

Quality of Life Therapy

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Introduction

Quality of Life Therapy (QOLT) (also known as Quality of Life Therapy and Coaching) aims to be a comprehensive, manualized (Frisch 2006), and individually-tailored package of positive psychology interventions suitable for both coaching and clinical applications (coaching clients are those devoid of DSM disorders who nevertheless wish to feel and function better in their daily lives). With respect to clients suffering from DSM-5 disorders, QOLT is meant to augment rather than to supplant evidence-based psychotherapies and pharmacotherapies (Land, 2006; Furey, 2007). Adding positive psychology to the treatment plan and thereby activating what Beck and his colleagues call the “constructive,” well-being, or happiness mode of emotion is essential to lasting psychotherapeutic change, according to Clark and Beck (1999). QOLT further integrates positive and clinical psychology by including techniques for the control of *negative* affect and feelings in addition to techniques aimed at boosting positive affective experience.

QOLT clients are taught strategies and skills aimed at helping them to identify, pursue, and fulfill their most cherished needs, goals, and wishes in sixteen valued areas of life said to comprise human well-being or happiness; these areas are defined in detail in Table 27.1 and also depicted in Figure 27.1 as part of a well-being assessment.

This theory-based approach offers an individually tailored *package* of well-being interventions to clients instead of single, brief interventions or a standard package of interventions offered to all clients (All of the client “toolbox” exercises in QOLT and mentioned in this chapter are available for download at: <http://www.wiley.com/go/frisch>).

QOLT uses an individualized assessment, the Quality of Life Inventory (QOLI) (Frisch, Clark, Rouse, Rudd, Paweleck, & Greenstone, 2005; Frisch 2009), to individually tailor interventions to the particular needs of clients, to assess progress and outcome, to fine-tune treatment, and to assess the risk of a well-being or unhappiness “relapse” (Frisch 2006). The QOLT theory that undergirds the approach attempts to integrate the findings from the fields of positive psychology, well-being, happiness, quality of life and social indicators research, coaching, psychotherapy, in general, and Beck’s cognitive therapy, in particular (Clark 2006; Diener, 2006).

The present chapter reviews randomized controlled trials of QOLT and proposes the adoption of standards from clinical psychology for “evidence-based” *treatments* and (in the case of coaching clients) *interventions* in positive psychology. The basic theory and steps of QOLT are delineated and illustrated with a case study. Research and service delivery system action steps are also proposed.

Table 27.1 The "sweet 16" areas in Quality of Life Therapy and Coaching and the Quality of Life Inventory or QOLI®: Sixteen Areas of Life Which May Constitute a Person's Overall Quality of Life.*

- 1 *Health* is being physically fit, not sick, and without pain or disability.
- 2 *Self-Esteem* means liking and respecting yourself in light of your strengths and weaknesses, successes and failures, and ability to handle problems.
- 3 *Goals-and-Values* (or philosophy of life) are your beliefs about what matters most in life and how you should live, both now and in the future. This includes your goals in life, what you think is right or wrong, and the purpose or meaning of life as you see it. It may or may not include spiritual beliefs.
- 4 *Money* (or standard of living) is made of three things. It is the money you earn, the things you own (like a car or furniture), and believing that you will have the money and things that you need in the future.
- 5 *Work* means your career or how you spend most of your time. You may work at a job, at home taking care of your family, or at school as a student. *Work* includes your duties on the job, the money you earn (if any), and the people you work with.
- 6 *Play* (or recreation) means what you do in your free time to relax, have fun, or improve yourself. This could include watching movies, visiting friends, or pursuing a hobby like sports or gardening.
- 7 *Learning* means gaining new skills or information about things that interest you. *Learning* can come from reading books or taking classes on subjects like history, car repair, or using a computer.
- 8 *Creativity* is using your imagination to come up with new and clever ways to solve everyday problems or to pursue a hobby such as painting, photography, or needlework. This can include decorating your home, playing the guitar, or finding a new way to solve a problem at work.
- 9 *Helping* (social service and civic action) means helping others in need or helping to make your community a better place to live. *Helping* can be done on your own or in a group such as a church, a neighborhood association, or a political party. *Helping* can include doing volunteer work at a school or giving money to a good cause. *Helping* means helping people who are not your friends or relatives.
- 10 *Love* (or love relationship) is a very close romantic relationship with another person. *Love* usually includes sexual feelings and feeling loved, cared for, and understood.
- 11 *Friends* (or friendships) are people (not relatives) you know well and care about who have interests and opinions like yours. *Friends* have fun together, talk about personal problems, and help each other out.
- 12 *Children* means how you get along with your child (or children). Think of how you get along as you care for, visit, or play with your child.
- 13 *Relatives* means how you get along with your parents, grandparents, brothers, sisters, aunts, uncles, and in-laws. Think about how you get along when you are doing things together, such as visiting, talking on the telephone, or helping each other out.
- 14 *Home* is where you live. It is your house or apartment and the yard around it. Think about how nice it looks, how big it is, and your rent or house payment.
- 15 *Neighborhood* is the area around your home. Think about how nice it looks, the amount of crime in the area, and how well you like the people.
- 16 *Community* is the whole city, town, or rural area where you live (it is not just your neighborhood). *Community* includes how nice the area looks, the amount of crime, and how well you like the people. It also includes places to go for fun like parks, concerts, sporting events, and restaurants. You may also consider the cost of things you need to buy, the availability of jobs, the government, schools, taxes, and pollution.

