Which path does she follow? How is she going to resolve the situation? Time and a great deal of inner work is required during this incubation stage in our dreams, self, and social relations to facilitate gene expression and brain plasticity in this new brief neuroscience of psychotherapy.

I peek inside the classroom and catch the professor’s eye. He recognizes me. He has been looking for me. “Please come in,” he says. “I want to take you to lunch when the class is over. Do you have time?”

“Sure,” I say. I sit down. There were about a dozen other students. On the blackboard were 24 math problems to solve. These problems were spatial in nature, but I immediately understood that there had to be a numerical answer. I was transfixed and wanted to try to solve each puzzle.

The other students had lots of paper and were madly copying a problem down and trying to solve it. I found a piece of scrap paper. I was too shy to ask anyone for more. I wrote down the numbers 1 to 24 and proceeded to thoughtfully look at the first spatial puzzle and began in my mind to eliminate everything I thought was not relevant. I could see the solution in my mind’s eye to the first puzzle and wrote the numerical answer on my scrap paper. I did this for each of the 24 puzzles. This took me about 25 minutes.

Stage 3: Illumination: Getting a New Idea

This is a stage of intuition, of enlightenment, of the “aha” experience, of the surprise of discovery. Violet discovered and was surprised by her strengths and resources to solve math problems.

Just as I was finished, one of the students ran up to the blackboard and began to erase elements of the third spatial problem. She was ecstatic! She found the solution to the problem and wanted to show everyone the correct answer. The professor was very complimentary to her. The rest of the students returned to concentrate on their own work.

Since the other students did not talk to the professor, I asked him if he would look over my answers. He leaned over my paper and circled a problem saying “This is the only one that is not correct.” I then took a moment and put my left hand to my left temple in a gesture indicating that I knew where I had made my mistake. I then wrote down the correct answer.

Stage 4: Verification: Exploring New Possibilities in the Real World

In the final step, clients apply their “aha” experience to their day-to-day life with a newly developed confidence to continue moving forward, just as Violet’s dream discovery empowered her to do.

The professor asked me if I had a doctorate degree in mathematics. Of course, I said, “No.” He then told me that this class was a graduate course in spatial mathematics and the questions on the blackboard were to be solved over the semester. In fact, he said, most students do not solve all of the questions even within the semester. How on earth, he wondered, did I do this? Did I really perform the calculations all in my head without writing anything down in the process?

Shyly I said, “I only had this scrap of paper. It was not an option for me to use any other way to solve the problems but in my head.”

He then asked me to explain my thought process to him for several of the questions. He confirmed that, yes, the steps I took in my own mind to solve the problems was exactly the proper way to go about it.

CREATIVE THERAPEUTIC HYPNOSIS TO FOCUS ATTENTION, GENE EXPRESSION AND BRAIN PLASTICITY

The Hand Mirroring Protocol

Violet did not know what her dream meant. In such situations, it is important the therapist sees that “not-knowing” as a therapeutic opportunity for introducing new learning (Rossi et al., 2008). My choice was to introduce therapeutic hypnosis for three reasons.

1. Therapeutic hypnosis involves flow, engagement, and focused attention, which are helpful skills for someone who had expressed concerns about memory and concentration to acquire.
2. Therapeutic hypnosis can facilitate creative processing and understanding of her dreams and intuitions about what was happening to her.
3. From our new psychosocial genomic perspective, therapeutic hypnosis is a mind-body process that can enhance gene expression and brain plasticity, as already discussed.

Introducing this as *a creative process of therapeutic hypnosis*, I asked Violet, “What do you think your dream means?”

“I’m really not sure. I’m no mathematician, that’s for sure. And I’ve never been a foreign student. Why would I be 23 years old?”

“What was the most surprising part of your dream?” This is a key question. What is *surprising, new, novel, and unexpected* is a precise psychobiological focus that may facilitate gene expression and brain plasticity.

“I would have to say solving all those math problems so quickly and accurately was the most *surprising* part of my dream.”

“Do you think of yourself as a brilliant problem solver?” I inquired.

“I’m pretty good, but I wouldn’t call myself a brilliant problem solver.”

“The professor in your dream seems to suggest otherwise. Could you be underestimating your own abilities?” I responded.

“Well, I’m not brilliant at this *Brain Fitness Program*,” Violet said very quickly. “I’m getting headaches and I feel frustrated enough to bleep it off my computer. Why is it *so hard* to grow my brain?”

“I wonder if you would like to explore this question with a new therapeutic process I call ‘the mirroring hands?’” (see Figure 21.3) The offer of an intervention at this stage is with the intention of helping her to move on to the third and fourth creative stages of illumination and verification for discovering her abilities and then going forward with confidence.

Violet was eager to try something new.

“Place your hands palm up holding your arms 6 or 8 inches above your lap. Look into one hand and then the other, tuning in with great sensitivity. In which hand can you sense this ‘feeling’ that it is ‘so hard’ to grow your brain?” I deliberately utilized her own exact words (Rossi et al., 2008).

Violet indicates this is her left hand.

“That is wonderful, Violet. Now, by way of contrast, what do you experience as the opposite of the ‘so hard’ in your other hand?”




	<p>1. Preparation: Facilitating Self-Awareness and Self-Sensitivity.</p> <p><i>When you are ready to do some important inner work on that problem, will you hold your hands above your lap with your palms up . . . as when you are ready to receive something? [Therapist models.]</i></p> <p><i>As you focus on those hands in a sensitive manner, I wonder if you can begin by letting me know which hand seems to experience or express that fear (or whatever the negative side of the patient's conflict may be) more than the other? [As soon as the person indicates that one hand is more expressive of the problem or symptom than the other, the therapist goes on to stage 2.]</i></p>
	<p>2. Incubation: Accessing Resources and Creative Review. Integrating the Opposites.</p> <p><i>Wonderful . . . now I wonder what you experience in your other hand, by contrast, at the same time? What do you experience in that other hand that is the opposite of your problem [issue, symptom, etc.]?</i></p> <p><i>Good, as you continue experiencing both sides of that conflict [or whatever] at the same time, will it be okay to let me know what begins to happen next? Reviewing and replaying that until . . . ?</i></p>
	<p>3. Insight: Creative Replay, Intuition and Creative Possibilities.</p> <p><i>Becoming more aware of . . . ?</i></p> <p><i>Interesting . . . ? Something changing . . . ?</i></p> <p><i>And is that going well . . . ?</i></p> <p><i>Is it really possible . . . ? Something new? . . .</i></p> <p><i>Continuing to explore positive possibilities . . .</i></p> <p><i>Appreciating the value of what you are experiencing . . . knowing what is best . . . most important? . . . Your own way of helping yourself? . . .</i></p>

Figure 21.3 Problem Solving by Integrating the Opposites (Source: Updated from Rossi, 2002)


	<p>4. Verification: Reintegration, Reframing, and Self-Prescriptions.</p> <p><i>What does all this experience mean to you . . . ?</i></p> <p><i>How will you experience [behave, think, feel, or whatever] differently now . . . ?</i></p> <p><i>How will your life be different now . . . ?</i></p> <p><i>How will your behavior change now . . . ?</i></p> <p><i>What will you do that is different now . . . ?</i></p> <p><i>What recommendations do you prescribe for yourself as a result of this creative experience?</i></p>
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Figure 21.3 (Continued)

Violet hesitates, frowns with uncertainty and the struggle of her inner search. After a few moments, she nods slowly, acknowledging she can experience the opposite as “confidence” in her left hand.

“Very good, Violet. And now, while experiencing both sides at the same time, I wonder what you will notice between those hands on the inner stage of your creative imagination? Is one hand heavier and the other hand lighter? (Pause for about a minute.) Is one hand warmer and the other hand cooler? Do the hands move together or apart as their relationship changes?”

During this time, I became quiet and carefully observed the minimal cues of Violet’s inner focus. She moved her head and eyes slowly from side to side, looking from one hand to the other. I saw very small vibrating micromovements of her fingers on both hands. She then began to slowly and experimentally oscillate her hands, moving them up and down, together and apart. Her hands then circled around one another until the left hand became stationary and the right hand circled around the other hand.

“Yes, Violet. Continue with that. And I don’t know if that brings you to childhood, or to those teenage years, or maybe even in your early 20s, or 30s, or 40s, or maybe even now? (Pause for about a minute or two.) Is that really happening all by itself?” My remark suggested that the dissociations and reassociations characteristic of the autonomous ideodynamic creative process of therapeutic hypnosis may be evoking gene expression and brain plasticity. From our new neuroscience perspective, the word *ideodynamic* means that a novel, creative *idea* (*ideo*) may be activating a brain *dynamic* of gene expression and brain plasticity.

Violet slowly nodded yes, and then her eyes spontaneously closed. I had not suggested that she close her eyes! Their closing spontaneously may be a more meaningful sign of intense focusing than if I were to tell her to close them.

Violet’s movements became slower and her head spontaneously nodded, yes, about her inner work. Her chin was almost resting on her chest. Her right arm dropped down to her lap. Her left hand stayed stationary in front of her.

I remained very quiet while her creative inner work proceeded well enough alone—without any further possible distractions by excessive verbiage from the therapist. Less is often more during such delicate inner work!

A Spontaneous Recovery of Childhood Learning Experiences

Violet's brow furrowed in concentration. A teardrop began to form, coming out of her right eye. Her breathing was slower. She swallowed. Her eyes slowly opened and looked unfocused. She was not really looking at anything in particular. When such behavior is spontaneous (not suggested by the therapist), it is characteristic of a special psychobiological state we call therapeutic hypnosis.

"I remember being in the third grade. I just could not seem to learn my multiplication tables. It was so hard. I had to give up recess every single day and spend time with my teacher to learn the multiplication tables. At first, there were other students there too, but then they all successfully memorized the tables, leaving me alone with the teacher. It was humiliating that I just couldn't learn them. At home, I spent hours writing out the tables. I'm sure my teacher wished that she had a private lunchtime too. Finally, after great effort, I successfully memorized the multiplication tables up to 12 times 12. We even got a lot of bonus points for memorizing right up to 15 times 15. It was hard to learn but I did it. I'm still really good at multiplication in my head. This came from working so hard to learn it.

"The experience I had in early grade school is almost exactly the experience that I have now. In other words, learning is just as hard now as it was back then when I was 8 years old. Learning is not harder because I'm in my 50s. Learning is just a lot of work!"

"Yes, Violet. This is the simple truth. Learning is not harder because you're in your 50s. Learning is a lot of work," I said, repeating and reinforcing her wise insight.

Violet's left hand was still in the same position, stationary in front of her. This let me know that she continued to be active in therapeutic trance. I remained quiet, looking for what would come next. She closed her eyes and took a deep breath.

"Simply receive that, Violet. Receive as much as you need to receive and . . ." I left the sentence dangling, to give her the creative opportunity to complete the sentence or thought.

Violet began to nod her head up and down. I saw the beginnings of a small smile. First, the right corner of her mouth started to rise and then the left corner of her mouth joined into a distinct smile. This is very characteristic of stage 3 of the creative process, the joy of an "aha" experience.

"Yes," Violet said. "This is the truth. Learning is hard. It's only with good daily practice that I'm going to be able to be successful in growing my brain. I know how to grow my brain. I did it in the third grade and I'm doing it right now. I am laying down new circuits in my brain. There is no other explanation for it. I've been successful in life because I stay with things to completion."

Violet opened her eyes and looked directly at me. I nodded yes while looking into Violet's eyes.

"And how will you apply this new knowledge today, tomorrow, next week, and for the rest of your life?" I asked, seeking to facilitate her fourth, or verification, stage of the creative process: the application of her new learning into her day-to-day life.

"I will continue each day to apply myself to the best of my abilities to develop this new learning with the *Brain Fitness Program*. I will complete the program. I do not need to be anxious about my progress. I know I will grow my brain. I don't know *how much* I will grow my brain, but I know I *will* grow my brain. I plan on enjoying each day with the knowledge that I will be successful."

This *behavioral self-prescription* documenting how she will utilize her therapeutic insights in her real everyday life is typical during stage 4 of the creative process. Clients discover their own paths toward healing and well-being.

FOLLOW-UP

Within two months, Violet completed the *Brain Fitness Program*. Her improvements are listed in Table 21.1. Noteworthy is the increase in her brain processing speed (faster synapses) and ability to discriminate sounds (sensitivity). These are two of the most basic building blocks for cognition and language. During Violet’s most difficult and challenging periods with the *Brain Fitness Program*, she occasionally suffered headaches. While such difficulties may not be characteristic of most people, this was probably when she improved the most. Note that Violet’s score on Sound Precision was low. As she was a musician, she had a natural talent for recognizing sounds precisely and was so advanced at the onset that she had minimal improvements with the program.

“Violet,” I said. “You have really worked hard. These successes are phenomenal. What do you have to say about your current menopausal transition now?”

“I did work hard. I now know it is possible to grow my brain. The *Brain Fitness* exercises brought me back in time to memories of grammar school. It was just as hard to learn new skills then as it is now. It’s only after you really learn something that it becomes easy. If you had not taught me about the importance of brain plasticity and brain functioning, even down to the gene expression level, I don’t think I would have had the faith in myself to try so hard. The fact that my dreams were so involved with this process was amazing. I have so much confidence now that I can learn anything I want.”

“How about your memory? Has it improved to your satisfaction?”

“Memory is interesting. I am great if a memory is meaningful and in an important context. But if it is random, like remembering a list of things in a particular order—well, I’m still in the process of consolidating that. ‘Solid’ is part of ‘con-solid-ating.’ You could say that I am not completely solid in my memory but I am a work in progress.”

“What will you do now to make your memory solid?”

“I am thoroughly enjoying practice, practice, practice, celebrating successes, and being relaxed about the whole thing. When I remember someone’s name, along with the names of their spouses and children, I am so happy. I really try now, after learning something new, to

Table 21.1 Violet’s Improvement with the *Brain Fitness Program*

Category	Skill Set	% Improvement
High/Low	Processing speed	32%
Tell Us Apart	Discriminating sounds	56%
Match It	Sound precision	4%
Sound Replay	Sound sequencing	23%
Listen and Do	Working memory	14%
Story Teller	Narrative memory	22%

plan out how I will share it. My friends are thrilled about all my new learning and are more interested in our conversations than ever before.”

“So, in a nutshell, it seems as though you have transformed your mind-body experience of anxiety into creative energy for improving your memory and growing your brain!”

“Absolutely!” Violet concluded. “And dreams are my friends. Looking for the four stages of the creative process in my dreams allows me a whole new level of bringing the ‘new’ in me alive. Thank you!”

Putting It into Practice

1. Offer a psychotherapeutic reframe via neuroscience.

The neuroscience model can help clients reframe distressing symptoms of change to positive signs of development and growth. With menopause as an example of a psychobiological or mind-body transition, Violet illustrates how understanding the natural dialogue among the mind, brain, and body can help a person normalize and grow through what otherwise could be a distressing period. A neuroscience framework offers clients a way to cooperate with natural processes in creating a better quality of life. It helps for the therapist to keep up-to-date with the growing body of research in this area.

2. Use the four-stage creative process.

Any process of change or transition can herald a period of potential creative growth. What are the signs or indications that your clients are in, or about to enter into, a creative process? For Violet, there were cognitive changes, self-disparagement, fears of losing her mind, and vivid dreams. She was guided through the four stages of creative processing in understanding her dreams and in the therapeutic hypnotic intervention.

- a. *Stage 1: Data Collection.* In this initial stage of the process, clients are faced with the challenge of the transition, collecting the information about what they want, and assessing their potential opportunities. In Violet’s dream, this was the stage of wanting to learn, go to college, and seek out the library.
- b. *Stage 2: Incubation.* Here the client is fully involved in the heart of the problem and, at times, may even seem to be at an impasse—the stage when we need to focus attention to activate gene expression and brain plasticity. Violet’s dream was focused on blackboard math problems. Which way do clients go? Which path do they follow? How are they going to resolve the situation?
- c. *Stage 3: Illumination.* This is a stage of intuition, of enlightenment, of the “aha” experience, of the surprise of discovery—the outcome of which is evident when one has successfully turned on gene expression and brain plasticity. Violet discovered and was surprised by her strengths and resources to solve math problems.

- d. *Stage 4: Verification.* In the final step, clients apply their new insight from stage 3 into their day-to-day life with a developed confidence to continue moving forward, just as Violet's dream discovery empowered her to do.
3. Consider a therapeutic hypnotic intervention with a hand-mirroring process. Since therapeutic hypnosis can be a creative mind-body intervention, it is a logical choice for working with creativity in a psychobiological transition such as menopause. Focusing attention with a hand-mirroring protocol engages the mind-body interaction. As seen with Violet, this can facilitate the discovery of innovative resolutions.

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CHAPTER 22

Can We Play Again?

Applying Positive Psychology Principles in Cognitive-Behavioral Play Therapy

Beth L. Pearson and Tori Sacha Cordiano

MEET THE CONTRIBUTORS

Beth Pearson, PhD, is a graduate of the clinical psychology program at Case Western Reserve University in Cleveland, Ohio. Currently, she is a postdoctoral fellow at The Children's Health Council in Palo Alto, California. While a graduate student, Beth studied processes related to resilience, including pretend play processes and hopeful thinking. For her dissertation, she created a cognitive-behavioral play intervention that aimed to increase preschool children's hope. She continues to be fascinated by the way that an ordinary daily activity such as play can yield so many positive benefits to children. In her future research, she plans to continue the development of play interventions that optimize children's functioning. Clinically, Beth works with both children and adults, in an integrative manner, frequently drawing on the principles of positive psychology.

Tori Sacha Cordiano, MA, is a predoctoral psychology intern at Applewood

Centers, Inc., in Cleveland, Ohio. She graduated in 2009 from Case Western Reserve University's clinical psychology program. Her research focuses on pretend play, creativity, and aspects of child development and parenting. Her clinical interests include child assessment and working with children and families with various mental health issues, including anxiety disorders, mood disorders, and attention and behavior disorders. Tori has provided therapy and assessment services to families within community mental health, pediatric outpatient, and private practice settings. She first became interested in creative processes through teaching dance to young children and frequently uses play and creativity in her work with children and families. Tori hopes to continue her research in the areas of play and positive psychology and is particularly interested in the development of these processes in clinical populations.

David had “told on” his mother for her alleged physical abuse to him and his brother. He was responsible for he and his brother being removed to foster care for six months, for his parents separating, and for all the trouble that followed. Or, at least, that was how it seemed and felt inside the head of this very distressed and unhappy nine-year-old.

David was brought to our inner-city outpatient clinic for therapy by his mother as a continuation of the mandatory counseling and parenting classes she had to attend for the reunification of the family. She was genuinely attempting to shift toward disciplinary strategies (e.g., time-out and privilege removal) instead of the former corporal punishment. While she acknowledged needing continued support in this area, she was also concerned about David’s noncompliance and oppositional behavior at home and in the classroom. He had been given a provisional diagnosis of oppositional defiant disorder prior to meeting me (TSC), but it soon became clear that his mental health needs could not be easily conceptualized by this diagnosis alone.

David was warm and friendly toward me during our first therapy sessions of which a significant portion of the time was spent with him and his mother, gathering information and crafting treatment goals. He appeared amenable to treatment and acknowledged his behavior problems, especially in the classroom. Nonetheless, he obviously felt uneasy, frequently asking such questions as “Am I in trouble?” or “Was that okay to say?” He often needed reassurance that his mother was present and that he was not acting in a way that displeased her.

It seemed we had two prime therapeutic issues.

1. While David’s mother appeared to have adequate knowledge of basic parenting skills, she needed continued work in generalizing these techniques at home, especially when she became overwhelmed by David’s behavior.
2. David’s feelings of anxiety, guilt, and aggression needed to be addressed separately from the parenting work.