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Randomized Trials of Quality of Life Therapy

James R. Rodrigue of Beth Israel and Harvard Medical centers and his colleagues have conducted two US NIH-grant funded studies of QOLT, with a third NIH-funded trial currently underway. These trials include severely ill patients waiting for lung transplants, waiting for kidney transplants, and using implantable cardioverter defibrillators (ICDs), respectively.

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The years it usually takes to obtain a lung transplant are stressful for lung patients and their caregiving spouses. Both the wait of one to three years and the demands of managing this serious and chronic disease contribute to lowered well-being and quality of life, heightened stress, and strained relationships with caregiving spouses, making these patients and their loved ones prime candidates for well-being/positive psychology interventions. In the first trial, patients with severe lung disease awaiting lung transplants were randomly assigned to either QOLT ($N = 17$) or a treatment-as-usual (TAU) ($N = 18$) condition (Rodrigue, Baz, Widows, & Ehlers, 2005).

QOLI® Profile Report
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ID: 1
Blacksheep-PreTx

OVERALL QUALITY OF LIFE CLASSIFICATION

The client's satisfaction with life is Low. This person is generally unhappy and unfulfilled in life. People scoring in this range cannot get their basic needs met and cannot achieve their goals in several important areas of life. However, this person is able to achieve satisfaction in some areas of life, a fact that can be used in treatment to encourage his efforts to change. Although this person may not show obvious signs of distress or psychological disturbance, he may nevertheless be disturbed. Even if this person is not currently impaired, he is at risk for developing physical and mental health disorders, especially clinical depression. This risk remains until the client's score reaches or exceeds the Average range. You may wish to investigate this individual's status with further psychological assessment.

WEIGHTED SATISFACTION PROFILE

The Weighted Satisfaction Profile helps to explain a person's Overall Quality of Life by identifying the specific areas of satisfaction and dissatisfaction that contribute to the QOLI raw score. Clinical experience suggests that any negative weighted satisfaction rating denotes an area of life in which the individual may benefit from treatment; ratings of -6 and -4 are of greatest concern and urgency. Specific reasons for dissatisfaction should be investigated more fully with the client in a clinical interview. The *Manual and Treatment Guide for the Quality of Life Inventory* suggests treatment techniques for improving patient satisfaction in each area of life assessed by the QOLI.

The following weighted satisfaction ratings indicate areas of dissatisfaction for the client:

<u>Area</u>	<u>Weighted Satisfaction Rating</u>
Health	-6
Love	-4
Self-Esteem	-2
Community	-2
Learning	-1
Helping	-1
Relatives	-1

OMITTED ITEMS

None omitted.

End of Report

Figure 27.1 Quality of Life Inventory Profile. Case of B: Excerpt from client online profile report. Copyright © 1998, 1994, Michael B. Frisch, Ph.D. Reproduced with permission of NCS Pearson, Inc. All rights reserved. "QOLI" is a trademark of Michael B. Frisch, Ph.D.

INTRODUCTION

The Quality of Life Inventory (QOLI) provides a score that indicates a person's overall satisfaction with life. People's life satisfaction is based on how well their needs, goals, and wishes are being met in important areas of life. The information in this report should be used in conjunction with professional judgment, taking into account any other pertinent information concerning the individual.