A second more detailed psychological evaluation had indicated that David met criteria for a diagnosis of adjustment disorder with mixed disturbance of emotions and conduct and a secondary diagnosis of separation anxiety disorder.

Based on these separate needs, I spent the first portion of most sessions with David and his mother, practicing behavior management techniques to reinforce the parenting skills his mother had learned, and the second portion with David alone. This chapter focuses primarily on my work with David.

David’s behavior changed significantly between these segments of the therapy session. While he remained friendly and engaged when his mother was present, his behavior became distrustful and oppositional when alone with me. Frequently, he would begin to disclose details about his stay in foster care or his feelings about his estranged father, then quickly shift gears and make a statement such as “I don’t want to talk about that; it’s not your business.” His mistrust was apparent in frequent questions, such as “What happens here to kids who are whipped?” and “Who here takes kids away?”

He feared he would again be removed from his mother, blamed himself for his parents’ separation, and felt guilty for having “told on” his mother. He experienced the trauma of separation and significant ongoing anxiety. His coping skills and emotion regulation were quite poor. Additionally, he had very little tolerance for his own affect and became frustrated when he “caught himself” displaying emotions. Striking examples of this occurred when

David would acknowledge sadness or fear at having to live in foster care, then contradict himself, saying “No, it was my fault. I told. I deserved to be there.”

David’s mother was concerned about his poor coping skills in relation to behavior problems at school. When he received even minor criticism, his aggressive behavior would escalate to such a lack of control that the school needed to call her to retrieve him. He possessed a hostile attribution bias that resulted in him instigating fights with other children (some older and significantly bigger than he) following minor incidents. As it seemed important to develop David’s coping and emotion regulation abilities, I planned on using a traditional cognitive-behavior approach that had served me well in addressing these issues with other children in the past.

A FORTUITOUS SHIFT: MOVING TO A POSITIVE-PSYCHOLOGY-BASED COGNITIVE-BEHAVIORAL PLAY THERAPY

David’s mother was continuing to progress with her parenting skills at home, but in therapy, David’s trust in me and our communication did not seem to be improving. I had tried many methods of rapport building at this point, including playing games, drawing, and engaging in structured and unstructured conversations. Although I frequently use pretend play with younger children in session, for several reasons I had not initially tried this approach with David because he was very sensitive to being treated “like a baby” and quickly dismissed many activities as “babyish.” This made me reluctant to introduce puppets or similar types of toys. However, one day, he asked, “Could we play with those?” pointing to a bucket of trucks stored on a high shelf. Instead of continuing with the intervention we had been doing, I agreed and we each chose several trucks for our own. David quickly became interested in crashing his trucks against mine in a very aggressive manner. During one of these crashes, I began to think about the intervention we had been attempting, which was related to appropriate responses to perceived aggression from other children. I had not planned on this happening with the trucks, but the opportunity seemed to present itself. And surely the art of all good therapy is recognizing and utilizing such events as opportunities to move toward the therapeutic goals.

To this end, I vocalized distress on behalf of my truck. “It makes me mad when other trucks crash into me.”

I was pleasantly surprised when David picked up on this thread of conversation and said, “I’m mad at you!”

“Why are you mad at me?” I asked.

“Because I *hate* when people make fun of me!” he responded.

As I was not sure that David would be able to develop an appropriate coping strategy independently at this point in our therapy, I interjected into the play, “Hmmm, I wonder what else you could have done to tell me you were mad at me.”

“Tell you not to make fun of me?” David asked hesitantly while, at the same time, coming up with a more appropriate coping strategy. We continued using the trucks in this manner to discuss why they were angry at each other and how they might deal with that more appropriately.

The following 10 minutes held the best work we had done together thus far. As I reflected on the session afterward, it became clear that rather than talking about David’s

difficulties and teaching him skills directly, engaging in play therapy based in positive psychology principles would be the most appropriate approach. As Seligman (1999) notes, clinical psychology has developed many therapeutic interventions that help eliminate symptoms but until recently has not attended to helping individuals to lead optimal, fulfilling lives. In contrast, a positive psychology approach attempts to build on clients' strengths and enables them to flourish. I hoped, of course, that in using play therapy, David's behavioral problems (e.g., his symptoms) would decrease. Additionally, however, I hoped to develop and expand David's coping skills and resilience, his emotional regulation capacities, his range of positive emotions, and his strengths. Thus, I started to consider incorporating play, cognitive-behavior therapy, and the principles of positive psychology for extending his therapy.

PRETEND PLAY AND POSITIVE PSYCHOLOGY

From a developmental perspective, play is critically important for children's socioemotional and cognitive growth. In a meta-analysis of 46 studies, both correlational and experimental, Fisher (1992) concluded that play results in improvement in children's development. The strongest effect size for pretend play was with perspective taking (the ability to empathically assume another person's point of view) and for ideational fluency (the ability to generate a variety of ideas). In addition, engaging in pretend play has been found to relate to many areas of adaptive functioning (Russ, 2004), not just in reducing problems but also in building a range of different capacities.

One definition of positive psychology is "the study of the conditions and processes that contribute to the flourishing or optimal functioning of people, groups, and institutions" (Gable & Haidt, 2005, p. 104). Pretend play is comprised of a variety of cognitive, affective, and interpersonal processes that can be observed and measured (Russ, 2004). A recent review elaborated on the ways that these pretend play processes relate to areas of optimal functioning, such as creativity, coping, emotion regulation, empathy, emotional understanding, and hope (Pearson, Russ, & Cain Spannagel, 2008)—all core elements of my therapeutic goals with David.

When focusing on pretend play (as opposed to play in general) we are referring to "a symbolic behavior in which one thing is playfully treated *as if* it were something else" (Fein, 1987, p. 282). For example, in pretend, a child might use a shoebox as a doll's bed or a sock to act like a talking puppet. When pretend playing, a child is involved in a number of cognitive, affective, and interpersonal processes, including:

- Organization (telling a story with a logical time sequence)
- Divergent thinking (generating a number of different ideas)
- Symbolism (transforming objects into representations of other objects)
- Fantasy and make-believe (engaging in "as if" play behavior)
- Expression of emotional content themes (reflecting affective processes)
- Comfort and enjoyment in the play experience
- Emotion regulation and modulation (containing the emotion within the narrative)
- Empathy and interpersonal communication
- Interpersonal schema (representing others and trusting in others) (Russ, 2004)

THE BENEFITS OF PLAY THERAPY

Although play has a purpose in the everyday experience of all children, play is also an essential element in helping children in therapeutic situations. Currently, play is used—in one form or another—by the majority of child clinicians (Koocher & D’Angelo, 1992). One reason for this is that children often lack the cognitive and verbal abilities to express what they feel. Play is a mode of revealing (a) what the child has experienced, (b) the child’s feelings and reactions to what was experienced, (c) what the child wants, and (d) the child’s perception of self (Landreth, 2002). According to Erikson (1963), play is a function of the ego used to gain mastery over the self and various parts of life. In play, children can arrange toys any way they like and choose which character to be and how to respond. Erikson draws on Freud’s concept of turning passivity into activity. He describes a child as playing “at doing something that was in reality done to him” (p. 217). In pretend play, the child is the master over a microsphere: “the small world of manageable toys.” That play allows children to control a part of the world and to gain mastery over experiences makes it such a critical aspect of healthy development and an important part of child therapy.

Russ (2004) identifies four broad functions of play within therapy:

1. Play is a means of expressing feelings and thoughts.
2. Play is a form of communication between the child and therapist. When a therapist empathizes and interprets the child’s play, the child feels understood.
3. In some forms of play therapy (psychodynamic but not cognitive-behavior), play can be a vehicle for the experience of insight and working through.
4. Play provides opportunities to practice ideas, behaviors, and verbal expressions in a permissive, nonjudgmental environment.

Play therapy has been found to be effective at helping children manage their distress and increasing adjustment. A meta-analysis of 93 studies focusing on the efficacy of play therapy found a large treatment effect size for children in play therapy compared to children who received no treatment (Bratton, Ray, & Rhine, 2005).

Given all of the benefits that come from play, it is unsurprising that play therapy has a long history. Melanie Klein (1955) and Anna Freud (1966) are credited with first adapting traditional psychoanalytic techniques for children by incorporating play into the sessions. Whereas Anna Freud used play to help establish a therapeutic alliance with her patients, Klein used play as a substitution for verbalizations (Schaefer & O’Connor, 1983). Virginia Axline (1947) modified Carl Rogers’s client-centered approach into child-centered play therapy for children, in which the therapist is nondirective, focusing on conveying empathy and genuineness to allow the child’s natural developmental process to take over (Russ, 2004). Cognitive-behavioral play therapy (CBPT) is a recent addition to the tradition of play therapy (Knell, 1993a, 1998). CBPT modifies both cognitive therapy, as conceptualized by Aaron Beck (e.g., 1976), and traditional behavior therapy by using play as the primary way that therapists convey information to their clients (Knell, 1998).

COGNITIVE-BEHAVIORAL PLAY THERAPY

Seeing the benefits of that transformative session playing with the trucks, I decided to shift from using a traditional cognitive-behavior approach with David to one that incorporated

play. CBPT was designed to be used with children ages 2½ to 6 years of age but can be modified for older children such as David.

Because children may not differentiate between irrational and logical thinking, the cognitive element of CBPT focuses on either modifying thoughts that are maladaptive or increasing adaptive beliefs that may not be present. Some cognitive interventions used in CBPT include recording maladaptive thoughts (by drawing pictures or recording with a tape recorder), generating alternative explanations (guided largely by the therapist), bibliotherapy, self-instruction, and developing and practicing positive self-statements (Knell, 1998).

Based on the behavioral principles of classical conditioning, operant conditioning, and social learning, CBPT utilizes systematic desensitization, contingency management, positive reinforcement, shaping, stimulus fading, extinction, differential reinforcement of other behaviors, self-monitoring, and activity scheduling as the active behavioral interventions (Knell, 1998). All of these behavioral interventions can be demonstrated to the child by a model (e.g., a doll or puppet). In this way, social learning is one of the primary means of helping the child.

CBPT is similar to other play therapies in that it uses play with toys, puppets, and stuffed animals as communication between therapist and child (Knell, 1998). Unlike traditional play therapy, in CBPT, the therapist is not a neutral observer but an active participant. The therapist provides direction, establishes goals, develops interventions that are suited to facilitating those goals, selects the play materials with the child, and provides psychoeducation to the child (Knell, 1998). Overall, CBPT is intended to be a short-term, goal-oriented intervention. Although Knell's CBPT is based on the principles and strategies of cognitive-behavior therapy, an empirically validated treatment approach, it has not yet been compared to other treatments in randomized controlled trials. There is, however, significant evidence from clinical case studies that CBPT can be used to successfully treat children who have selective mutism (Knell, 1993b), separation anxiety (Knell, 1999), anxiety disorders (Knell, 2000; Knell & Dasari, 2006), histories of sexual abuse (Knell & Ruma, 1996, 2003), sleep problems (Knell, 2000), encopresis (Knell & Moore, 1990), acting-out behaviors (Knell, 2000), and adjustment difficulties with parental divorce (Knell, 1993a).

Drawing on the principles of positive psychology, I formulated four prime goals to work on in our therapeutic play:

1. Build appropriate coping skills
2. Strengthen emotional regulation
3. Expand capacity for experiencing positive emotions
4. Find and foster strengths

THE INTERVENTIONS

Building Appropriate Coping Skills

"Can we play with the trucks again?" asked David at the start of our next session.

"Sure," I agreed. As he continued to express a considerable amount of negative affect in his play, I led the discussion toward ways in which the trucks could manage their anger, looking to introduce coping skills directly into the play. "Let's remember some of the other ways our trucks can tell each other they're mad," I interjected.

"I'm *mad* at you!" David's truck told mine. "I'm mad at you because you made fun of me!"

To allow David more control over the play, I asked, “What would you tell your truck to do next time someone made fun of him?”

“He could walk away or he could tell the teacher.”

“Great idea! I think we should try playing with the trucks that way! Maybe your truck could help my truck when someone makes fun of him?”

“Okay!” David responded. He appeared to appreciate being given the “expert” role in the play and went on to share several appropriate coping strategies with my truck.

After playing with the trucks for a while, I brought out a pile of puppets. David was enthusiastic and quickly chose several for him and me to use.

Although David’s mother had improved her parenting skills significantly and appeared sincere in her efforts to provide a loving, stable home for David and his brother, I imagined the family’s road would likely be a bumpy one. I therefore wanted to provide David with as much of an opportunity for healthy developmental outcomes as possible, despite whatever stressors he and his family might confront in the future. Perhaps the puppets could provide an opportunity to draw from positive psychology and help increase his resilience.

Resilience is best seen as an outcome or end product and therefore not directly teachable (Masten, 2001). Good coping skills provide the process or processes for attaining it, and can be taught (Compas, Connor-Smith, Saltzman, Thomsen, & Wadsworth, 2001; Lazarus & Folkman, 1984). A wide range of studies have found pretend play and coping to be positively related (Christiano & Russ, 1996; Goldstein & Russ, 2000–2001; Russ, Robins, & Christiano, 1999).

How could I use David’s interest in the puppets to help him develop his coping skills? Perhaps the puppets could model or teach him strategies such as relaxation exercises and positive self-talk. In previous attempts to teach him these without the use of play, his attention had quickly waned, but, with the puppets, they became a favorite part of our play. His superheroes often swooped in and helped coach my puppet out of difficult situations. Although his solutions were initially more aggressive than appropriate, he responded well to being redirected to try self-talk.

“I know I shouldn’t hit him, but I’m mad!” I would say through my puppet. “What can I tell myself to calm down?”

“Say ‘It isn’t worth me getting in trouble over!’” David’s superhero character would respond.

Using the puppets in this way, a child can create situations that are different and separate from his own (yet related), without directly acknowledging that the issue is personally relevant. It is often easier to work with children symbolically through play characters than through direct conversations about their own thoughts and feelings. David was no exception. Rather than talking about the trouble he had getting along with teachers and classmates at school, we made up stories about puppets that had trouble at school.

“I hate that teacher. I want to beat him up,” a puppet that was being picked on would say.

David’s superhero would swoop in and model coping skills with such comments as “Walk away and practice your deep breathing.” Although initially their behavior was not always appropriate, this opened the opportunity to play out different coping scenarios. While it was the puppets who supposedly were practicing and learning the coping skills, David, of course, was developing a coping repertoire that would help increase his resilience and develop his self-esteem.

Strengthening Emotional Regulation

A second important goal of our therapy was to strengthen David's emotion regulation abilities, given that his adaptive functioning was significantly compromised by his inability to regulate strong negative emotions. As successful regulation of the intensity and duration of feelings and arousal enables people to better reach their goals (Eisenberg & Fabes, 2006), my positively oriented therapeutic approach was aimed not merely at reducing his negative emotions but also at modulating his emotions so that he could reach whatever positive life goals he set for himself. For example, by helping him learn appropriate ways to manage conflict in social situations, he would be likely to make friends more easily in the future. Good social relationships have strong correlates with happiness and well-being, and could further build his resilience.

I had observed that David's mother avoided discussing negative emotions, changing the subject whenever David raised them. Therefore, part of my work with the family included practicing the discussion of negative emotions together. I encouraged his mother to allow David to express whatever feelings he possessed, emphasizing with David that any feeling is okay to have but that the expression of, and behaviors stemming from, our feelings need modulation. To increase his emotion regulation capacities, we spent large portions of the play simply labeling and verbalizing feelings. Allowing David to structure the storyline of our play provided him with a sense of control and mastery that I believe helped strengthen his emotion regulation. He began to "test out" emotions during the play.

"I hate when the other kids pick on me," David said through his puppet.

"Yeah," my puppet agreed. "That makes me feel . . ."

"Mad!" David finished.

In this way, he slowly introduced affect expression into his play and let his guard down in a way he appeared uncomfortable with in normal conversation.

Expanding the Capacity for Experiencing Positive Emotions

Fredrickson's broaden-and-build theory states that positive emotions all "share the ability to broaden people's momentary thought-action repertoires and build their enduring personal resources, ranging from physical and intellectual resources to social and psychological resources" (2001, p. 219). This theory claims that positive affect is associated with more creative, flexible cognitions. Being able to experience pleasure and think broadly and creatively are important aspects of living an optimal life, or "a life worth leading."

One important element of play in broadening positive emotions is that it is intrinsically pleasurable (Segal, 2004). If the activities were not enjoyable, we would not consider them true play. Therefore, each moment spent in play was an opportunity for David to experience pleasure.

"How can our puppets have more fun?" I asked, seeking to help "broaden" his emotional repertoire into more positive feelings.

"If that feels good, how can they do more of it?" I inquired, seeking to "build" his experiencing of positive emotions.

David immersed himself in the moment and truly seemed to enjoy it. When his superhero characters successfully navigated a situation, he was joyous. They even had "dance parties" in celebration!

As David's ability to express and modulate both negative and positive emotions grew, I began to notice that outside of play, he could tolerate more conversations about feelings. We could talk about certain feelings or incidents without his attitude regressing into a stance of mistrust and defiance.

Finding and Fostering Strengths

Play also afforded me the opportunity to notice strengths in David that I had not seen before. When we began therapy, I had been targeting, and trying to talk about, problems directly. In retrospect, this would have made any nine-year-old wary. As I reconceptualized our directions and moved away from problems toward building on his strengths, David felt appreciated. As such, he was better able to demonstrate a variety of resources that had previously been hidden. For example, I learned that while he had been in foster care, he used his imagination to visualize the future, when he would be reunited with his mother. His imagination and ability to generate hope, even in difficult situations, were positive sources of resilience. His capacity for hope strengthened as he learned new strategies through play that could help him reach his life goals in the future.

Another of David's strengths that became apparent through our play-based approach was his innate creativity. Using a wide variety of unstructured toys (trucks, Lego blocks, puppets), he developed imaginative, original stories through which he accessed and expressed his natural creativity. As Erik Erikson (1994) noted, "Children . . . have enormous creativity, and whatever's in them rises to the surface in . . . play" (p. C16). A substantial body of research shows that play is correlated with and facilitates creative processes (see Russ, 1999, 2004; Pearson et al., 2008, for reviews). As David continued to use play in our therapeutic work, his natural creative tendencies were continuing to be enhanced.

Yet another strength was David's fierce, sincere protectiveness of his younger brother. At the start of treatment, David felt guilty that he had "told on" his mother and, as a result, his younger brother spent time in foster care. He further blamed himself for his parents' subsequent separation. Although his guilt was unsurprising, given the egocentric nature of children, who often think they are responsible for their parents' problems, I hoped that it would diminish over the course of our work together. Building on his positive affection toward his brother, I frequently commented on his loyalty to his family, including his parents and his brother. He seemed grateful whenever I acknowledged this strength, and slowly his guilt about the family's separation diminished in association with him gaining a sense of pride in a core aspect of who he was.

Further, while I had initially conceptualized David as having a restricted range of emotions, it became clear over time that his emotional range was actually quite broad. Like many children, he simply was better able to communicate these emotions through play rather than through direct talk. Using the principles of positive psychology, through the medium of CBPT, allowed us to strengthen our therapeutic relationship and enabled his personality strengths to shine rather than to remain hidden.

OUTCOMES

At the time of writing, I had seen David every second week for approximately four months. In that time, he has made steady progress toward the therapy goals. In a recent situation

when he was quick to react angrily to a provocation at school, he reported being aware of his response and removing himself from the situation—just as one of his superhero puppets may have done. His mother shared that David appeared more open and better able to regulate the expression of negative feelings—something I took as a sign that he was more secure in their relationship, less afraid of being separated from her, and perhaps less guilty.