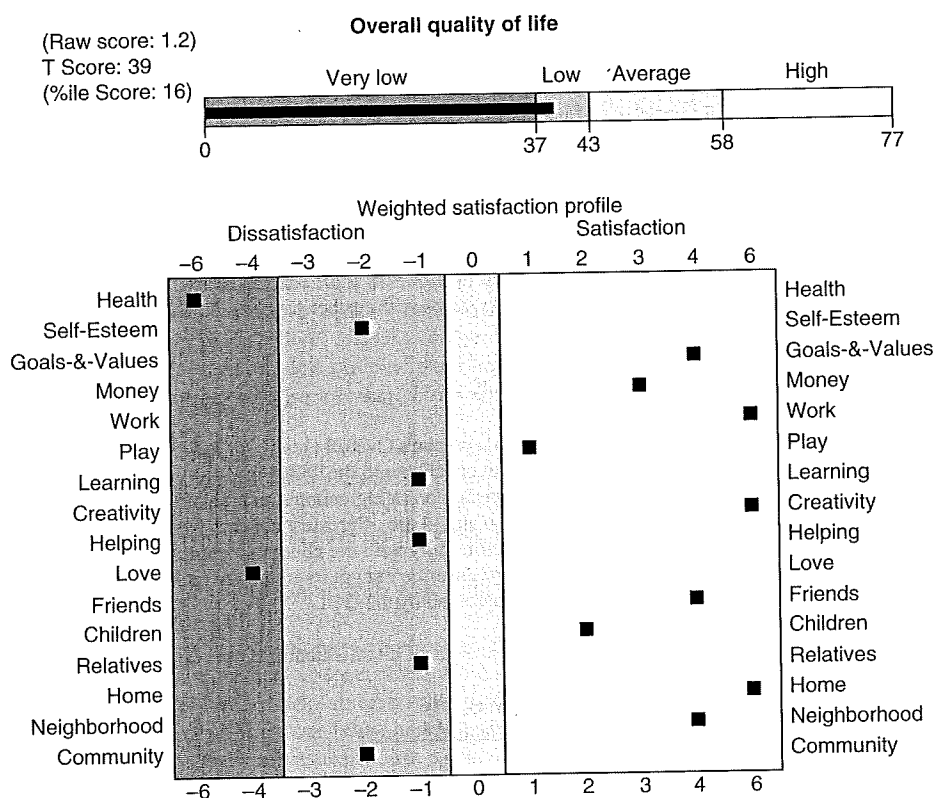


Figure 27.1 (Continued)

The TAU group was designed to mimic the usual treatment for lung patients awaiting transplants, including emotional and educational support, empathic listening to concerns, discussing activities, and encouraging contact with friends, relatives, and other support systems. The mean age of patients was 48.7 years and each received between eight to twelve sessions of treatment. Those collecting data were unaware of patients' treatment condition. QOLT here involved identifying two to five areas of life on the QOLI deemed very important, but also unfulfilling or dis-satisfying that a patient wished to work on. Next, interventions were administered in order to boost client's level of satisfaction with each of these areas of life. For example, relationship skills such as the "Take a Letter Technique" were applied to estranged relationships in order to reestablish contact and closeness. The Five Paths to Happiness exercise was also employed for each area of life, along with emotional control techniques aimed at minimizing negative affect.

While the two groups did not differ significantly at pre-intervention, QOLT patients were significantly more satisfied with their lives than TAU patients at the two follow-up periods of one and three months (post-tests were not conducted). In a measure of clinical or practical significance (Kazdin, 2003) that was also found to be statistically significant, 13 of 17 or 76.47% of the QOLT patients moved to within the normal range on the QOLI for a nonclinical, functional, nationwide standardization sample at the three-month follow-up, compared with only 5 of 18 or 27% of TAU patients. QOLT patients reported significantly greater social intimacy and closeness with their caregiving spouses/partners at the one-month follow-up and significantly less negative affect at the three-month follow up assessment than TAU patients. Changes in health status and therapy-therapist process ratings were comparable for each intervention group at the study's conclusion, making it less likely that these factors affected outcomes.

The caregiving spouses or partners of patients assigned to the two groups took the same assessments at the same times as patients in an effort to see if positive treatment effects might be "contagious" or accrue to spouses or partners not in treatment themselves. These findings are reported in a separate article by Rodrigue, Widows, and Baz (2006). Relative to the caregivers of patients assigned to the TAU condition, caregivers of patients assigned to the QOLT condition reported significantly greater social intimacy at both the one- and three-month follow up assessments, along with greater life satisfaction/quality of life (QOLI) at the one-month follow up and significantly less negative affect at the three-month follow up. This pattern of results for spouse/partners on all three measures directly mirrors that of patients who received QOLT training as reported in Rodrigue et al. (2005). That is, both patients receiving QOLT and the spouse/partner/caregivers that they lived with while receiving QOLT, significantly improved in their quality of life, mood, and social intimacy (relative to those involved in the supportive treatment group) after the QOLT intervention was delivered:

Caregivers whose patients received Quality of Life Therapy reported vicarious gains in quality of life, mood, and social intimacy, relative to those whose patients received ... the usual or standard intervention. These findings suggest that Quality of Life Therapy has beneficial effects that extend beyond the patient to their caregivers ... Findings from this study suggest that Quality of Life Therapy provides an opportunity to improve the lives both of patients awaiting a lung transplant and their primary caregivers. Mood disturbance and social intimacy benefits for caregivers may last as long as three months following the patient's completion of psychological treatment. (Rodrigue et al., 2006, p. 341)

The vicarious gains of spouse/partners of QOLT patients may be due to patients sharing and discussing QOLT treatment ideas and homework assignments with their spouse or partner over the course of QOLT. Finally, improvements in patients' quality of life and mood as a result of QOLT predicted higher functioning in their caregiving spouses or partners, thereby helping to maintain a crucial social support system.

The randomized controlled trial with lung patients was replicated in a second NIH grant-funded trial with adults with end-stage renal disease who were awaiting kidney transplantation (Rodrigue, Mandelbrot, & Pavlakis, 2011). Patients were randomly assigned to a no (psychological) treatment control (NTC) group ($N = 20$) or to eight weekly sessions of either QOLT ($N = 22$) or TAU ($N = 20$), which was an elaboration and expansion of the TAU condition present in the lung patient study.

Patients assigned to the QOLT group had significantly higher life satisfaction/quality of life scores than either TAU or NTC patients at both post-treatment and (three-month) follow-up assessments. The QOLT group mean moved from the low to the average range on the QOLI from pre-treatment to post-treatment and follow-up. This move denotes clinically significant change in so far as patients moved to within one standard deviation of the average

range for a US nationwide standardization sample of functional, nonclinical adults (Kazdin, 2003). Group means for the other two groups remained in the low or very low range at all times of assessment, indicating an inability to reach the mean (or above) for the functional standardization sample.

Patients assigned to the QOLT group had significantly higher SF-36 Mental Functioning scores than either the TAU or NTC group at the three-month follow up assessment. At follow-up, patients assigned to the QOLT group had significantly higher social intimacy (with caregiver) scores than NTC patients, who failed to differ from TAU patients; the same pattern was found on a measure of negative affect. That is, QOLT patients had significantly lower levels of negative affect, as measured by the Profile of Mood States – Short Form, at follow up than NTC patients who failed to differ from TAU patients. Both QOLT and TAU patients had lower scores than NTC patients at follow up on two symptom measures: the Hopkins Symptom Checklist-25, and the Hopkins' Number of Unhealthy Mental Health Days in the past month.

The two NIH grant-supported studies of QOLT by Rodrigue and his colleagues were replicated in a randomized controlled trial conducted by a different laboratory in a different country, using a heretofore untested population. This third trial involved the often beleaguered parents of children with a challenging DSM psychiatric/mental disorder, that is, obsessive-compulsive disorder (Abedi & Vostanis, 2010). Forty parents living in Iran were randomly assigned to QOLT ($N = 20$) or a wait list control group ($N = 20$). Training in QOLT was conducted in eight 90-minute group sessions, with ten participants each, over a four-week period. QOLT consisted of strategies for identifying life goals and for increasing happiness and satisfaction in the 16 areas of life said to comprise overall quality of life. As part of the Five Paths intervention, parents also learned to lower expectations, change life priorities, reduce perfectionism, and to adopt a more positive attitude toward their children's symptoms. Parents were also taught time management skills and the need for balance in their lives (Balanced Life Tenet), including time for themselves away from the family. Relative to controls, QOLT parents had higher quality of life or life satisfaction scores (QOLI) at post-test. Indeed, the mean QOLI scores of parents receiving QOLT moved from the very low range (first to tenth percentile scores) to well within the average range of the functional standardization sample, while the mean QOLI scores of parents in the control condition remained in the very low range throughout the study. In a replication of the Rodrigue et al. (2006) "social contagion effect," parents' gains in quality of life generalized to their children even though the children were not exposed to QOLT. Specifically, children of parents in QOLT reported higher overall quality of life and quality of life in three of five specific childhood domains on a measure designed for children. Additionally, children of parents in QOLT reported significant reductions (relative to children of control participants) in general anxiety and OCD symptoms. In contrast to the two Rodrigue studies, this study lacked an active and established treatment/intervention control group.