Our therapeutic bond was significantly strengthened through the use of pretend play and a positive psychology conceptualization to our work. David's comfort with feelings blossomed, along with his strengths, creativity, coping capacities, and emotion regulation abilities. These emerging sources of resilience are strong indicators of the power of positive pretend play.

LESSONS LEARNED

I have mentioned some of the things I taught David, but what have I learned from him? They can be broken down into three areas.

1. I approached his case by attempting to “fix” his problems with structured cognitive-behavior interventions. While these are long-established, evidence based, and have worked in many previous cases, it was only when I was met with resistance that I began to conceptualize this case from a positive psychology perspective. Instead of focusing on what needed to be “fixed,” I shifted to exploring how David's strengths could be used to improve his adaptive functioning by building on his natural creativity, enhancing his coping skills, and developing his capacities for emotion regulation. I truly believe this has and will continue to increase his resilience in the future.
2. I have used my experience with David to inform my work with other clients. I have now come to realize that children whom I might have assumed in the past were too old to benefit from play in psychotherapy might have a much easier time expressing emotions and building positive outcomes in this way.
3. Keeping in mind the inherent positive processes within pretend play as mechanisms for change has shed new light on my approach to therapeutic work with children.

Putting It into Practice

1. Set therapeutic goals based on the principles of positive psychology.
David's four prime therapeutic goals were formulated on positive, outcome-oriented principles. Look not at just what needs to be reduced in your young clients but what needs to be built, such as building appropriate coping skills, strengthening emotional regulation, expanding capacity for experiencing positive emotions, and fostering strengths.

2. Consider cognitive-behavioral play therapy (CBPT).

CBPT, a recent addition to the tradition of play therapy, combines both cognitive therapy and behavior therapy by using play as the primary way that therapists interact with and convey information to their clients. Ask yourself how you can offer sound therapeutic interventions through play and playfulness. For David, it was through the medium of trucks and puppets.

3. Build appropriate coping skills.

Play can foster coping skills, and good coping skills provide the processes or means for attaining resilience. What toys interest your clients? How can you use those toys to model or teach your clients more effective coping strategies?

4. Strengthen emotional regulation.

Successful regulation of the intensity and duration of feelings enables both children and adults to better reach their goals. Helping David learn more appropriate ways to regulate his negative feelings and manage conflict in social situations will likely help him make friends more easily in the future. What toys and play can best communicate emotional regulation and improved social skills to your child?

5. Expand positive emotions.

Working on the basis of Fredrickson's broaden-and-build model, I used the intrinsically pleasurable aspects of play to help David build a broader, positive emotional repertoire. Children commonly immerse themselves in play, learning about pleasure, enjoyment, optimal functioning, optimal learning, and being in the moment. David's puppets discovered joyfulness and celebratory "dance parties." This can make therapy fun for you as well as your child client.

6. Find and foster strengths.

Play afforded the opportunity to notice, and seek to develop, strengths in David, such as his ability to generate hope, employ innate creativity, and demonstrate caring protectiveness of his younger brother. Look for, affirm, and utilize the strengths you find emerging in play.

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CHAPTER 23

Inspiring Change

How to Use Tools of Intention for Positive Outcomes

Stephen R. Lankton

MEET THE CONTRIBUTOR

Stephen R. Lankton, MSW, DAHB, is a licensed clinical social worker practicing in Phoenix, Arizona. For the last 30 years he has trained therapists throughout the world and authored 19 books, taught at Arizona State University, and published dozens of professional chapters. He is editor of the *American Journal of Clinical Hypnosis* and a recipient of the Erickson Foundation's Lifetime Achievement Award for Outstanding Contribution to the Field of Psychotherapy. Stephen is a fellow of the American Society of Clinical Hypnosis, American Association for Marriage and Family Therapy,

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Our intentions inspire us. Yet little has been written about using intention to help clients achieve their therapeutic goals. The tools of intention, provided in this chapter, promote positive *experiencing* and not just positive *thinking*. As will be seen in the case of Edgar, the expression of intention by these tools can help clients attract what they want in feelings,

attitudes, and measurable interpersonal goals. Each tool offers a different method for clients to gain the experiences they need, in the contexts they need . . . and thus inspires greater levels of health, happiness, and well-being.

Edgar was a 52-year-old Caucasian male married 10 years with seven-year-old fraternal twins. This was his first marriage and he had no other children. He was in serious financial difficulties and debt. He reported that his wife was very critical about his failure to bring in an income for the last year and a half.

Edgar's chief complaint was his anxiety and almost debilitating stress. This was especially brought to the surface due to the demands of his career. He completed college and law school at Berkeley and had been practicing as an attorney for 18 years. However, he had recently been considering making a career change to go into financial management and was taking classes to complete his credentials in that area. This career change was the result of being called before the Arizona Bar with complaints about his professional conduct, specifically related to completing paperwork and paying attention to detail. There had been a series of three complaints. He was sanctioned with a reprimand and placed on probation. Consequently, he was fearful about opening any correspondence from the bar as he assumed it would be more bad news. As a result, any legal work he performed caused great anxiety and stress.

During the initial assessment interview he said, "My marriage sucks." While not blaming his wife's conduct for his feelings or behavior, he viewed this as yet another of his failures. Edgar came to therapy at his wife's insistence and, in fact, had with him a sealed envelope containing a letter from his wife presumably describing his unacceptable conduct. I did not open the letter and explained to him that she would be welcome to come in and talk to me in person. He said his marriage was poor in communication but he did not want to discuss it further. He did report feeling that he had failed at many things in the past few years, and his affect reflected feelings of anxiety, exasperation, and shame.

Edgar described a controlling and domineering mother to whom he took a passive role. "I could never do enough to gain her approval or praise," he said. This would seem to have resulted in his passive-submissive behavior and low self-esteem. He portrayed his father as passive and avoidant of the client's mother. His parents were financially well off but had never voluntarily helped him, as they had done with his two younger siblings.

The main therapeutic goals for Edgar's initial therapy were to help him immediately reduce the stress caused by his paperwork and in-person commitments so he could attend to the obligations he had in his law practice. Most of his clients' cases were on a contingency basis, which meant his lack of motivation and avoidance of his duties destined him to have no income. This, in turn, left him depressed and anxious and was snowballing into debilitating helplessness. To reverse this growing habit, the therapeutic interventions I taught him were cognitive tools I call *chunking logic* to begin accentuating positive experiences each day. I followed this with an experiential/imagery tool I call *vivid symbolic imagery* to retrieve previously learned (strong) positive experiences that would help him recapture a positive sense of self.

Once he began reversing these debilitating feelings, the next goal was to address his desire to become comfortably assertive. The most important of his unsolved cases involved

an opposing and challenging female counsel. He needed to regain his joy of, and his comfort with, assertiveness—and he especially needed to gain assertiveness toward women he experienced as demanding. These emotions and skills were among his weakest, given the dynamics in his family of origin. The therapeutic interventions I used included building on the previous interventions and amplifying the positive results with two cognitive/experiential tools: *self-image thinking* and *appreciation lists*. I have found these protocols to be useful—even life changing—with hundreds of clients.

Goals regarding his communication with his wife and subsequent marital therapy were postponed until these financially critical matters were put into motion. In fact, some of their marital conflict was the direct result of the very real financial crisis into which he had propelled them. Correcting the behaviors that led to that crisis would ease the marital tension and provide a better picture of problematic marital dynamics at a later time. To this end, I used the tool I call *emanated images*, anticipating it would result in more confidence, self-esteem, and drive.

ABOUT THE INTERVENTIONS

Over the 30 years of my career, I have been drawn to those theories and therapies that found ways to explain human behavior without postulating negative aspects of the human being. I preferred Gestalt therapy to Freudian dynamic theory, Maslow and Rogers to ego analysis, transactional analysis to Gestalt, Ericksonian to transactional analysis. Finally, after studying with Milton Erickson for many years, I found the path I have followed for the last 22 years.

During these years, I have detailed new interventions and steps for these protocols. Subsequently, I have continued to use some of these interventions with nearly every client. Why, you might ask, would I use the same interventions with numerous clients? The answer comes from the heart of my approach. Most people rely on others to control their own feelings. People simply have not learned the impact of their own perceiving, thinking, anticipating, and concentrating. They do not know how they are creating experiences that affect them every minute of every day. And, when it becomes time for change, all they can do is rely on the old methods, steps, and habits that got them in the undesirable situation in the first place. It is insanity for them to persist in doing the same thing over and over while expecting different results.

The interventions I describe are built on the same mental skills that people have come to use to create their understanding, mood, attitude, self-image, and self-fulfilling prophecies. But they are different because they are made conscious and laid out in nearly foolproof steps.

Be aware that each client does not only get the same handful of interventions, but often, regardless of the seemingly unique problems they each face, their stress and lack of satisfaction displays a common need of some fundamental learnings and skills that these interventions and protocols provide. Our social institutions and families lack both an understanding and an ability to train people about how to manage their experiences. The fact that cognitive-behavior therapy, a rudimentary tool of managing experiences with rational thought, has risen in popularity is testimony to how impoverished people are in this area of self-management.

GETTING STARTED

Before the first session begins, each client must complete certain paperwork that provides appropriate demographic information and a signed consent to treatment. Before the end of our first session, the client and I complete and sign a treatment plan. The treatment plan includes four major sections.

1. Two or three sentences state our best summary of the goals. In Edgar's case, these were to reduce anxiety and depression, to gain assertiveness, and to begin tackling the backlog of paperwork in his law practice.
2. A simple discussion with clients provides them initial and basic understanding of the fact that the protocols are voluntary exercises that involve imagery, memory, experience, and conditioning through practice. Their signed initials on each item indicates their informed consent.
3. We decide on a date 60 to 90 days in the future and agree to review the treatment plan on or before that date.
4. We each sign and date the plan.

Clients are informed that, at any time either of us can revisit this plan to improve on it for their benefit.

AN OVERVIEW OF THE INTERVENTIONS

The key feature of these tools and interventions is that they target experience. The target is not simply thinking but rather perceiving, labeling, thinking, anticipating, concentrating, and even obsessing (if you will) in order to have experiences and use them. The manner of using experiences varies from simply recovering and holding onto desired feelings to a more complicated rehearsal and projection of desired feelings in visual rehearsal. It might be necessary to repeat the process with the goal of using these tools—not so much as positive thinking or positive visualization but as reconditioning experience.

For example, if clients come to the office with elevator phobia, they need to leave the office with feelings of comfort, safety, and even nonchalance available in the context of using an elevator. This very goal-oriented and positive approach relies on the ability of clients to revivify an *experiential* memory of each of these desired experiences, hold onto or embrace these experiences, and recondition their occurrence through the use of anticipation and visual rehearsal. With more complicated situations such as the one Edgar finds himself in, the same principles apply but the pathway to success will require more twists and turns than in the case of simple phobias.

Chunking Logic

Chunking logic is a term that I apply to the act of noticing and labeling ongoing daily experiences. Applying appropriate chunking logic is a matter of learning to monitor one's observations and judgments that label events and eventually learn to actively seek ongoing moments of experience that will maintain positive and delightful feelings. Happiness is in

large part determined by the chunking logic that individuals apply to reality. Almost any event can be judged to be positive or negative, and any of these positives and negatives can be discounted or made more grandiose by our thinking process.

While it is true that the death of a loved one is most likely going to be a negative event (and the same would be true for acts of violence, etc.), such calamities do not occur on a daily basis. In fact, they occur for most of us rather rarely. On a daily basis, fortunately, there are hundreds, perhaps thousands of events that we can and do interpret and experience as an act of free will. It is rather striking how this goes unnoticed by so many people throughout the day. In general, people, especially our clients, ignore uncountable opportunities to experience the world afresh, beautiful, calm, safe, and happy. Instead, they experience it totally opposite, and usually gather increasing stress that they unselfishly share with others. Learning chunking logic and making it as habitual as our thinking is an important step not just in establishing mental health but also in learning to be stress free and happy.

To introduce Edgar to this process, I took a deck of cards from my drawer and began by saying “I want to start by showing you something that’s an analogy to the way you think. This is the first time you have been in my office so you haven’t seen the card trick yet, have you?”

“No, I can’t say that I have,” said Edgar, giving a small chuckle. “But it looks like I’m going to.”

“This is a card trick called the Svengali deck,” I continued. “It is a real crowd-pleaser, as they say. I usually do it in groups of professionals in training because I want to make a point to them about how people think. I’m just going to fan through the deck and show you that it’s a normal deck of cards.”

“Okay. It looks like it, but I’m sure it’s a trick deck of some kind,” Edgar responded skeptically.

“Well, all you saw were random cards, right?” Edgar nods. “Now I’m going to fan through the deck slowly and at any point you tell me to stop. I’m going to pull out the card that we stopped on and we are going to say that card is symbolic of your *positive experience*.”

“Stop.”

Turning over the next card, I said, “Well, here you are. This is the king of clubs . . . so this represents your positive experience. I’ll put that here in my pocket. Here is how it is an analogy to your thinking. Every memory you have is negative like the cards in the deck and this one card, the king of clubs, is your only positive experience and memory.”

“Okay, I see what you mean,” Edgar said, chuckling again.

“Oh, but wait. I haven’t even begun yet. You didn’t know that there were other positive memories and experiences to be found . . . watch.” I cut the deck again and pull out *another* king of clubs and put it in my pocket. “Let me fan the deck again and show you that the king of clubs is gone. Right?”

Watching the cards carefully now, Edgar said, “Right” a little doubtfully.

“Are you sure?” I pressed.

He laughed “No, not anymore.”

“Exactly, and that is why this is analogous to how you think.” I pulled out yet another king of clubs, put it in my pocket, and then repeated this three more times—each time fanning the deck to Edgar so he could see there were no more kings of clubs present.

“Okay, I give up,” said Edgar. “Are you going to tell me how you do that?”

“There are 52 cards in the deck but the king of clubs is every other card and there are 26 of them. The other 26 cards are random. But the *trick* is that the normal, random cards are slightly larger than the 26 kings of clubs. So when I fan the cards, my thumb catches the higher cards and the shorter, kings of clubs cards fall facedown against the random cards. They fall so quickly they can’t be seen. The fanned deck appears to be random cards with no king of clubs. Yet there are 26 of them! This is how memory works. Here’s the connection: Sorting through your memories, your mind will bump into the large chunks of memory. If your large memories are negative and your positive memories are small, you will be depressed and lack the resources for success.

“Imagine that the memory of your life is just the same as the card trick. You could have half of your life very negative and half of your life very positive. I suppose that statistically that might be about right. Yet if you chunk the many positive experiences as insignificant and the fewer negative experiences as paramount, you will recall only the large negative experiences when you reflect on your life. Alternatively, if you categorize the positives as very significant, large chunks of experience, and you reduce the significance of the negative times, you will be happy and confident as you reflect on your life.

“Only the large memories will stand out. These can be the negatives or the positives. It is up to each person. And most events lend themselves to either interpretation. There are always four possibilities: large or small positive, and large or small negative labeling of events.

“Life presents us with a zillion experiences, and we get to frame them, label them, or categorize them. If there is a crack in the car windshield, we can say, ‘Oh no, the car is ruined’ and drive around obsessing that we will get ticketed. That is taking the experience and making it a large negative card in our deck. And the fact that it is a terrific day and we can drive slowly and pass lovely smelling blooms alongside the road—those things we fail to think are important—and they become small cards in our memory deck. When we do that all day long, everyday, pretty soon we find only negative, stress-producing memory. And guess what? We will be depressed.”

“Yeah, that makes a lot of sense,” Edgar said thoughtfully.

“Edgar, that’s what you’ve been doing at least since the Arizona Bar contacted you and maybe even before that. You’ve got to turn that pattern around.”

“You’re right. You are absolutely right,” he announced, giving a short example of how he failed to enjoy a recent weekend vacation with his children.

“Great,” I affirmed. “You’ve got the idea. Now, what do I have to do to get you to start applying this attitude on a daily basis?”

“You know what? I get it! I need to do this.”

Vivid Symbolic Imagery

Vivid symbolic imagery refers to a use of conscious intention. When people dwell on a memory or an event, they are making a vivid symbolic image of that event. This symbolic image affects different experiences over time. At first, the imagery will remind the people of the feeling they had during the event. Upon further rumination over days or weeks, the symbolic imagery will alter their self-image. Initially, their self-image will change to “this is one of my feelings,” and later the self-image will become defined by this feeling. For example, the champ who drops the potentially winning pass at a football game will feel disappointed whenever he remembers the vivid symbolic imagery of that event. If he

continues to obsess about it, within a matter of a few days or weeks, the bad feeling that he gets by remembering it will become a part of himself. Furthermore, if he continues to ruminate or obsess about it for a month or two, he will begin to alter his self-image even more to the point where he thinks “I am a disappointment” or “I am a loser.”

This is how the mind handles remembering, ruminating, or even obsessing about a vivid symbolic image. Those activities will retrieve the feeling and even forge it into part of people’s self-image. Why not then use this common mental skill for positive vivid imagery? By doing so, people can move beyond simple chunking logic and amplify their ability to reduce stress. In fact, they can deliberately shape a major part of their self-concept and self-image. People often achieve feelings of success, but they too often leave them in the past and move on to new obligations. I do not know where in cultural history our civilization learned to build and learn useful feelings simply to put them aside and forget about them. Doing that is a guaranteed method to increase stress. Building habits for finding and appreciating these feelings of success, calm, courage, health, love, and the like, however, is a necessary step for everyone who wants to be more stress free, effective, and happy.

Wanting to access and activate Edgar’s vivid symbolic imagery, I suggested, “Let yourself sit back and relax. Then for just a moment, think about this: When have you had attitudes or feelings that are part of who you want to be? Or, what is one of the desirable feelings that you want to have as part of your self-image for your ongoing life? Take just a moment and select one or two. When you’ve decided on one, let me know.”

Edgar nodded. “Okay.”

“Now think of a time in the past during which you had that experience . . . maybe the time you first learned it or had it . . . and let me know when you remember.” Edgar nodded again. “Great. Now, when reviewing those memories pick a single moment that really symbolizes the best of it.

After a minute or two passed, Edgar again nodded. “Okay.”

He accessed and described a great deal of positive experiences during his student days at Berkeley. The images he had of those times were to become his vivid symbolic images.

“Terrific, Edgar. Now, put yourself in the picture, if you are not already in it. Then I want you to reach your hands out and cup your hands like you’re reaching for something you hope to receive. Okay, now put the symbolic image in your hands and concentrate on every large and small detail of the image. Be sure to look at your face in the picture too. Keep making the symbolic image more vivid, and relaxing into it, until you start to again feel the feeling it represents.” I pause for a long time. “Now I want you to nod when you really feel the feeling again.” After another two- or three-minute pause, Edgar nodded. “Great. Now just keep feeling it, enjoy it, let it spread over your face and torso, intensify it. The goal is to be unshamed about recapturing it and making it yours. . . . After all, you learned it and so you’ve earned it.”

Instead of ruminating on his frightening letters from the Arizona Bar, he started “ruminating” on these symbols of his success, assertiveness, confidence, and pride. He was, of course, able to revivify these in sufficient detail to reexperience his confidence and assertiveness.

Self-Image Thinking

Self-image thinking is a more elaborate mental pattern than vivid symbolic imagery. Since 1979, I have written about this specific protocol for identifying and retrieving desired feelings, attitudes, and experiences and systematically anticipating using these resources

(Lankton & Lankton, 1980, 2008). This is also a method that is commonly used by almost everyone. Typically, when a person dreads an upcoming situation, he or she will imagine being in that future situation while experiencing a feeling of dread. The practice of this anticipation strongly increases the likelihood of actually having the feeling of dread in the future situation. (In the previous sentences, you could change the word *dread* to *anxiety*, *depression*, *fear*, *anger*, and so on.)

We have not taught our clients and our children that the activity of doing this experiential anticipation and rehearsal creates a self-fulfilling prophecy that increases the likelihood of having the negative feeling in the future. In fact, it almost guarantees it. The self-image thinking protocol is a powerful tool that clients can learn so they can use chunking logic and vivid symbolic imagery, as well as other deliberately chosen and revived positive experiences, to create a self-fulfilling prophecy for their success. At the very least, using positive experiences in these anticipatory rehearsals will increase the likelihood that they will have positive experiences in those future situations.

In our next session, I asked Edgar to do three things:

1. Experience and hold on to the positive feelings.
2. See an image of himself feeling them.
3. Change the background of the scene to reflect him being assertive with the female opposing counsel.

For 35 to 40 minutes, we did this experiential and visual rehearsal for the half-dozen confrontations he expected to have with her. As he anticipated the contact with her, I asked him to consider what he would say, feeling this way, and to rehearse his conversations. While we were on that theme, I also had him imagine being assertive and speaking to his mother and finally to his wife. In this latter imagination rehearsal, I asked him to stand up to his wife's challenges with his experience of being confident and assertive and to speak up for his desire for her support instead of her criticism. As well as explaining and rehearsing this tool with him, I also gave him one of my books with the steps to self-image thinking and vivid symbolic imagery clearly articulated along with chunking logic and nine other protocols (Lankton, 2008). He vowed to practice and rehearse them two or three times a day.

Appreciation Lists

Appreciation lists are a simple idea that many readers will have encountered in the past. The practice is simply to spend a few minutes at bedtime making a list of 6 to 10 moments throughout the day that you appreciated for some reason or another. You could have appreciated someone else's kindness, the pleasure or beauty of something in a moment when you chose to use chunking logic, or even your own choice of action. It could be remembering a smile on a child's face, the happiness of a coworker, the wink of a spouse, or the sound of a bird. The actual content of what you appreciated is immaterial. The important part of making appreciation lists is that you deliberately set out to write down your memory of what you appreciated during the day. Once clients become more skilled at keeping appreciation lists, I ask that they try to write down 12 to 20 items. Finally, upon awakening in the morning, I ask clients to recall the items written down on the list the previous night.

Initially, clients remember only about half of the items they have written on the list. However, over a period of a week or two, people will begin to remember almost all of the

items written down the night before. An interesting outcome of this exercise is that clients begin the day thinking about things they appreciate. This sets the stage nicely for using appropriate chunking logic throughout the day and makes it easier to do vivid symbolic imagery and self-image exercises.

Putting this into practice is straightforward: I simply asked Edgar to write appreciation lists nightly so he could begin the process of experiencing more of his days as positive.

Before two weeks had passed, he reported a significant change in his attitude about work. “I have been very assertive in the last two weeks,” he announced. “I have filed a few briefs that I had been avoiding. I also spoke with opposing counsel. When she said I was not adequately addressing the details of the case, I told her that I was and that we could let the judge decide the issue when I see her in court!” He further related that he told his wife to stop criticizing him as he was now doing everything that a lawyer could do to bring his cases to fruition.

By week 4, Edgar expressed the opinion that he had fully and competently addressed the problems in the case with the female opposing counsel and he was confident that he would win. He had several other cases that had required his attention (and for which he would be paid only if they won). He reported that he had caught up with his paperwork with each of them. He also had begun returning phone calls to new prospective clients. Still, the situation with his wife had not yet improved sufficiently. She wanted to review his e-mails and open a bank account for herself into which some of his income would be funneled, and continued to criticize him nightly.

Emanated Images

Emanated images is an interesting method of creating a positive presupposition about the future. If you think about the set of interventions listed so far, four points may become obvious:

1. Chunking logic is about the here and now.
2. Vivid symbolic imagery concerns orienting to the potentially distant past.
3. Appreciation lists are oriented to the recent past and the immediate future.
4. Self-image thinking is a tool oriented to the near or distant future.

Emanated images, however, are tools that reverse-engineer a future success. In short, clients are asked to imagine being in the future surrounded by success in every area. From this imagined future, clients are urged to think back to the past (actually, the present day) and think through the steps that brought them from that past to this successful future that they are experiencing in the here and now. In the process of doing an emanated image exercise, people will think through difficulties that they encountered along the way to their success. However, they will have conditioned the positive feeling of success to these difficulties (which have not yet occurred) so that when, or if, they actually do encounter the difficulty, they have already framed it as a positive step toward their success.

I asked Edgar on week 5 to do an extensive emanated image exercise by becoming relaxed, mindful of his breathing, and then pretending—in vivid detail—that he was in the future. Specifically, I asked him to be in 2011.

“Edgar,” I began, “let yourself relax and become mindful of your breathing. Do a vivid symbolic imagery exercise to fill yourself with positive feelings. . . . Now imagine and

pretend that we are two years in the future and, in this special way, I want you to be here with me in 2011 fully surrounded with your success . . . and I'm going to speak like we are in 2011. Let your face and your body be filled with the joy of your success. Remember, you have won that large legal case. Your friends are happy to be around you, your wife is happy, and your kids are oblivious and joyful as they should be. You are healthy, the weather is terrific, and the Arizona Bar has exonerated you of any wrongdoing. Let me know, by nodding your head, that you are here in 2011 with those great feelings you have worked for and earned."

In a few minutes Edgar nodded.

"Now, hold on to the feeling you have worked so hard to earn. I want you to think back to 2009—back to last sitting in my office. At that time, you had a number of uphill battles to overcome. I would like you to think back to six things you did between 2009 and now that you did to improve your marital communication." I paused for several minutes. "Now think back to 2009 and recall the steps you took to improve your responsiveness with clients so they are now satisfied. (Another long pause.) Now think back to the steps you took to report successfully to the Arizona Bar. Think about the risks you took. Consider the sure steps you made. Remember the false starts and dead-ends that you took. Remember the things you did that were real payoffs and had value."

This session took the entire hour. Edgar was again encouraged to continue his homework, which consisted of writing appreciation lists, vivid symbolic imagery, self-image thinking, and even emanated images.

THE OUTCOME

On week 6, Edgar reported that his opposing counsel had admitted that she would lose the case—although it still had to go before a judge. He was, therefore, destined to make about \$400,000 from this judgment in the next few months. As a result of his assertive behavior toward her, his wife had become more encouraging and supportive. While he was not yet certain that the marital communication and support was secure, it was nonetheless a refreshing change. In turn, Edgar was vibrant, happy, and showed no signs of his original depression.

I saw Edgar for four more weeks. Primarily, he continued because he could not really believe that he was feeling so optimistic so easily. But this is a statement of our current situation in mental health. Both the pharmaceutical industry and medical practice seem to promote an image of disempowerment to us. We are not taught the richness of human experience. Commonly, we are seen as simply the result of chemistry or conditioning, when we are complex self-determining organisms. Teaching clients only a few tools that empower them to direct and use their experience as they intend can result in profound change. This is why the field of positive psychotherapy is essential to the empowerment and vitalization of our culture.

Edgar contacted me nine weeks later. He had won the case and received the financial settlement. The change in his economic situation and his assertiveness resulted in a 180-degree change in his marital communication. And he was taking the final steps to settle a new case that would bring him a continuous income and allow him actually to retire from law. Needless to say, he was very happy and grateful to have learned how to use his mind and experiences for his own gain.

But what if the outcome had not been as fortuitous as this? What if he had not won the case, achieved financial security, or gained the support of his wife? Would he still have been happy? And could he have maintained that in the long term? As these questions are hypothetical, there obviously are no answers, but, nonetheless, they are important questions. Therapy was not directed toward an end goal of financial success but rather toward using the tools of intention to get the experiences Edgar needed in the contexts he needed them. This is what constitutes health, happiness, and well-being—whether the outcome was as he desired or not. The simple fact is that life does not always go the way we plan, imagine, or dream it will, as Edgar was experiencing prior to therapy. We need the means to cope with that possibility and also the tools to work toward our intended destiny. If Edgar had lost his case, he would still have gained valuable skills that he could employ to enhance both his current and future well-being. He was a talented man who, when enabled with these resources, could free up his talents. In this way, he is like so many of our clients whose lives unfold more favorably when they are allowed to truly express their intentions.

Putting It into Practice

1. Formulate a treatment plan. This should include:
 - a. Summary of the therapeutic goals
 - b. An initial, basic understanding of the treatment protocols
 - c. An agreed date to review the treatment plan
 - d. Signing of the plan
2. Explain and engage chunking logic.

Help clients become aware of and observe the way they notice and label their ongoing daily experiences. By doing so, they will learn to actively seek ongoing moments of experience that will maintain positive and delightful feelings. Happiness is, in large part, determined by the chunking logic that people apply to reality. For Edgar, this was demonstrated by the Svengali deck of cards.
3. Elicit vivid symbolic imagery.

Inquire about your clients' positive symbolic images. Such images can affect different experiences over time and will begin to alter self-image. Edgar described positive experiences from his student days that were to become his vivid symbolic images. Instead of ruminating on anticipated frightening letters, he started ruminating on these symbols of his success, assertiveness, confidence, and pride.
4. Identify, retrieve, and use self-image thinking.

This specific protocol is for identifying and retrieving desired feelings, attitudes, and experiences, and systematically anticipating using these resources. Anticipation strongly increases the likelihood of actually having the anticipated feeling in future situations. To use this therapeutically, invite your clients to:

(Continued)

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- a. Visualize their positive symbolic image(s) until they experience the desired feeling.
 - b. See themselves feeling those feelings.
 - c. Change the background of the scene to the desired outcome.
 - d. Have them practice this experiential and visual rehearsal.
5. Build appreciation lists.

As illustrated in Edgar's case, invite your clients to spend a few minutes at bedtime making a list of 6 to 10 moments throughout the day that they appreciated for some reason or another. It is a simple yet powerful tool.

6. Create emanated images.

Ask your clients to imagine being in the future surrounded by success in every area. From this imagined future, urge them to think back to the past (actually, the present day) and step through what brought them from that past to this successful future that they are experiencing in the here and now. In the process of creating an emanated image, people will think through difficulties that they encountered along the way to their success and frame them as positive steps toward their success.

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CHAPTER 24

A Positive Way of Addressing Negatives

Using Strengths-Based Interventions in Coaching and Therapy

Robert Biswas-Diener

MEET THE CONTRIBUTOR

Robert Biswas-Diener is widely known as the Indiana Jones of Positive Psychology because his research in subjective well-being has taken him to such far-flung destinations as Greenland, Kenya, and India. He has published more than two dozen articles and chapters on happiness and strengths in peer-reviewed books and journals. Robert serves on the editorial boards of the *Journal of Positive Psychology*, the *Journal of Happiness Studies*,

and *Coaching*. He is the program director for Education & Learning at the United Kingdom-based Centre for Applied Positive Psychology and is also part-time lecturer at Portland State University in Portland, Oregon. Robert is author of *Positive Psychology Coaching* and co-author of *Happiness: Unlocking the Mysteries of Psychological Wealth*, which won the 2008 PROSE award for excellence in academic publishing.

“I feel unmoored. . . . Like I am floating in space,” Linda told me on our first meeting. Her feeling was understandable. After working as a regional sales manager for a national construction firm for six and a half years, Linda had been laid off due to economic trends outside her direct control. A 36-year-old high school graduate, Linda initially came to see me because she wanted help “planning the next steps.” She was divorced with no children and not currently in a romantic relationship. In our initial meeting, Linda expressed an urgent need to find a job and reported feeling “stressed out” but did not present with symptoms of clinically significant mood or anxiety disorders. She appeared intelligent,

articulate, and highly motivated. Linda established her desired outcome from our relationship: She wanted to “explore” her sense of mission and values so that she could use the period without work to plan her “dream life.” Although she had a positive attitude toward her future, the economic and work pressures she experienced often interfered with her ability to maintain a positive focus. Her case presents an interesting challenge: What do you do when you take a positive, strengths-based approach and your client does not respond as positively as anticipated, deflecting or even rejecting it?

It is an exciting time to be in the helping professions. As therapists, coaches, psychologists, psychiatrists, and others who deliver counseling related services, we live in a period where we have more professional tools available to us than at any time in history. Advances in psychopharmacology have translated to more effective drug-based interventions for mental disorders. Advances in technology have resulted in a variety of new delivery methods for counseling, such as online and telecounseling (Jerome et al., 2000). A trend toward more eclectic psychotherapy orientations has largely meant the death of old feuds over professional turf and led to more flexibility and creativity in treating mental illness (Norcross & Goldfried, 2005). While time and empirical study ultimately will decide whether these changes are substantive improvements, there can be little question that, as professionals, we are in a period of enormous transition. This can be seen especially well in the example of positive psychology. The advent of new theories, research, assessment, and intervention in positive psychology is a paradigm shift for the field of psychology.

Positive psychology is the scientific study of human flourishing as opposed to mental illness (Snyder & Lopez, 2007). In its earliest incarnation, positive psychology was cobbled together from a group of social and clinical psychologists conducting research on positive topics such as genius, happiness, and hope. The early emphasis was on establishing positive psychology as a separate (but related) and legitimate program of scientific research (Seligman & Csikszentmihalyi, 2000). Because it includes the study of subjective well-being, flow, optimism, and other positive aspects of human psychology, positive psychology promises applications relevant to both clinical and nonclinical populations. Indeed, positive psychology assessments and interventions are already being used in organizations (Fredrickson, 2003) and coaching (Biswas-Diener & Dean, 2007) and are beginning to be used in therapy (Joseph & Linley, 2006). Positive interventions generally are considered to be those that:

- Harness the therapeutic value of focusing on positives, such as solution-focused therapy (e.g., De Jong & Berg, 2002)
- Take a fundamentally positive view of human nature, such as humanistic therapies (e.g., Rogers, 1980)
- Focus on nonclinical concerns, such as happiness interventions (e.g., Lyubomirsky, 2008)

In this chapter, I present a single area of positive psychology theory and research: strengths. I describe background theory of strengths development and recent research on strengths assessment and intervention. I use a case study to illustrate working with strengths in a professional relationship and, in a larger sense, highlight the promise of positive psychology itself. I focus on advanced issues related to using a strengths focus; specifically, on dealing with client deflection of strengths interventions. Finally, I discuss some of the limitations and future directions of strengths-based interventions.

WHAT ARE STRENGTHS?

Before going further, however, it is important to ask what we mean when we speak about strengths. Linley (2008) defines strengths as “a pre-existing capacity for a particular way of behaving, thinking, or feeling that is authentic and energizing to the user, and enables optimal functioning, development, and performance” (p. 9). That is, strengths are not aspirations but are traits that are authentic to the user, generate enthusiasm when employed, and lead to desirable outcomes. Strengths are innate resources, such as creativity, charisma, and curiosity, that come naturally and easily to a person and to which success in life can easily be attributed. A sense of “energy”—linguistic shorthand for biological and affective arousal and increased motivation—is frequently cited as a hallmark characteristic of strengths. In addition to Linley, for example, Buckingham and Clifton (2001) say that strengths often can be identified, in part, by the joy, satisfaction, and sense of engagement that come with using them. This idea, that working with a person’s—or group’s—best qualities can elicit enthusiasm and motivation, is also central to the appreciative inquiry (AI) process (Cooperrider, Whitney, & Stavros, 2008). In more behavioral terms, an emphasis on the identification, development, and proper use of personal strengths is associated with higher productivity and better job performance (Clifton & Harter, 2003).

So-called strengths psychology has its intellectual roots in the personality psychology of the 20th century. Allport (1966) was among the first scientists to categorize descriptive personal traits and suggest that they might be useful in distinguishing people from one another. Cattell (1945) took Allport’s enormous list of characteristics and reduced them to 16 dichotomous pairings, such as “outgoing-reserved” and “conscientious-impulsive.” Cattell’s research was an early scientific effort to identify psychological characteristics that were positive and functional. Former Gallup chief executive officer Don Clifton, sometimes referred to as the “father of modern strengths psychology,” includes a focus on strengths as an essential part of organizational intervention and leadership development (Buckingham & Clifton, 2001). In the modern positive psychology movement, many researchers have attended to strengths as a potentially fruitful area of research and intervention. For example, Peterson and Seligman (2004) created the Values in Action (VIA) classification of strengths as an intellectual counterpoint to the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994). To the extent that positive psychology is about addressing what is “right” rather than what is “wrong” with people, the VIA provides a taxonomy for identifying individual strengths that are widely culturally valued (Biswas-Diener, 2006).

HOW MIGHT STRENGTHS BE USED THERAPEUTICALLY?

Recently, I led a positive psychology training of more than 100 psychiatrists and psychologists. I began by asking a simple question: How many of you believe that it is appropriate to discuss your client’s strengths with your client during a session? Only half of the people present raised their hands. Although it may seem alarming that many practitioners do not see the therapeutic value of strengths, it is also to be expected. There is a natural tendency for us to focus on problems (Rozin & Royzman, 2001), be vigilant for dangers (Baumeister, Bratslavsky, Finkenauer, & Vohs, 2001), and avoid risks (Kahneman & Tversky, 2003). Linley (2008) suggests that people believe their areas of weakness are their greatest areas for

growth or their problems feel too pressing to attend to strengths development. However, Linley also argues that although we are naturally predisposed to a negativity bias, it “leaves us with a significant opportunity cost—the cost of failing to pay attention to, identify and build on what works” (p. 53). Indeed, many seasoned practitioners will recognize that humor, client resources, and measurements of progress have their place alongside traditional foci on diagnoses, early life traumas, and other negative aspects of human functioning. It is on the basis of this more holistic conceptualization of clients that positive psychology pioneers have begun testing strengths-based interventions.

Although positive psychology is a nascent field, and strengths interventions in the clinical setting are fairly rudimentary, there is data to suggest that this may be an effective approach to treatment and merits further attention. Seligman, Rashid, and Parks (2006), for example, tested what they call positive psychotherapy (PPT), which emphasized the use of strengths, gratitude, savoring, and other positive interventions. They present this rationale for attention to positive factors:

On the one hand, patients have long been socialized into believing that therapy entails talking about troubles. Any perceived failure to take their troubles seriously violates these expectations and can undermine good rapport.

On the other hand . . . at the very onset of CBT [cognitive-behavior therapy], the therapist asks clients to record their pessimistic, self-critical, and globally negative thoughts and then helps them to identify how such thinking causes and maintains depression.

From the onset, PPT, in contrast, builds a congenial and positive relationship by asking clients to introduce themselves through telling a real-life story that shows them at their best. This is followed by clients’ identifying signature strengths and the therapist coaching them to find practical ways of using these strengths more often (Seligman et al., 2006, p. 780).

Seligman et al. (2006) found that when PPT was used in group therapy for individuals with mild to moderate depression, those clients showed significantly lower scores on the Beck Depression Inventory (BDI; Beck & Steer, 1992) than people in a no-treatment control group. Although a no-treatment comparison group does not offer the most compelling evidence of efficacy, it is worth noting that the individuals in the PPT group reported consistently decreasing BDI scores (lower indicates less depression) at three months, six months, and one year. In a second study of individual counseling with people suffering severe unipolar depression, Seligman and his colleagues found that PPT led to significantly lower depression and outperformed both “treatment as usual” and “therapy plus antidepressant medication” groups. While these studies represent a limited sample and a single piece of evidence, they offer encouragement for a further exploration of strengths-based clinical interventions.

A second source of data suggestive of the clinical potential of strengths interventions comes from using the VIA assessment of strengths with a nondepressed, nonclinical sample. Seligman and colleagues assigned research participants to either a strengths intervention condition or a no-treatment control condition. One of the strengths interventions was “identify your strengths,” in which participants simply completed the online VIA questionnaire and received feedback on their “top five signature strengths.” Another such intervention instructed participants to use strengths in a new way every day for one week. The results of their study revealed that the “using strengths” intervention increased happiness and decreased scores on the BDI one, three, and six months posttreatment. Seligman and his colleagues (2005) conclude:

We found that the participants who continued to benefit from the [use your strengths exercise] were those people who spontaneously did them beyond the required one-week period, without our instruction to do so.

We believe that these two interventions [using your strengths and expressing gratitude] involve skills that improve with practice, that are fun, and that thus are self-maintaining. Unlike many therapeutic outcomes, such as weight loss from dieting, these exercises are self-reinforcing (p. 420).

Finally, it is worth noting that the positive perspective inherent to strengths interventions is likely to have an effect on the therapist as well as the client. Linley and Joseph (2007), for example, analyzed the reported burnout and feelings of personal growth of 156 therapists. They found that the number of years in practice was positively associated with greater feelings of burnout and that growth varied by professional training, such that humanistic psychotherapists were more likely to report growth than were cognitive-behavior therapists. Although it is a premise requiring empirical support, it is possible that a positive, strengths-based approach might protect therapists from burnout by giving them professional growth opportunities or by focusing their attention on successes as well as on problems and failures.

THE CASE OF LINDA

In the interest of full disclosure, I should point out that I practice as a professional and executive coach rather than as a psychotherapist. Although coaching and counseling may look similar to the uninitiated, there are large and important differences between these two ways of working with clients. The most obvious differences are the clientele and purpose of the work. Historically, coaching clients are high-functioning individuals and relatively free of chronic psychopathology. Further, coaching often is viewed as a cognitive-behavioral method to enhance performance. That is, the work of coaching is fundamentally about building motivation and skills and not about the treatment of mental disorders. I have argued elsewhere (Biswas-Diener, 2009) that many coaching interventions are directly transferable and relevant to clinical practice. You will note in this case that although Linda did not present with a diagnosable mood or anxiety disorder, she did complain of worry related to loss of income, struggled with identity issues, and had a tendency to lapse into pessimism, all concerns that overlap with traditional therapy.

Establishing Trust and Rapport

In the initial session, I used empathic responding to establish trust and rapport with Linda. However, I also remained vigilant for any mention or show of personal strengths. I was wary of being drawn too deeply into “problem talk” and was eager to establish our relationship as a venue where personal successes were discussed and celebrated.

LINDA: I feel unmoored. . . . Like I am floating in space. I’m just not really used to not having a job. I have always had a job and I hardly know what to do with myself.

COACH: You enjoy work.

- LINDA: Oh, definitely! I work hard. I have always been the first-in, last-to-leave type person.
Now I'm—
- COACH (interrupting): I really admire that! It sounds like you have a terrific work ethic.
- LINDA: I suppose so.
- COACH: How are you using that same work ethic in your hunt for a new job?
- LINDA (thinking): Ummmmm I'm not.
- COACH: But you sound proud of being a hard worker.
- LINDA: I am!
- COACH: What could you be doing right now to capitalize on that—that sense of determination and motivation?
- LINDA: I'm not sure.
- COACH: Well, what are you doing to look for a new job?
- LINDA: You'll laugh at me, but I am going to these fancy dinners and events because I know that's where some of the people are who could hire me. I'm networking, I guess.
- COACH: Oh ho! So not only are you a hard worker, but you have some social savvy; you are a networker.
- LINDA: You have to be.

You'll notice that in this first session, I attempted to label as many different strengths as possible: work ethic, determination, motivation, social savvy, networker. I was operating from a fundamental assumption that the answer to Linda's problems lay, at least in part, in her best attributes. However, Linda—focused heavily on her problems—was slow to accept the labels, answering with statements such as “I suppose so” or deflecting personal credit with statements such as “you have to be [a networker].” Speaking openly about personal strengths is often awkward for people and can be especially difficult for clients because their attention is naturally so drawn toward risk, deficits, and problems.

While there is good evidence of the relationship between strengths and well-being, and good reasons for the application of strength-based approaches in coaching and therapy (see Linley and Burns, Chapter 1, this volume), what do you do if your client, like Linda, is reluctant to accept, or is even rejecting of, the labeling and highlighting of strengths? There may be many long-established cultural, religious, or individual bases for why people are self-effacing, have difficulty in accepting compliments, and are reluctant to acknowledge strengths. For clients who experience primary or secondary problems of depression—the major percentage of any therapeutic clientele—this is particularly so. In fact, in this area there is a paradox. Learning to acknowledge and use strengths is likely to build depression-alleviating qualities such as self-esteem, hope, pleasure, engagement, and meaning. However, when a person is depressed, he or she is prone to being self-effacing, if not self-derogatory, and therefore less likely to accept the labeling of strengths.

So how do you handle a situation, such as the one with Linda, wherein a client may gain from a strengths-based intervention but is deflecting or rejecting of it? Let me offer five suggestions:

1. *Offer the rationale.* At times, explaining the reasons for, and advantages of, focusing on strengths can be helpful, especially for high-functioning coaching clients. Depressed clients, however, are likely to be more global and negative in their thinking and thus less able to accept the specific, positive rationale for

strengths. Many clients come into therapy with the intuitive expectation that problems are supposed to be the focus of clinical attention. Setting up the therapy or coaching session as a place where it is safe (and even expected) to discuss and celebrate strengths and successes is often attractive to clients.

2. *Help the client experience the rationale emotionally.* It is possible to discuss or actively engage the client's strengths in a session, giving the client the emotional experience of the engagement, enthusiasm, and positivity that typically are associated with strengths use. Asking clients to discuss past examples of behavioral strengths, such as leadership or courage, can spark positivity in them. For more cognitive strengths, such as curiosity and creativity, it is possible to engage these qualities within the session, allowing clients an in-the-moment experience of positivity.
3. *Help the client build a strengths vocabulary.* Often, the largest hindrance to discussing and accepting strengths is the fact that most people do not have well-developed strengths vocabularies. Offering a definition of strengths, pointing out strengths where you observe them, giving strengths-spotting homework assignments, and similar activities can help clients build their strengths vocabularies. As clients become better at noticing and labeling strengths, they often become more at ease with the approach and are better able to develop their own strengths.
4. *Undertake an Individual Strengths Assessment (ISA).* The conversational questions of the ISA encourage people to look for strengths within themselves. As they are elicited from clients, they are less likely to be rejected than if suggested by a third person, such as a therapist (see Linley, 2008; Linley and Burns, Chapter 1, this volume). This is a particularly important point as matching client language can help fortify the therapeutic alliance.
5. *Engage the client's strengths.* If identifying strengths leads to deflection or rejection, then it may be best to avoid that step and simply focus on how clients can best use them.

Mindful of the professional adage to “join with the client where she is,” I was careful not to push the identifying of strengths too far with Linda and instead chose the final option of engaging her strengths. I paid attention to visual cues of Linda's engagement, such as her posture, inflection, and hand gestures. Whenever we discussed an area of strength—her hard work, her attending parties to make professional contacts—she “came alive,” sitting up straighter and speaking more rapidly. Whenever I labeled these strengths, however, she became somewhat awkward and appeared less enthusiastic. As a result, I opted to drop the strength labeling strategy but keep focusing on these resources as potential solutions to her problems.

Focusing on and Engaging Resources

COACH: Tell me about some of the successes you have been having at these parties.

LINDA (laughing): None! Well, I've been gaining weight because the food is so good.

COACH (also laughing): What are you hoping to get out of these parties?

LINDA: Best-case scenario? An on-the-spot offer. Second choice? Good leads and contacts.

COACH: I am curious about something. What do you say to these people at these parties?

LINDA: That's just it. I don't really have an elevator speech or anything. It feels awkward to say 'Hey, I was in your line of work and am really hoping to get employment at your company!'

COACH: Would it be helpful if you and I worked on your speech?

LINDA: Yeah.

COACH: Okay, I want you to take your time . . . just kind of think out loud . . . no right or wrong answers . . . and say what it is you would most like to say. I mean, from the bottom of your heart without worrying about what's socially appropriate or any of that—we can clean it up later.

LINDA (after some thought): I am really creative. In fact, I am more creative than the sales manager you have working for you. If you hire me, I will bring you not only the numbers but a lot of fun and originality on top!

COACH: Wow.

LINDA: Yeah! But you can't say that in real life!

COACH: But did you see how you shifted? You sat up straighter? Your voice sounded powerful? It was a real transformation.

(Linda nods.)

COACH: Okay, so would you like to take this little speech—where you basically get to say “look what you are missing!”—and play with it a bit? Use some of that creativity? Refine it?

LINDA: Definitely!

This was the turning point of our first session. We encountered a moment where we could stop discussing Linda's strengths and actually engage one of them (creativity) in the moment. Linda, as I learned over the next few sessions, was humble enough that direct praise of her strengths made her uncomfortable, but not so humble as to avoid showcasing her strengths in front of me! She appeared eager for the challenge of using her creativity in this new way, and her mood and motivation seemed to increase dramatically.

In session 6, Linda was more frustrated than I had seen her previously. In earlier sessions, we had planned new ways to identify and to use her strengths, created a strategy for networking, and articulated a “personal mission statement” for her. Immediately prior to our sixth session, she attended a professionals group where she was very hopeful to connect with an old colleague and believed she was all but assured of a job offer. Her acquaintance had rejected her application, however. Linda presented in the session as disappointed and frustrated, alternately.

Redirecting Negative Conversations

LINDA: It just makes me think, you know? When I am in here with you and you say “way to go,” I feel like I can do anything. But out there, in the real world, our role-plays don't pan out.

COACH: Tell me what your colleague said to you exactly.

LINDA: He said, “Linda, I know you are a great worker. I've seen you work. The problem is there are three great workers applying for this position and I can tell you that the other two have college degrees.”

COACH: So there it is.

LINDA: Yes. I feel like I've been adrift at sea and when I finally got rescued my old job was taken, and my boss says, “Sorry, while you were stranded out there on that island everyone else learned a bunch of fancy computer programs.”

COACH: You feel like it comes down to an almost arbitrary qualification—whether or not you have a college degree?

LINDA: I do. I mean it's like having all the job skills and all the strengths in the world don't matter.

COACH: You mind if I challenge you on that?
(Linda shrugs.)

COACH: I bet you don't really believe that. I bet you think that strengths and skills play into the equation.

LINDA (sounding resigned): I do, but . . .

It was at this point that I could feel that Linda's negativity was contagious. I felt heavy and could sense my positive mood slipping. And what does a positive therapist or coach do when he starts to get caught in the client's negativity? I thought that Linda and I had a choice. On one hand, we could discuss her feelings of disappointment in depth, allowing her to rehash the feelings, explore the roots of her emotional reaction, and then look for ways to address her emotions. On the other hand, we could remain future focused, exploring how she might deal with this setback without first focusing on her negative mood. I decided to redirect our conversation away from this issue.

COACH (interrupting): What did you say to your colleague?

LINDA: What?

COACH: What did you say in response?

LINDA (smiling): I said "They don't teach integrity in college!"

COACH: Wow!

LINDA: Yeah, wow . . . except he just kind of walked away from me.

COACH: Walked away from you and your integrity, you mean!

LINDA (laughing): That's right!

COACH: So I guess the question is, what should someone who has integrity, a work ethic, and creativity do when life deals her a disappointment?

LINDA: Well, I moped a bit. That was kind of fun. But now I am ready to move on. Let's get working!

CASE SUMMARY AND DISCUSSION

Linda appeared more positive and was ready to quit focusing on problems for the time being in favor of brainstorming the next steps in her job search. Together we devised a plan in which she would apply for a number of positions she considered "second choice" and intended to hold for only a temporary period (no more than two years). At the same time, we continued to work together on identifying what her "dream job" would be and lining up the information, mentors, education, and other resources she would need to successfully attain it. We modified our meeting schedule to once a month, with homework assignments between sessions. Two months later she received two job offers, both for second-choice positions. She accepted the local offer, and Linda and I continued to meet for a total of 15 sessions. She felt she had a clear plan for transitioning, over time, from her new job to her "dream job." I invited her to resume the relationship at any time she felt it would be helpful and asked her to update me periodically with any noteworthy successes.

Although Linda presented with subclinical symptoms, many of her problems and complaints were of a psychological nature and resembled traditional clinical concerns,

such as low self-esteem and hopelessness about the future. Early on we established the culture of our relationship as one in which humor, attention to success, and identification of strengths were, themselves, of primary therapeutic benefit. I generally avoided lengthy discussions of problems (rumination) and favored topics and directions that promoted motivation and enthusiasm. One noteworthy element of this case is that the labeling of strengths was not immediately beneficial. Linda resisted this approach, and I quickly found that sustained efforts at identifying her strengths thwarted our forward progress. This point neatly underscores the important caveat of strengths interventions: They are not one-size-fits-all solutions. A degree of professional judgment, based on experience and competence, is necessary to modify interventions so that they can be locally effective (see discussion of the “local clinical scientist” model advocated by Treiweiler & Stricker, 1998).

FINAL DISCUSSION

In the end, the data suggest that attention to client strengths can be an effective therapeutic tool. Specific strengths interventions are, as yet, not overly sophisticated and need to be tested in a wider range of clinical contexts. Even so, evidence from empirical and case studies suggests that there is utility in focusing on clients’ positive aspects. Moreover, strengths-based interventions are an appropriate add-on to many existing psychotherapy approaches and need not be thought of as a replacement for existing psychotherapies.

In a broader sense, in many ways, it is difficult to come to terms with a strengths-based clinical psychology. While, on one hand, I recognize that strengths assessments and interventions can be added as an adjunct to most existing psychotherapy practices regardless of orientation, I am also suggesting something more radical. Maddux, Snyder, and Lopez (2004) observed that “in building a positive clinical psychology, we must adopt not only a new ideology but also a new language for talking about human behavior” (p. 330). Phrases like *new ideology* and *new language* are suggestive of a very fundamental paradigm shift, and I recognize not everyone will be able to take this professional leap of faith. I believe it is prudent for all reflective practitioners to consider how, when, and why integrating positive psychology in general, and strengths in particular, might benefit their practice. Potential benefits include the fact that clients generally seem predisposed to enjoy some attention to positive topics, therapists may buffer themselves from burnout by focusing on positives, and using strengths may have psychologically tonic effects on their users. Ultimately, these hypotheses of taking a positive approach to addressing negatives will have to be tested, both in the laboratory and in the consulting room.

Putting It into Practice

1. Establish trust and rapport.

Finding strengths can help build rapport, and empathically joining with your clients can facilitate opportunities to move toward positive outcomes.

As a vital part of forming your relationship with your clients, be up front with them about expectations for therapy outcomes and content. Address the issue of strengths early on with your clients, explaining that you often look for strengths and believe there is as much value in talking about what is going right as what is going wrong.

2. Remain vigilant for signs of personal strengths.

Pay attention to the visual and auditory cues from your clients' engagement, such as their posture, inflection, and hand gestures. In a brief part of the first session, Linda communicated many different strengths, including a strong work ethic, determination, motivation, social savvy, and being a networker. Start looking for and listening to the strengths your clients reveal.

3. Be wary of being drawn into "problem talk."

Be eager to establish a relationship where personal successes are discussed and celebrated rather than where problems are ruminated on. By the time clients get to coaches or therapists, they often have been over their problems innumerable times without adequate solution. That is why they come to us—to seek a solution. Watch for the problem talk, ensure your client is heard, and avoid the trap of getting caught in it.

4. Look for deflection or rejection of strength labeling.

If this happens, you may offer a rationale, help the client experience the rationale emotionally, help build a strengths vocabulary, undertake an Individual Strengths Assessment (ISA), or engage the client's strengths.

5. Focus on and engage resources.

Once strengths or resources have been identified, the next question for the therapist and, indeed, the client, is: How do we help clients engage or utilize them to attain their goal? One of Linda's strengths was her creativity, which was engaged to form a plan of transition.

6. Redirect negative conversations.

Observe your client, and observe yourself. Negativity can be contagious. Ask yourself: Am I feeling heavy? Is my positive mood or orientation slipping? If so, is this a helpful direction for us to be heading? If not, is it better to redirect our conversation?

7. Make a paradigm shift.

Consider how, when, and why integrating positive psychology in general, and strengths in particular, might benefit your work with each individual client. Three potential benefits include:

- a. Clients are more predisposed to enjoying positive topics.
- b. Therapists buffer themselves against burnout.
- c. Both clients and therapists experience the psychologically tonic effects of using strengths.

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CHAPTER 25

There Is a Fly in the Urinal

Developing Therapeutic Possibilities from Research Findings

Bill O'Hanlon

MEET THE CONTRIBUTOR

Bill O'Hanlon is a therapist trainer, professional speaker, and prolific author (29 books so far). Trained as a psychotherapist, he has become known as the developer of solution-oriented therapy and possibility therapy, which often are considered among the original applications of positive approaches to psychotherapy. He is a frequent keynote, conference, motivational, and business speaker. Bill is a diplomate, board member, fellow, and master therapist in the American Psychotherapy

Association, a lifetime fellow of the Association for Neurolinguistic Programming, certified by the National Board of Certified Clinical Hypnotherapists, and a licensed marriage and family therapist, among other professional awards. When not hurling his body through space in a large metal tube two to three times a month to give talks around the world, he enjoys time at home with his guitar, piano, dog “The Biscuit” (cutest dog in the whole world!), and favorite foods.

I am an information junkie and, as a psychotherapist and writer, regularly come across research that I think could make a positive difference in our lives. For some time I have been on a mission of finding interesting new psychological research that can make a positive difference in people's lives and help them to realize new possibilities. In this chapter, I offer short summaries of psychological research and show how I have used that research to

develop therapeutic possibilities to assist clients create a better life, be happier, and have better relationships. But first a little background.

How I got started in the area of solution-oriented, possibility, and positive therapy was through a very personal route. Back in 1971, feeling very depressed and lonely, and seeing limited possibilities for the future apart from the continuance of the misery of the past, I decided to kill myself.

When I told one of my friends my suicidal plans, she became upset. I explained the problem was that I could not handle dealing with people, was disillusioned by the hypocrisy I saw in society, and wanted to live the life of a poet rather than earning an income. She told me she had some maiden aunts from whom she would inherit some farmland in Nebraska and promised to let me live in the farmhouse on her land rent free if I promised not to kill myself. Her offer gave me hope; it opened up a new possibility and had me looking toward a more positive future.

Now that I had a future I could live for, the challenge was to do so in a way that was less miserable. I started to study and, learning new things, steadily began to feel better. Her aunts, who were of solid Nebraska farm stock, lived to a ripe old age, and I never did get to take her up on her side of the deal because by the time she had inherited the farm, I was already happy and successful.

I now have a great life, enjoy a successful career of doing something I love, and have a good income. In essence, I am glad to be on the planet. Some of what I discovered on that journey from misery and suicidal depression to happiness and success have shaped my thoughts about therapy and life, about looking for solutions rather than problems, about searching for possibilities rather than focusing on the lack of them, and about being oriented to the future rather than the past. I have become passionate about spreading the word that there is a route from misery to happiness, from frustration to success. It is about helping people focus on their competence rather than their deficits, their strengths rather than their weaknesses, and their possibilities rather than their limitations.

I remember the first case in which I (somewhat by accident) used a solution orientation that tapped into the client's resources and allowed her to see the possibilities toward her desired outcome. At the time, I was working in a mental health center when a former client of another colleague requested emergency assistance. As this woman's therapist was on a vacation, I agreed to see her. I inquired about what had brought her to therapy that particular day and whether it was related to what she had seen the other therapist about previously. She replied that it had been for depression over a period of about a year and that they had ceased therapy when she had overcome the depression.

I asked, "How did you learn to overcome the depression?" She gave a detailed description of several strategies that she and the other therapist had worked with to enable her to avoid sinking into depression when she had started to feel down. This included strategies like calling a friend, going for rides on her bicycle, and making sure that she continued regular activities, such as going to college and work. Even while discussing these ideas she brightened considerably.

I asked, "Do you think that these things would work for you now?"

She replied that she thought they would, but she had forgotten about them until I had asked. Knowing what she needed to do, she added that she did not have to be in therapy to solve her problem, but also acknowledged that if she had not come in, she probably would have lapsed into a deep depression.

The interview lasted just 20 minutes. Several weeks later, when the other therapist returned from her vacation, she made a follow-up call to the ex-client. The woman reported that she was doing well and had had no recurrence of the depression.

Decades ago, pioneering therapists Jay Haley (1976) and Thomas Szasz (1961) put forward the idea that it is best to treat people as if they are normal, because when people are treated as normal, they tend to act more normally. Solution-oriented approaches to therapy maintain such presuppositions that enhance client-therapist cooperation, empower clients, and thus make therapy a more effective and enjoyable process. They do this not by labeling or pathologizing but by holding assumptions that focus on strengths and possibilities—assumptions that also help create self-fulfilling prophecies (O’Hanlon, 2005; O’Hanlon & Beadle, 1994; O’Hanlon & Weiner-Davis, 1989).

In recent years, the positive psychology movement has drawn research attention to the characteristics of people when they are normal, flourishing, and happy. What are the factors that contribute to well-being? What is that research showing us? And, more important, how might practitioners employ that research in their therapeutic practices? In the rest of this chapter, I provide some examples of research that attracted my interest and how I have developed therapeutic possibilities based on that research. In doing so, I hope to provide specific examples of therapeutic strategies and illustrations of the process by which other therapists can adopt this same approach. In accord with the old saying that holds special relevance for therapy: It is better to teach people to fish than to give them a fish. Here I hope to offer some samples of what the fish tastes like but, more important, show the art of how to fish, in a metaphoric sense.

CLOSE RELATIONSHIPS ARE RELATED TO HAPPINESS LEVELS

Several studies have shown that having good friendships and family relationships is related to increased levels of reported and measured happiness. Magen, Birenbaum, and Pery (1996) found that people with close relationships are four times more likely to feel good about themselves than people without close relationships. Surveys by the University of Chicago’s National Opinion Research Center (www.norc.uchicago.edu) have found that those with five or more close friends (other than family members) are 50 percent more likely to describe themselves as “very happy” than those with smaller social circles. Interestingly, American’s social networks outside their families have shrunk radically over the past 20 years (www.dukenews.duke.edu/2006/06/socialisolation.html).

Finding or Renewing Relationships

If having close relationships is related to our levels of happiness, how can we help clients build better relationships? Here are seven suggestions for small actions that can be offered as homework exercises to create or renew connections with people.

1. Think of one thing you could do to reconnect to a friend or social acquaintance you have neglected, severed, or lost.
2. Write a card, e-mail, or letter to a friend you have put off writing to.
3. Phone someone you have been meaning to call.

4. Break your routine by attending functions in which you might meet or connect with people.
5. Develop an exercise ritual, such as walking or playing racquetball, with one or more of your friends.
6. Talk to a stranger in some circumstance that seems safe and in which you would usually shrink, isolate, or avoid connection.
7. Volunteer at some institution that helps people.

POSITIVE ILLUSIONS IN RELATIONSHIPS

I guess rose-colored glasses can really work (at least for couples). Sandra Murray and colleagues at the State University of New York, Buffalo, have done many research studies in which they have found that if one sees one's partner more positively than one sees oneself, the relationship is rated as more positive and more satisfying (Murray & Holmes, 1993; Murray, Holmes, Dolderman & Griffin, 2000; Murray, Holmes, & Griffin, 1996a; Murray, Holmes, & Griffin, 1996b). Seeing one's partner more positively than oneself also helps to reframe the partner's negative qualities as assets.

Looking for the Positives in a Relationship

Without minimizing or denying serious problems (such as violence or severe betrayals and harmful habits or actions), help your clients search for the admirable qualities in those with whom they have relationships. Attention might be focused in these directions with questions such as:

- What are your partner's or friend's positive coping abilities? Instead of focusing on the person being depressed, for example, notice how much effort he puts forth in the face of depression. Instead of thinking of the weight she has gained since having a child, focus on how well she is managing her time since the change in schedule and demands on her time.
- What strengths or admirable qualities have you noticed in the person in any context? Challenge yourself to notice those strengths or traits. Then let that person know that you appreciate or admire those traits.
- What are the personality traits that serve the person and others well? For example, instead of thinking of that person as "too sensitive," could you consider that he or she "feels things strongly"?
- How can you recast annoying habits or qualities into assets? Rather than focusing on how obsessive the person is, can you instead appreciate her commitment to doing things well and correctly? Rather than worrying or being judgmental about how he spends too much, can you notice how generous he is with you and others?
- If you cannot find anything to admire or see in a positive light, how can you shift into neutral? When you get upset or judge people harshly, remind yourself that you do not fully understand them, their motives, their story, their values, or their experiences. If people were critical of you and you had a chance to tell them your life story or what was in your heart, they might be less harsh in their view of you.

BE GRATEFUL AND INCREASE YOUR HAPPINESS LEVELS

Expressing gratitude has a short-term positive effect by increasing happiness levels up to 25 percent over several weeks. Those who are typically or habitually grateful are happier than those who are not habitually grateful. This 25 percent increment in happiness levels was also reported by people who noted weekly the things they were grateful for compared to people who noted their complaints or were just asked to note any events that had occurred during the week (Emmons & McCullough, 2003).

There is also evidence of long-term benefits. Ask people, at the end of the day, after dinner and before going to sleep, to write down three things that went well during the day. Request they do this every night for a week. The three things they list can be relatively small or large in importance, it does not really matter. After each positive event on their list, ask them to express in their own words why this good thing happened. In one study, after doing this for just one week, participant happiness increased and depression decreased for up to six months. In addition, 60 percent of participants carried on the habit (Seligman, Steen, Park, & Peterson, 2005).

The impact of a simple exercise such as expressing gratitude can have even more profound effect, as shown in a study with people who scored as severely depressed on a depression inventory. Participants were instructed to recall and write down three good things that happened each day for 15 days. An amazing 94 percent of them went from severely depressed to mildly to moderately depressed during that time—with one simple exercise (Seligman, 2002). This seems to be a simple yet profoundly effective and soundly researched therapeutic tool.

Building Gratitude and Appreciation

There are three types of appreciation:

1. **Highlighting gratitude to oneself**
Ask clients to note for themselves things that they can be grateful for. As a way to do this, they could note three things they appreciate about the day or the week. They could focus on the people they appreciate. Or they could note the things that others are struggling with (such as hunger, homelessness, serious illness or loss) and use that as the basis for appreciation and gratitude of their own circumstances. What is helpful and important is to develop a habit of gratitude and appreciation.
2. **Savoring**
Suggest your clients note down, and take time to enjoy, what they appreciate aesthetically, such as a beautiful sunset, a good meal, or a lovely painting. This usually involves attending to sensory experience (sights, sounds, smells, touch, and tastes) in the present (Burns, 1998, 2005, 2009, Chapter 20 this volume).
Another element of savoring is not to multitask. Do—and notice—just the thing you are involved in or doing. This might mean turning off the television or not reading while you are eating and instead focusing on the taste, texture, or smells of the food you are eating.
3. **Expressing gratitude to others**
Invite clients to explore possible ways they can express appreciation to the people they value and are grateful to. Positive psychology researchers often

recommend writing a “Gratitude Letter” to someone to whom you are grateful and have never fully expressed your appreciation. They also recommend you be present when the person reads the letter. If that is too difficult, they suggest being on the phone or on a Skype video when the person reads the letter.

Try writing your own gratitude letter to someone. Be as specific as possible about the things you are grateful for and appreciate about the person and/or what he or she has done for you.

SHIFTING PERCEPTIONS AS A STRATEGY FOR CHANGE

Alia Crum and Ellen Langer from the Harvard Psychology Department did an experiment in which they matched two groups of hotel room cleaners (84 subjects spread across seven hotels). These housekeepers get many hours of exercise per day (cleaning on average 15 rooms per day, each taking 20 to 30 minutes; they are pressured to finish the cleaning task quickly) but do not typically think of themselves as exercising. The experimenters told the cleaners from four hotels that they were getting the amount of exercise the surgeon general recommends to maintain a healthy lifestyle; they did not tell the cleaners from the other hotels anything. When the researchers returned to measure the results a mere four weeks later, they found that the women who had been told they were exercising enough had lost an average of two pounds, that their blood pressure was almost 10 percent lower as a group, and that they were significantly healthier in measures of body fat percentage, body mass index, and waist-to-hip ratio. No such changes were noted in the control group (Crum & Langer, 2007). It is not clear whether the housekeepers who were told they were exercising enough instituted other changes that facilitated the healthier outcomes or if those results were mainly due to a shift in perception. In any case, that is an amazing result for such a short follow-up.

What You Attend to Typically Expands in Your Life

Since attention can be a powerful force, and so many things are vying for our attention (television, radio, the Internet, video games, movies, family, work, etc.), it behooves us to manage attention wisely. Where people put their attention often expands that area in their awareness and in their life.

Many years ago, there was a rumor going around in a certain western state that there was some pollutant in the air that was causing pockmarks on car windshields. Panic set in, and investigations were begun. The investigators measured pockmarks on windshields in the state in which the rumors were rampant and in a state with a similar climate and level of pollution in which there was no concern. They found the exact same number of pockmarks per square inch in both states. The difference was that once people heard the rumor, they noticed the pockmarks for the first time or they noticed them much more. This same phenomenon can be used in a positive way in your clients’ lives. Follow these four steps:

1. Find a focus.

Ask clients to decide an area of their life they would like to expand. It might be more exercise, better eating, more time with family, more leisure time, more creative

work, more reading, being more responsible about spending money, or something else entirely.

2. Record activity or attention to that area.

Invite clients to get a little notebook and carry it around for a week or two. Whenever they get a chance, as soon as possible after they notice it, they are to write down anything they have done related to that area. If they have to wait until evening to jot it down, do it then. At the next session, ask if they have noticed whether this area has expanded in their life.

3. Increase the amount of time they spend in this area by a small amount each day.

Suggest clients commit to spending as little as five minutes each day doing something related to this area. They should commit to doing this for small time periods, such as a week or two. They can always continue it if it is working, but committing to it for too long a time period may be a setup for failure.

4. Ask clients to think about this area in spare moments.

Suggest that clients use spare moments while waiting for an appointment, riding the bus or subway to work, waiting for the bath to fill or for the kids to get bundled up and into the car, to focus briefly on what they would like to do or have done in this area.

SELF-COMPASSION IS GOOD FOR YOU

A study by Pargament, Smith, Koenig, and Perez (1998) found that people who are unable to forgive themselves or others also have an increased incidence of depression and callousness toward others. Self-compassion involves feeling forgiveness or softening toward ourselves and a decrease in the usual judgmental or critical attitude we take toward ourselves.

Here are some questions for clients to consider regarding self-compassion:

- Is there any area in which you are critical or nonaccepting of yourself?
- What do you think is your most unacceptable aspect or part of your body?
- What is one step you could take toward valuing or at least moving toward accepting that aspect?
- If that trait or aspect was one of your best friend's, how would you assure him or her it is okay?
- How have you softened or become more accepting of yourself in the past?
- Can you use any of that right now to help you become more self-compassionate?

BETTER THAN ZOLOFT

According to the SMILE (Standard Medical Intervention and Long-Term Exercise) study at Duke University (Blumenthal et al., 2007), depressed people who exercised (supervised group exercise or at-home exercise) were just as likely to recover from major depression as people on Zoloft. What stood out, however, was that the exercisers were more likely to still *not* be depressed two years later than people just on Zoloft or people who took Zoloft in addition to exercising.

If exercise helps, the next question becomes: How much exercise does a person need to do to gain the benefits? Evidence shows that every 50 minutes of exercise per week correlates to a significant 50 percent drop in depression levels (Trivedi, Greer, Grannemann, Chambliss, & Jordan, 2006).

Another study found that people who participated in moderately intense aerobics, such as exercising on a treadmill or stationary bicycle—whether it was for three or five days per week—experienced an average decline in depressive symptoms of 47 percent after 12 weeks. Those doing less frequent exercise benefited to a lesser degree with a 30 percent reduction in symptoms. Another interesting result from this research is that people who were unresponsive to medications showed improvement in symptoms by participating in an exercise regime (Dunn, Trivedi, Kampert, Clark, & Chambliss, 2005).

Helping Clients Develop the Habit of Regular Exercise

Everyone has a different process of finding the motivation to exercise. Your clients might be able to use or modify these possibilities, which have worked for others:

- Discover and use preferred motivational strategy.
Typically there are two kinds of motivation:
 - a. *Avoidance*. These are the things you want to get away from, avoid, or are concerned you will lose. For example, one of my motivations to exercise is to get rid of the midlife spare tire I developed during my years of couch potato behavior.
 - b. *Approach*. These are the things you want or yearn for. Another of my motivations for exercising is that I have become convinced that regular vigorous exercise facilitates better learning by stimulating the neuronal growth factor in the brain for hours just after exercising. Since I highly value learning, this helps me stay motivated. If you can discover your motivational strategy and link it to your exercise, it will most probably work better.
- Find the right activities and settings. Here are three possibilities:
 - a. Some people like to exercise outdoors. Others like to be inside in a gym. Some like to be around other people while others prefer solitary exercise. Some prefer unisex settings (e.g., fitness clubs just for women). My preference is running on a treadmill because I like to watch the numbers on how far I have gone and how long I have been exercising click by.
 - b. Classes and teachers can also make a major difference in keeping some people motivated.
 - c. It is also important to find the exercise that works for your client. Is it swimming, walking, running, weight training, flexibility training, yoga, Pilates, or something else? All can have different joys and challenges. If clients are not sure which is for them, encourage that they sample as many as possible before settling on one or more.
- Use the small steps or short sessions strategy.
Suggest clients start with something small to ensure that they will not be too discouraged or overwhelmed. Moving for three minutes is better than not moving

at all. Increasing the time or activities in small increments can make exercise more palatable and increase the odds clients will stick with it.

- Try the buddy method.

Many studies have shown that some people are more likely to stick with exercise if they do it with a friend or colleague. When one person wants to flake out, the other can offer encouragement or motivation by obligation.

- Employ the solution-oriented method.

Ask your clients, “How have you ever done anything difficult or challenging before? When and how have you developed another habit in the past?” Use these previous experiences to help clients draw on, develop, and maintain the habit of exercising.

- Stick to the no-exceptions rule.

Some people do better when they make a rule that they will exercise every day, without exception, no matter how they feel. When I began, I made this rule, and it has served me well. On a few days I had to miss exercising (e.g., when I was too ill or time really did not allow it), but because of that rule, I ended up exercising five or six days that week anyway.

- “Regroove” the brain.

From what I know about the new brain science, it takes about 40 days on average to “regroove” the brain. That is approximately the time it requires to get the brain out of its old habitual patterns and develop new neurological/physiological patterns. Explaining this to clients may help them stick with exercising until they develop a more positive pattern to exercise.

THERE IS A FLY IN THE URINAL

The title of this chapter and this section is quirky and offbeat—not mainstream (so to speak) in the psychological literature. However, it illustrates that there can be benefits in looking outside of our usual frames of reference for useful information that might inform therapeutic practice. This study was performed at Amsterdam’s Schipol Airport. Men, as we all know, have a tendency to pee outside the urinal or toilet. Through a simple experiment, the airport was able to reduce “spillage” by 80 percent simply by etching the image of a black fly into the urinals. As a result, men’s attention was more focused, resulting in better aim. (Read about the experiment at www.coathanger.com.au/archive/dibblys/loo.htm.)

And what, I hear you ask, does this have to do with therapy? Well, being focused or mindful of what we are doing enhances performance, facilitates problem resolution and contributes to our overall well-being (see Hassed, Chapter 14, this volume). Here are six suggestions as to how focus might be developed.

1. Follow your energy.

One way for your clients to develop focus is to attend to and follow what energizes them. Discover what is compelling to them, what has natural energy and “juice.” Invite them to spend as much time and energy as they can on these areas in their personal life and work.

As a previously scattered person, finding what I was blissed about (Milton Erickson's psychotherapeutic work) and cheesed off about (the disrespectful and ineffective nature of much of psychotherapy) helped me focus my energy enough to write my first 15 books. I had so much energy, I could overcome much of my typical unfocused habit.

2. Develop your focus muscle.

Just as when you exercise, doing a little bit more than you feel like doing, or think you can do, develops muscles. It is possible for clients (and you) to apply this principle to become more focused. When clients feel like jumping from one thing to another, ask them to focus just a little longer than feels natural and thus develop their "focus muscle."

3. Create timelines/upcoming events.

I read a story about a businessman who found that when he had a trip coming up, he focused and got a lot more done right before he left for a trip. He traveled quite frequently, so he told his secretary to book fake trips four times a year and tell him they were fake only at the end of the day just before he would have left. Work with clients to create deadlines, timelines, and upcoming events to help them become more focused. Ask them to notice what they do to focus and determine whether they can use the same strategies to get focused at other times.

4. Make reminders/written notes.

It has become more necessary as I have aged, but I find that writing myself notes that will get my attention naturally (e.g., posting them by the door just before I go out of the house or on my computer screen) helps me stay focused on tasks or activities.

5. Establish habits.

This strategy uses your brain and body to help you stay focused. Once a person develops a habit (e.g., driving the same route to work each day, journaling every evening at the same time of night, or running every morning), there is a natural tendency to stay in that groove without effort. Assist your clients to develop habits of doing things they want to focus on and let that habit create a natural focus for them.

6. Use individual quirky patterns of focusing.

I discovered through some experimentation that I could focus much more on writing my books when I listened to loud music while writing. Others are appalled at this, wondering how it can help me focus. It just does. Still others nod, having discovered the same thing about themselves. Ask what things help your clients focus, and explore the ways they might use them.

CONCLUSIONS

As I mentioned at the beginning, I am an information junkie. However, while information in itself may be interesting, I believe it opens up possibilities for making a positive difference in a person's life only when it can be applied in a practical way. I hope I have been able to provide some examples of how research can generate possibilities for therapeutic strategies and shown the processes you may be able to use in your own therapeutic work.

Putting It into Practice

1. Become an information junkie.

Read, read, and read some more. The more you keep up with the literature, the more research knowledge you have up your sleeve, and the more information you acquire, the more you are going to have to offer to your clients.

2. Keep a solution-oriented focus.

A solution-oriented focus is about helping people focus on their competence rather than their deficits, their strengths rather than their weaknesses, and their possibilities rather than their limitations. It seeks to enhance client-therapist cooperation, empower clients, and make therapy a more effective and enjoyable process. To employ a solution-oriented approach:

- a. Adopt an orientation toward the future rather than the past.
- b. Help your clients look toward the outcome rather than back at the problem.
- c. Ask what is right with this person and how that might be used to help him or her manage even better.

3. Create possibilities.

People usually struggle, become anxious, depressed, or angry when they see their options as limited. The more possibilities that exist, the greater the choices a person has, the more they are likely to feel in control of their destiny. As a therapist, keep your mind open to possibilities. Help your clients search for, discover, and experiment with possibilities.

4. Seek information outside of therapy.

While the professional literature is a major source of important information, it may not be the sole source. When was the last time you read a professional journal that talked about the therapeutic possibilities that could be drawn from etching a fly on an airport urinal? There might be useful information in sources other than those we usually read. It helps to keep an open mind to new knowledge and the sources of that knowledge.

5. Ask how the research findings might be applied.

Research can supply us with sound, evidence-based information about what works and what does not work for people. The challenge for the therapist is to examine *how* that can be applied for the clients in our consulting rooms. If science has shown, for example, that close relationships are related to people's levels of happiness, then the therapist needs to ask: How can I help this particular person find or renew close, positive relationships? If there is good evidence that exercise is better than taking anti-depressant medication, then the therapist could well ask: How can I help this client find possibilities for exercising more?

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CHAPTER 26

Soaring to New Heights

Outcome-Oriented Metaphor in a Case of Severe Phobia

George W. Burns

MEET THE CONTRIBUTOR

George's Meet the Contributor details are provided at the beginning of Chapter 1.

Once upon a time a young octopus lived in the warm, shallow, and clear waters close to a sandy shore. Life was carefree. She swam over reefs, mingled with colorful fish, and was lulled in the gentle wash of the waves, but there was something a little different about this octopus. She liked to hang on to things. Sometimes it was for a sense of exhilaration that she would wrap her tentacles around a fish and go for a joy ride. Sometimes she would wrap her tentacles around a firm and solid rock where she could feel comfortable and secure.

Thus began the outcome-oriented metaphor I told to Phillipa. It was designed to do four things:

1. Identify with her problem (the need to hang on to something for comfort and security).
2. Alert her to past positive experiences when her current problem did not exist.
3. Highlight that there had been times when her life was more carefree.
4. Teach more specific thinking in that *sometimes* hanging on to things could be a problem and *sometimes* it might provide pleasure, fun, comfort, or security. (See Garnier & Yapko, Chapter 12, this volume.)

Phillipa was one of the most phobic people I have ever encountered in my career as a clinical psychologist. She was terrified of being inside her home and terrified of being outside. Once her husband departed for work in the morning, panic crashed over her like a breaking

tsunami, and she would head for the lawn, the only somewhat safe place on the whole planet for her. There she would stand, sheltered between the tall brick wall that screened their home from the street and the incarcerating wooden walls of her house. She would spend almost all day, every day, standing there on those few square yards of grass, too scared to go inside and too scared to go outside.

Her husband coaxed her to leave the front lawn and attend her first appointment. Initially, she was too afraid to consult me without him being present and sat with her head hung low, her long hair falling moplike over her face, covering it as effectively as a veil. Her responses to my questions were minimal and monosyllabic, apparently guarded by the uncertainty of fear rather than the resistance of anger or disinterest of depression.

In this chapter, my aim is to weave four themes:

1. A discussion of how and why therapeutic metaphors can be used in positive therapy approaches
2. The case of Phillipa
3. The outcome-oriented metaphor told to her
4. An explanation of the therapeutic processes offered through the metaphor

WHY USE METAPHORS IN THERAPY?

Through the preceding pages of this book, I hope you have come to learn much about the research into clinical applications of positive psychology, about strategies, techniques, and inventions for applying it in your own work, and about how they can be employed with individual clients. Having those tools leads us to the next question: How can I now communicate those interventions to my client, most effectively?

In Phillipa's case, I am sure she probably had been offered some very sound advice—perhaps many times over—by well-meaning family, friends, physicians, and counselors. She probably had been told to stop being afraid, to get on with life, to find more meaningful interests for herself, and to sit back and relax more, but so far all such reasonable counsel had not helped. The art of therapy is largely about how to communicate these goals to her in a language she could identify with and in a way that could provide her with adequate, effective means to get there. And this is where metaphors have their place in therapy.

Most dictionaries or textbooks define *metaphor* as a comparison between two things, based on resemblance or similarity. Metaphors are a form of comparative language that uses one image to communicate something expressive, creative, perhaps challenging, and powerful about another image. As therapy is a language-based process of healing, heavily reliant on the effectiveness of communication between client and therapist, it helps for the therapist to be familiar with language structures, such as metaphor, that may best facilitate the client's process of change. In fact, Roffman (2008) claims that metaphor is ubiquitous, that we cannot communicate without metaphor, and that our language and concept formation are dependent on it. This being the case, it follows that the practice of therapy, "a discipline so inextricably bound up with language and communication, *requires* an understanding of how metaphor functions" (p. 247, emphasis added).

The origins of the systematic, structured, and intentional use of metaphor stories to create therapeutic gain can be found in the work of Milton Erickson, and have been extensively

documented by authors such as Lankton and Lankton, (1983, 1986, 1989), Rosen (1982), and Zeig (1980). Since then metaphors have been employed in a wide range of therapeutic models and diagnostic categories (see Burns, 2001, for a review) finding expression in areas such as hypnotherapy (Burns, 2006; Yapko, 2006), child and adolescent therapy (Burns, 2005b), mindfulness practice (Hassed, Chapter 14, this volume), and acceptance and commitment therapy (Walser & Chartier, Chapter 15, this volume). Metaphors have been incorporated into treatment models for depression and for the attainment of positive outcomes (Burns, 2006, 2007; Garnier & Yapko, Chapter 12, this volume) but, as a scan of the indexes of the major textbooks on positive psychology will show, have so far gained little attention in this field. Admittedly, some authors not only use metaphors but conclude—along with many others—that our human thinking depends on metaphors (Haidt, 2006).

All of us constantly speak in metaphors, and our clients are no exception. They say things like the case examples in this book have shown: “My life is slowly *falling apart*,” “Life *sucks*,” “Help me *put the lid on* my problems,” “I’m *losing* my mind,” “I desperately need help to *get back on track*,” “The *beast* has taken over my life,” “I feel *zoned out*,” or “My legs are *jelly*.” In fact, Ferrara (1994) found that clients used an average of three metaphors per 100 words in a single hour of therapy. If clients are using such frequent figurative language to express their experience, then it seems only appropriate, logical, and practical that the therapist joins that language, meets the client in his or her mode of communication, and facilitates both figurative and pragmatic processes of change.

WHY USE METAPHORS WITH PHILLIPA?

I had three reasons to use metaphors with Phillipa.

1. In telling a story, there was no demand for any verbal or overt responses from Phillipa in any way whatsoever—no pressure on her to communicate when she was obviously reluctant to do so. She was free not to communicate if she wished.
2. In the roles of teller and listener we would be forming a relationship. It became an activity we were sharing and experiencing together. No longer were we separate individuals with disparate goals because the process of participating in the story-telling experience together altered the relationship and facilitated a common bonding.
3. It was my therapeutic objective that the story should relate my understanding of her problem, provide her with some sound, evidence-based means for resolving it, and express a realistic outcome. This I refer to as the PRO approach, for problems, resources, and outcomes, because, like all good stories, therapeutic metaphors have three core elements:
 - a. A beginning
 - b. A middle
 - c. An end

In a healing story, these three elements are:

- a. The problems the story addresses
- b. The resources it helps develop
- c. The outcomes it offers

Because the PRO approach is outcome-oriented, it takes a positive psychology approach to therapy. Metaphors built on this model are about finding strengths and resources, providing means or pathways for reaching a goal, instilling hope, and finding meaningful outcomes that will enhance a client's well-being.

THE PRO APPROACH

The Problems Addressed

As the little octopus grew, she began to venture farther and farther afield, exploring deeper waters. One day as she was swimming somewhat hesitantly through these new territories, she encountered a strange and unusual object. The hull of a large ship cast its gloomy shadow over the waters. Dangling from its bow was a strong sturdy anchor, around which the little octopus, seeking some source of security, wrapped her tentacles.

As she clung on, the anchor began to drop, plunging down through waters that grew darker and colder. The little octopus could feel the pressure of the water squashing in, as strongly as her apprehensions wanted to burst out. She didn't know whether to hang on or let go. While the anchor itself felt safe and strong, her descent into the gloom and pressure of the ocean felt frightening and, indeed, terrifying.

Initially the little octopus metaphorically represented the problem Phillipa was experiencing. Just as it was tenaciously but ambivalently clinging to its anchor, so she had been tenaciously but ambivalently clinging to the patch of front lawn, frightened to hang on and frightened to let go. Both the anchor and the lawn offered security but also had the character sinking into a dark, alien, depressive world.

The octopus was scared of letting go of what security there was in this unexpected change of events and frightened of the depths into which she was being plunged. As she hung on in her ambivalence and conflict, the anchor, with a thump, struck the sea floor. There both anchor and octopus sat at the bottom of the ocean. The little octopus grasped tighter, uncertain as to whether to continue to maintain her grip on what had plunged her into such unfamiliar depths. Somehow it seemed like a false security but, in the dark and gloom of the depths of that uncertainty, the little octopus felt reluctant to let go.

At that stage, I knew little about Phillip apart from what her husband had told me regarding her severe phobia. Because of her reluctance to communicate, initially it was difficult to ascertain her therapeutic goals. Obviously, she had a desire to be free of the fears, and one way to do that might be to help her build a better quality of life. Perhaps therapy might be able to assist her to be more independent, more valuing of her strengths, more hopeful, and more future-oriented—qualities that I hoped would help reciprocally inhibit (Wolpe, 1958) or “undo” (Fredrickson, 2008) the fears and anxieties.

At that stage, I was also just beginning to work with therapeutic metaphors. I would run out of story and need time between consultations to think about where the tale would go next. This, in fact, proved to be a distinct therapeutic advantage and enhanced my confidence about using metaphors by knowing that I did not have to magically have some wonderful, creative story right on the tip of my tongue at the very moment I expected I should.

As the story developed, Phillipa started to lift her head and seem more comfortable to attend me without her husband being present. She began arriving more enthusiastically

at her consultations and commenced conversation by saying “I know what happened to the octopus next,” keenly wanting to discuss the continuing adventures of our mutual friend. For the strengthspotting therapist, the telltale signs in her voice and enthusiasm were present (Linley, 2008; Linley & Burns, Chapter 1, this volume). Phillipa was engaged in the story, she was imaginative and creative, and she had skills in problem solving. She was able to see an outcome and develop hope based on this (Cheavons & Gum, Chapter 5, this volume). She also taught me about developing metaphors collaboratively with the client—a fact that I later discovered was a facilitator of therapeutic outcome (Martin, Cummings, & Halberg, 1992).

The Resources Developed

Here the story begins to move from the problem of the PRO approach to the resource section that seeks to offer ways and means to reach the therapeutic outcome. This is the part of the story that will help set the appropriate therapeutic goals (Street, Chapter 4, this volume), find pathways and agency (Cheavons & Gum, Chapter 5, this volume), access and enable strengths (Linley & Burns, Chapter 1, this volume), develop greater acceptance (Walser & Chartier, Chapter 15, this volume), or present the evidence-based strategies of effective therapy.

Though frightened, scared, and indecisive, the little octopus began to notice some different feelings emerging when a kindly looking fish emerged from the gloom. There was something reassuring, something hopeful about the presence of someone else. The octopus called out for help. The fish listened to her tale of what had happened, then said, “I am sorry. I cannot help you, but there is a bigger fish following me. He may be able to provide the help you need.”

The first fish in the story metaphorically represents her physician whom she initially approached for help and who referred her to the “bigger fish” for psychotherapy. In addition, the story here introduces two other concepts. The first is that feelings can change from fear and indecision to reassurance and hope. Emotions alter and are not permanent or fixed. The second concept is about the value of contact with others. We know clearly that happy people tend to be distinguished by the quantity and quality of their social relationships (Seligman, 2002). Here the presence of another is associated with a shift toward more positive feelings.

It wasn’t long before the bigger fish swam by, moving with a gentle, relaxed motion. Its eyes seemed kindly and caring. “I can help you,” said the fish in reply to her request for help, “but first you need to do something to help yourself. You need to let go of that anchor to which you have been holding on. Then I can show you a way.”

The story plants a seed of an idea in the reference to relaxation. It also goes on to offer hope that help is available while at the same time clearly communicating that actions need to be taken for that hope to be realized.

I don’t know how the little octopus let go of the anchor. I don’t know whether it was gradually and hesitantly, that she peeled off one tentacle at a time, or whether she was willing to let go of her grip completely and totally, all at once. She might have kept hanging on with one or two tentacles, feeling the freedom of the other limbs before finally choosing to venture into a more complete freedom. Maybe she needed to hold on just a little longer before building up the courage to set herself free.

Metaphorically, I let Phillipa know that there were many possibilities as to how she could free herself of the fear. It did not have to be suddenly (though that was one possibility). It could be gradual, at her pace, in the time and ways she chose. In fact, the suggestions have a strong emphasis on empowerment—the little octopus could choose how and when to let go. She could set herself free.

The kindly fish waited, encouraging and congratulating the octopus with each step forward. Then, when the little octopus had relinquished her tenacious grip, the fish said gently, “Follow me.”

The fish began to swim back and forth, gradually making its way upward. The ascent wasn’t as quick and as rapid as the octopus may have anticipated, but the fish seemed to know what it was doing, aware of the problems of ascending too quickly. It guided in such a way that the little octopus was learning how to manage by herself if ever she was again caught out of her depth. She began to feel stronger and more competent. No longer did she feel out of her depth. In fact, the journey into such unfamiliar territory began to feel like it had been a real adventure.

Here the story seeks to communicate three important coping strategies.

1. Although an experience may not be what we choose or want for ourselves, there may be things we can learn from it. The little octopus had not wanted to plunge to the bottom of the ocean, but she was learning ways to manage by herself and be better equipped to deal with such situations if ever “caught out of her depth” again.
2. If we are willing to learn from unwanted experiences, we can come out of them feeling stronger and more competent. We can see those experiences as opportunities for growth, for discovering new strengths, for building the skills to better cope with life’s inevitable challenges (Tedeschi & Calhoun, Chapter 19, this volume).
3. While the first two points here offer some reframing of the experience, this is reinforced in the language of the experience being a “journey” and an “adventure.” The little octopus presents Phillipa with an example of how to find positive meaning in an experience.

As they continued to ascend, the waters started to grow warmer and brighter. The little octopus began to feel lighter and happier. The oppression and despair of being in the gloom of those unfamiliar depths lifted and the octopus felt the joy of freedom returning.

As hinted at earlier in the story, both experiences and feelings can and will change. Day follows night. Spring follows winter. Night and winter will return but so will day and spring. As playwright Anton Chekov said in metaphor, “Let us learn to appreciate there will be times when the trees will look bare, and look forward to the time when we can pick the fruit.”

She caught up with the fish and, for a while, they swam side by side. No longer did she need to follow. At times she began to swim ahead, taking the lead and forging her own way forward. It didn’t seem long before the fish said, “From here you are ready to go on by yourself. You no longer need me to accompany you. You have learned the way up, the way to where you want to be.”

While it is okay to accept help and guidance from others at various times in life, it is important and desirable to learn from those experiences, to find ways to move on by oneself, and to build greater levels of independence.

The little octopus thanked the fish and swam on upward, as she had learned to do from her mentor.

This part of the story again affirms the concept of learning from others and introduces the concept of gratitude in that the little octopus thanked the fish for its help.

The waters continued to grow brighter and warmer. Light rippled off the surface and shone into the sea, highlighting the yellows, reds, and blues of the tiny fish that darted in and out of the naturally sculptured coral reefs.

Through the example of the little octopus, Phillipa is invited to focus on positive sensory experiences, be mindfully in the present, and value the pleasures inherent in nature.

Something had changed, not so much in what had happened but something had changed within the octopus. The octopus no longer felt contented just to be where she previously had been. She felt different. She made her way out of the water. She crawled up onto the beach and stretched out on the sand. For a while, she basked on the warm sand, enjoying the soporific comfort of the sunlight on her body, hearing the sounds of the sea birds overhead and the gentle swish of the wind in the palm trees. There was something nice about taking time out to recuperate.

Experiences can change us and afford us opportunities to extend ourselves beyond where we have been. Here again there is emphasis on nature, senses, and mindful awareness in ways that are self-nurturing and self-caring.

Not only was it a time for recuperation but one for consolidation and validation. Gently resting there in the pleasant warmth of the day, the little octopus's mind could reflect back on the things that had happened, affirming what she had learned and validating the message of that experience. The clingy little octopus seemed like a distant dream, a foggy image from back there somewhere in the deep depths of the ocean. With a new sense of strength, the octopus began to think that it was time to move on.

In this paragraph, the little octopus communicates two crucial aspects of the process of change:

1. There is a consolidation, affirming, and validation of what has been learned.
2. There is a shift of perspective from the seemingly "distant dream" of the past to looking and thinking ahead from a more future-oriented perspective.

Feeling warm, comfortable, and confident, she raised herself up on her tentacles and looked toward where she wanted to go. She studied the beach and the backdrop of limestone cliffs that rose abruptly toward the sky. Making her way across the sand, the octopus ventured toward the cliff. Using her tentacles wisely and carefully, she began her climb toward the cliff top. The going was not always easy, and the unfamiliar was challenging. At times, she really had to struggle. Nonetheless, she did not lose sight of her destination. She battled on, and was rewarded with the triumphant feeling of success.

To act on the newly found future-oriented perspective requires six steps.

1. The little octopus set a goal for herself in looking toward where she wanted to go.
2. She did her research by studying the terrain and what lay ahead.
3. She started to move toward her goal.

4. She discovered that progressing toward a goal is not always easy, and in fact at times can even be a struggle.
5. Despite this, she did not lose sight of her destination or objective.
6. Finally, through her own efforts, she gained the triumph of success.

At the top, a cool, refreshing breeze blew in from the ocean. As naturally as if she had been doing it all her life, the octopus spread her tentacles out like wings and began to lift on the breeze. Like an eagle she soared into the air, riding the gentle currents, gliding on the thermals, and experiencing the pure enjoyment of flying to new heights.

Who would ever expect that an octopus could fly like an eagle? Who could know the latent talents hidden in the very fearful Phillipa? This part of the story opens the possibility to discovering new abilities, new strengths, and new potentials. It suggests we might surprise ourselves by what we are capable of doing and seeks to build hope in life being better than it was.

The Outcomes Offered

The outcome of the story is told at the end of the chapter. The little octopus, like an eagle, had attained the goal of freedom that Phillipa wanted for herself. Soaring to new heights represented a passage through time. She was able to look back to where she had come from (letting go of the past history of such an intense phobia). She was able to enjoy the experience of the moment (being in the present) and to anticipate the delights of what lay ahead (looking forward to the future).

HOW DO YOU PLAN AND CONSTRUCT A THERAPEUTIC METAPHOR?

The PRO approach that I have described and illustrated in the story of the little octopus refers to the sequence in which the story is told to the client. Like all good stories, it has a beginning, a middle, and an end. The beginning describes the problem the character is facing. The middle accesses the resources and shows how the character can use them to reach the end or the desired therapeutic outcome.

In planning or constructing the metaphor, however, it is helpful to use the reverse process. To do this, I usually ask myself four questions in this order.

1. What Is the Desired Outcome?

Phillipa's prime goal was to be free of the phobia, free to confidently enjoy her strengths and latent talents. This was the outcome to which the story needed to head.

2. What Resources Are Needed to Attain that Goal?

For Phillipa, the story needed to communicate a number of points, such as:

- Accepting that change may be a process.
- Others may help along the way.
- It is possible to reframe experiences or find positive meaning.

- Experiences can and will change.
- It is possible to be more independent.
- Focusing on positive sensory experiences may help.
- It may pay to be more self-nurturing.
- We can discover and build latent strengths.
- We can have hope.

3. What Is a Metaphoric Problem with Which the Client Can Identify?

Phillipa's problem was that she was as stuck, ambivalent, and fearful as a little octopus hanging on to an anchor that was plunging her into unwanted places.

4. Who Is a Character Who Could Communicate that Story?

Phillipa's story needed a character who could know fear and ambivalence, just as she did. It needed to be clingy, hanging on to something that offered a somewhat inappropriate and dysfunctional sense of security. And most important, it also needed to be able to let go of fears and insecurity while finding new and more appropriate means for becoming free and managing life. An octopus seemed a likely character due to its numerous tentacles that could tenaciously hang on to—and let go of—an object.

BUILDING ON THE METAPHOR

As anyone who has spent any time as a therapist will know, the principles of learning are such that a single intervention is rarely enough to help a person change a lifelong problem and maintain the benefits of that change into their future. This was also true for Phillipa. Although the term *positive psychology* had not been coined at the time of Phillipa's therapy, my work was informed by approaches like Ericksonian psychotherapy (Erickson, Chapter 3, this volume; Lankton, Chapter 23, this volume) and solution-focused therapy (O'Hanlon, Chapter 25, this volume; Perloiro, Neto, & Marujo, Chapter 2, this volume) that were orienting therapists and clients toward outcomes, resources, strengths, and possibilities. Over the initial nine weekly sessions that Phillipa attended me, and a further three sessions about one month apart, several such interventions were included in therapy to help her find solutions and enhance well-being. She was:

1. Taught self-hypnosis and mindfulness exercises to build greater feelings of relaxation that would help reciprocally inhibit (Wolpe, 1958) or “undo” (Fredrickson, 2008) the fears and anxieties.
2. Introduced to nature-guided therapy with a focus on sensory awareness and the enjoyment of the pleasurable, engaging, and meaningful experiences available through contact with nature (Burns, 1998, 2005a, 2009).
3. Engaged in therapeutic conversations based on the principles and language of solution-focused therapy (de Shazer, 1991, 1994; O'Hanlon & Weiner-Davis, 1989).

However, let me make reference to two particularly important interventions.

Successive Approximations

Although Phillipa began to relax well in my office and at home, she still had difficulty generalizing this outside of those situations. To assist this process, she was given behavioral assignments of successive approximations toward her goal. Initially, I paid a home visit and took her on a short accompanied walk to a local shopping center. Within the first four weeks of commencing therapy, she was joining her husband on daily walks with their dogs through the local park. In two months, she had left home for a weekend to celebrate their 22nd wedding anniversary at a five-star hotel, and before the end of therapy she had taken a 30-minute light aircraft flight to an island resort for a vacation.

Strengthspotting

Although the delightful term *strengthspotting* was not in the psychological language at the time of Phillipa's therapy, the Ericksonian school of psychotherapy was asking such questions as: What is right with this person? What resources or skills does this person have to resolve his or her problems? How might those resources be utilized? (Erickson, Chapter 3, this volume).

Soon after the little octopus had evolved into the story I have summarized here, Phillipa spontaneously produced, and brought into therapy, a series of felt-pen drawings depicting the theme of our tale. Herein was a very obvious and latent artistic talent. In discussing her paintings of our story, her voice was animated, her face lit in a smile, and there were no signs of the previous intense fear. She spoke with the sounds of strength and the telltale signs of optimal functioning (Linley & Burns, Chapter 1, this volume). Consequently, we began to explore possibilities of how she might develop this ability. While she had long wanted to go to art classes, the phobia had thus far prevented her, but she acknowledged that she might be able to do so in the company of her daughter.

Going through my morning mail a year or so later, I found an invitation to the opening of an exhibition: Phillipa's exhibition! Together with her daughter, she had attended art classes. The teacher was so impressed with her skills that he selected her work for a solo exhibition. When I arrived at the opening, Phillipa ran over to me, took me by the hand, and led me around the gallery, enthusiastically describing each painting in turn. Her head was held high, her face was beaming with delight, and, though to the trained eye subtle signs of anxiety were—perhaps rather normally—present, she seemed comparatively comfortable away from home, amid a crowd of people.

Phillipa's artistic talents have gone on to win her wider acclaim—talents she has used not for personal gains but for helping others (Schwartz, Chapter 13, this volume). She has initiated and engaged in charity projects, such as to provide children in hospital with teddy bears and to place a teddy bear in every state police car so that officers attending the scene of an accident, violence, or abuse involving a child can give a bear for comfort. I have since seen her and her works photographed in the newspapers and watched her being interviewed on television about how she has continued to generously use her talents to support children in need.

FOLLOW-UP

It is rare in clinical work to have a follow-up on a client—even rarer to have a long-term follow-up—but Phillipa has made this possible. Every Christmas since she first attended

therapy some 25 years ago, she has been in touch with a story to tell—and in doing so, she has allowed me a privileged opportunity to follow someone’s posttherapy life story for such an extended period. Indeed, that is one of my main reasons for telling Phillipa’s story here. It offers a unique, long-term follow-up of communicating positive interventions and outcomes through metaphor.

She is long free of the walls that confined her to those few square yards of her front lawn. Currently, she gets out, walks the dogs with her husband, enjoys time with her family, goes shopping, has flown overseas, utilizes her artistic talents, and continues to give generously and warm-heartedly to others.

The outcome-oriented story we shared informed me a lot about the use of therapeutic metaphor and about working collaboratively with a client toward positive outcomes. More important, it was a facilitator in empowering Phillipa to alter the balance of her life and initiate such powerful healing. But the story alone was not the complete picture. It did offer hope. It did provide pathways or resources for her to follow, along with the agency to put them into practice. However, the conclusion may have been different without Phillipa’s talents, acknowledgment of those talents, and application to make life better.

As the octopus soared like an eagle, she looked down to watch the undulating waves of the ocean beneath her. She could see where she had come from.

Looking up, she viewed the open expanse of a clear blue sky, an expanse that seemed symbolic of a new sense of anticipation and held hope of a new set of aspirations. At last, the octopus knew her new ability to fly free, to let go of the past, to enjoy the experience of the moment, and to anticipate the delights of what lay ahead.

Putting It into Practice

1. Set the therapeutic goals.

If you know where you are going, it is easier to get there. This is true of pursuing a career, taking a vacation, doing therapy, or living life. If you establish clear, specific, approachable and attainable goals with your client, it becomes easier to find the means to achieve them.

2. Ask if a metaphor is helpful.

Metaphors are *one* way of communicating the positive messages of therapy, helping to instill hope, and imparting the skills for living a happier life. Ask if they are appropriate and likely to be helpful for this client at this time. For when and how *not* to use metaphors, see Burns (2001, pp. 217–220; 2007, p. 12).

3. Plan and construct the metaphor.

- a. *Decide on the metaphor’s outcome.* Here the story describes the experiences and feelings of having reached the metaphor’s objective as well as the ongoing benefits that are likely to be gained. Phillipa’s prime goal was to be free of the phobia, as free as an eagle. This was the outcome to which the story needed to head.

(Continued)

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- b. *Decide on the resources needed to reach that outcome.* What will this client need to reach the therapeutic goal? What do I know from the research and literature in positive psychology and other fields that may be helpful? The little octopus sought to show Phillipa a number of means to reach her end.
 - c. *Decide on the metaphoric problem.* What hurdles or obstacles does your client need to overcome to reach the therapeutic goal? If clients identify with the problem, they are also likely to with the resources and means to reach the outcome. Phillipa was stuck, ambivalent, and fearful—just like the little octopus hanging on to an anchor.
 - d. *Decide on a character to communicate the story.* What character can best present the problem, find resources for working through it, and reach a satisfactory outcome? The character should parallel the characteristics and challenges of the client. The little octopus reflected Phillipa's fear and ambivalence and her ability to fly like an eagle.
4. Present the metaphor to the client.
Using the PRO approach, tell the metaphoric tale to the client, introducing the character and moving from the problem through the resources to the outcome. This can be done conversationally or in conjunction with hypnosis, meditation, mindfulness, or deep relaxation.
 5. Build on the metaphor.
Build on the metaphor with other positive approaches that are helpful for moving toward the therapeutic goal.

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CHAPTER 27

Are There Times *Not* to Use Positive Therapy? *Some Concluding Thoughts*

George W. Burns

MEET THE CONTRIBUTOR

George's Meet the Contributor details are provided at the beginning of Chapter 1.

To be successful at anything we do, we, as much as our clients, need to know how and when to use the skills we have acquired as well as to know how and when *not* to do so. In driving an automobile, for example, you need to be specific and discriminating about when you push your foot down on the accelerator and when you do not. To succeed in relationships, you need to make discriminatory choices about when to be jovial, when to be serious, when to be intimate, and when not to be. In therapy, success is equally contingent on such mindful, specific, discriminatory thinking and choices about what to use and what to avoid.

I hope that we, the contributors to this book, have offered some useful skills and interventions to enhance your therapeutic practice and the lives of your clients. I hope that we have provided some very good reasons for considering and applying positive psychology approaches to therapy. However, some contributors have raised what they call caveats or warnings that are prudent for all of us to heed if we wish to employ these approaches successfully. These cautions lead to several important questions:

- What are the danger signs or risks to look out for in applying positive interventions?
- What precautions might I need to take?
- Are there times not to use positive therapy?

In addressing these questions, I have listed some of the precautions of concern to myself and other contributors. The headings detail things you may wish to avoid and the discussions present some suggestions and thoughts to be mindful of if you wish to succeed as a positive therapist.

POINTS TO BE MINDFUL OF

An Oversimplified Approach

Antonella Della Fave, in Chapter 8 of this volume, issues a warning about the growing level of trust in what she calls “the astonishing powers” of positive psychology and highlights two risks this may entail. The first is a concern that both the profession and the public may adopt an oversimplified approach to the complexity of human thought, feeling, and behavior. This in turn, has two potential consequences.

1. Dichotomizing experiences into the bipolar opposites of positive and negative diminishes the reality of the natural mixture of experiences that occur throughout our daily life. Robyn Walser and Maggie Chartier (Chapter 15, this volume) emphasize the need to fully experience *all* that there is to experience whatever and whenever those experiences arise without labeling them as either positive or negative. Their approach is about increasing the richness of living through the acceptance of all internal experience without evaluative judgment.
2. The dichotomous labeling of positive and negative implies a value judgment: Positive feelings are good and desirable whereas negative feelings are bad and undesirable. The reality of emotions, however, is not that simplistic. Grief, for example, may not feel positive, but it can have beneficial effects in enabling us to withdraw for a temporary period as we adjust to a significant loss. Similarly, anxiety may not feel good, but it can provide us with the necessary arousal to engage in life-saving action when faced by threatening circumstances. Rather than use the language of positive and negative that implies polar extremes of feel-good and feel-bad emotions, it may be better for us as therapists to think in terms of emotions that are helpful or beneficial to the client—and also assist clients to adjust their concepts in a similar direction.

A Panacea for All Problems

In discussing the second risk, Antonella Della Fave cautions about developing an excessive trust in positive therapeutic interventions, such as in seeing them as a panacea for all problems. As she says this, the old saying “Give a man a hammer and he will see every problem as a nail” comes to mind. All carpenters know they need many tools in their tool kit to undertake the variety of jobs they are likely to encounter in their trade. How much more complex is human functioning than the building or repair of a house? The broader and more expansive tool kit you have as a therapist, the more you are best likely to meet the needs of your clients and best facilitate their movement toward well-being. The strategies, techniques, and interventions that we as contributors have offered throughout this book are just *some* of the ways of doing therapy. As Bill O’Hanlon reminds us in Chapter 25, it is important to be

open to the growing body of knowledge and develop the therapeutic skills that can best match the needs of our individual clients.

Generalizable Laws

The psychological research—including positive psychological research—almost always looks for the consistencies across groups and populations. The search is for generalizable laws that apply to the majority of people in the majority of situations (Linley & Burns, Chapter 1, this volume). While there are some obvious advantages of knowing the trends and patterns that apply to most people, not everyone fits those laws and not everyone responds in the same way to the same technique. Robert Biswas-Diener (Chapter 24, this volume) gives us a case example of what happens when a client does not respond as expected to the solid body of evidence for using strengths in therapy. We have a professional responsibility as practitioners to be up-to-date with the research that points to those general trends and at the same time have a practical openness to the individual needs and characteristics of our clients. In other words, we need to be constantly searching for what fits and what does not.

Prescriptive, Formulaic Approach

Following on this theme, Maria Perloiro, Luís Neto, and Helena Marujo (Chapter 2, this volume) caution us against allowing positive psychotherapy to become too formulaic or prescriptive. They say that we should not base our sole direction on moving to a predetermined and prearranged outcome through a rigidly programmed approach. Science can serve a sound basis. Structure and techniques can provide us with ways and means for doing therapy, but over and beyond that, we need to recognize the importance of the person as a uniquely separate individual with unique needs, capabilities, experiences, background, and learning. Perloiro, Neto, and Marujo advocate that there also needs to be “the space for creativity and art; the space to feel, explore and connect.” As Milton Erickson simply put it, “Therapy should always be designed to fit the patient and not the patient fit the therapy” (Erickson & Rossi, 1979, p. 415).

Dismissal of the Problem

Often clients want to have their story heard. They may feel that their therapist is being dismissive if he or she downplays the problem and pushes the positive. There is a story I like of an elderly woman who called her telephone company to complain that whenever her phone rang, her dog moaned and urinated. The company sent a technician to investigate, and this is what he found: The dog was tied by a metal chain and collar to a pipe through which the telephone cable ran. The cable was not connected properly to the ground rod and released a charge whenever the phone rang, giving the dog a 90-volt shock that caused it to moan and pee. As a consequence, the technician was thus alerted to and fixed the problem. The moral of the story is this: If you have a problem, sometimes it pays to be peed off, have a good moan, and ensure it is heard.

Tedeschi and Calhoun remind us in Chapter 19 that we should never downplay the negative aspects a client experiences; not only do they need to be heard and acknowledged, but they also can serve as a very important basis for potential growth.

The Symptoms of Depression

At times when people are experiencing significantly depressed feelings, cognitions, and behaviors, they may have difficulty engaging in the active and interactive processes required by a positive therapeutic approach. When being self-effacing, it might be extremely hard for a person to recognize, acknowledge, or engage strengths. From a position of lethargy and enervation, it is a big leap to see the pathways and find the agency necessary to elevate hope. From the bleakness of depression, the transition to happiness might appear as improbable as the ability of a caveman to visit the moon. The skillful therapist will, it is hoped, (a) be aware of the discrepancy between the client's current position and the desired therapeutic goal, (b) offer empathy, and (c) carefully guide the client with successive approximations along the transitional journey.

When Something Is Not Working

As Robert Biswas-Diener points out in Chapter 24, if something is not working—no matter how empirically validated it may be—there is no point in persisting. The bottom line is, if it is not working, give up and try something different. This applies to positive therapeutic approaches as much as any therapeutic intervention from any therapeutic model.

Under Pressure to Be Happy

Michael Yapko has devoted his professional life to studying, writing about, treating, and training colleagues to treat depression. He says that as we promote the concepts of happiness and the resultant benefits of emotional well-being, health, and longevity, we raise the risk that people who have never really thought about whether they were (or needed to be) happy or not—the people who just got on with life reasonably contentedly—might feel pressured or cajoled into getting onto a new treadmill of striving for a goal of happiness (Yapko, 2006). Helping to establish the client's clear and specific therapeutic goals might be a way of minimizing this risk factor.

An Emotional Focus

As humans, we have a ready tendency to define ourselves according to our feelings, says Yapko (2006). For example, a depressed person who is advised about the benefits of exercising may respond, "I know that, but I don't *feel* like doing it." If we therapeutically direct clients' attention to positive feelings and emotions, are we fostering a process of emotional attention in people who are already too wrapped up in, and too driven by, their emotions? Whether focusing on negative or positive emotions, the process is much the same: Emotions still are the focus of attention and the driving force behind behaviors. Yapko cautions that encouraging more emotional focus may not be a good idea for some clients. In that case, it may be beneficial to focus therapy on fostering more discriminatory cognitive functioning (Garnier & Yapko, Chapter 12, this volume), meaning (Burns, Chapter 11, this volume), and values (Walser & Chartier, Chapter 15, this volume).

Global Thinking

One of the many things we have learned from the cognitive literature is how most humans are surprisingly global in their thinking (Yapko, 2006). This is particularly true for depression, when people make such global attributions as “Nobody loves me,” “Life sucks,” or “I have always been depressed.” Ask such people how they want to feel and if you get beyond “I don’t know,” the next response is likely to be something very global, such as “I want to be happy.” Yapko asks, “How much more global a statement can anyone make?” This raises an important question: Does the therapeutic pursuit of happiness encourage such global thinking, or does it provide an opportunity for us as therapists to help clients adopt more specific patterns of cognition about how to experience happiness, recognize its parameters, or even grasp when it is irrelevant?

Happiness as an End Goal

Many cultures have a long-held wisdom that is expressed in this proverb: “It is better to travel than arrive.” This saying suggests that the destination is not as important as the journey—and this can hold no greater truth than in the “pursuit” of happiness. Positive psychology has a potential risk of failing to heed this advice if it sets, or even appears to set, happiness as a goal or destination rather than perceiving happiness as the pleasure, engagement, and meaning a person can be grateful for along the journey of life. All too often, people make their happiness conditional with such statements as “I won’t be happy until . . .”—until I have attained my desired promotion at work, paid off my home mortgage, won the lottery, or have my ex-partner return, and so on. By making happiness a goal, particularly a conditional goal on things that may or may not happen, we miss out on the richness of life’s journey. We miss what is happening while we wait for what might—or might not—happen. As Helen Street reminds us in Chapter 4, therapy is likely to be more effective when it encourages clients to enjoy the journey or the process rather than await a distant goal or destination.

The Myth of Making

I once had a client who said of her partner, “He used to make me so happy, now all he does is make me unhappy, but being alone makes me unhappy too.” She had gotten herself in a very stuck position because to think that someone or something *makes* her happy or unhappy is disempowering. Conceptually, she was handing the power of her emotions to an external source, in this case her partner. Believing that something *makes* or *does not make* us happy is an attitude that is almost a guaranteed formula for unhappiness. Attributing the power of happiness to someone or something else puts a person in a victim role, and this, of course, is counterproductive for well-being. Thus, when therapists or researchers ask, “What makes you happy?” are they modeling or reinforcing a concept of disempowerment?

Conversely, when people feel they have some choice about how they respond to events in their life, they are likely to feel more empowerment and greater well-being. To facilitate this, watch the language you use with clients and the concepts your language may communicate. If you find yourself asking disempowering questions such as “What *makes* you happy?” it might help to rephrase them into more empowering questions: “What do *you* do to facilitate your own happiness? What are the times *you* feel most content?”

HAPPINESS, HEALING, ENHANCEMENT

All of us who have contributed to this book have done so with hope. We hope that it will add new tools to your therapeutic tool kit, strengthen your practice of therapy, and contribute to the enjoyment, engagement, and meaning you find in your work. We have sought to highlight some of the research in the various areas of positive psychology and translate that into practical therapeutic applications for the benefit of our clients. If we tread the therapeutic path with respect, offer expert companionship, base our approaches in sound knowledge and wisdom, are mindful of the potential danger signs, and allow space for art, creativity, and exploration, we are most likely to provide our clients with the pathways and agency not just to overcome life's challenging problems but also to live a full, flourishing life.

I am sure I speak for all contributors when I say we hope what we have offered in these pages will contribute to the happiness, healing, and enhancement of your clients . . . and also yourself.

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GEORGE W. BURNS is an internationally recognized clinical psychologist, author, and therapist trainer. He is Director of the Milton H. Erickson Institute of Western Australia and The Hypnotherapy Centre of Western Australia. He lectures around the world and is an adjunct senior lecturer at Edith Cowan University. He has published several books, including *101 Healing Stories*, *Healing with Stories*, and *101 Healing Stories for Kids and Teens*, all published by Wiley.