The Elephant in the Room or What Constitutes an Evidence-based Intervention?

The delineation of evidence-based treatments has become an international movement involving myriad fields and professions, including medicine, dentistry, nursing, clinical psychology, education, social services, and social work (Kazdin, 2006). While touting the pre-eminent importance of using only evidence-based interventions and assessments in their practice, positive psychologists have ignored the proverbial elephant in the room, that is, the lack of agreed-on criteria for reliably designating an intervention "evidence-based" to begin with. Without these criteria or guidelines, it becomes difficult, if not impossible, for practitioners to choose interventions with adequate research support. One solution to this conundrum is for positive psychologists to adopt the rigorous standards developed by clinical psychology (Wood & Tarrier, 2010); this solution is also consonant with QOLT's aim to integrate well-being with existing

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treatments for DSM disorders. In a review of clinical psychology criteria, Kazdin (2006) summarized the efforts to date, specifying that evidence-based treatments must be:

- 1 manualized such that the steps in treatment are specified in a written manual or book;
- 2 compared favorably (statistically significant) to either a no-treatment control group or another established intervention, such as “standard care” or treatment as usual in two or more randomized controlled clinical studies; and
- 3 found effective in at least one replication study beyond the original investigator or originator of treatment.

With only three randomized controlled trials to date, Quality of Life Therapy clearly needs more research to be an established positive psychology intervention package. Nevertheless (and based on the review of studies herein), Quality of Life Therapy meets the clinical psychology criteria summarized by Kazdin (2006) for an evidence-based intervention. Unfortunately, many positive psychology interventions lack even these three randomized controlled trials; rarer still are studies with active control groups that receive a currently used, standard, or established intervention (Wood & Tarrrier, 2010). Established treatment control groups may be especially important when extravagant claims are made that well-being interventions, by themselves, can effectively treat clinical disorders like major depressive disorder or nicotine use disorder. Adopting the criteria used herein or other strict criteria will certainly move the field forward, especially a field that seeks scientific respectability and touts the “empirical validation” of its techniques.

Theory and Therapy

Rationale and Motivation for Intervention

Clients are taught to expect a “trinity” of happiness benefits if they are successful in QOLT: (1) better health and longevity; (2) more rewarding relationships with others; and (3) greater success in work. It is also said that “helping”/altruism/prosocial behavior is positively impacted by greater happiness (the detailed theory of QOLT and supportive references may be found in “the manual” for QOLT) (Frisch 2006; also see Frisch, 2013). This is the rationale for QOLT with nonclinical, *coaching* clients such as the professional groups of lawyers, teachers, businesspeople, physicians, clergy, and police personnel. Clients in treatment for DSM-5 disorders are also taught to expect an increased acute care response when well-being interventions are added to typical psychotherapy and pharmacological regimens; well-being interventions may also prevent clinical relapse (see Fava, Chapter 26, this volume; Kennard et al., 2014; and the Rodrigue studies of QOLT reviewed here).

Clients are next taught the theory of QOLT in summary form (see Frisch 2006, 2013, for detailed theory). After factoring out temperament and so-called “scars of abuse” which may permanently alter baseline mood, 50–80% (Diener and Biswas-Diener 2008) of human happiness and meaning come from efforts to fulfill our most cherished needs, goals, and wishes in the “sweet 16” areas of life found to be related to human happiness (which are defined in detail in the QOLI test booklet and in Table 27.1 here). Our satisfaction with each area of life in the “sweet 16” are, in turn, determined by the area’s objective Circumstances, our Attitudes/interpretations about the area, our Standards of fulfillment for the area, and the Importance of and area or the extent to which we value, prize, or prioritize the area relative to others. These four components are combined with a fifth to make up the CASIO or Five Paths to Happiness problem-solving rubric in QOLT. The fifth path or “O” strategy refers to boosting satisfaction in Other areas of the “sweet sixteen” that are not a problem or focus of counseling with the understanding that any increase in satisfaction for a *specific* area will boost satisfaction or quality of life *overall*.

Five Paths is used in QOLT as a general approach to either problem solving or to boosting satisfaction/fulfillment in *any* area of life. A completed example of this exercise is depicted in Figure 27.2.

Besides the general Five Paths strategy, clients are taught to learn and apply area-specific interventions in QOLT. For example, interventions from the Work and Retirement chapter of the manual (Frisch 2006) have been successfully applied to clients' work goals and general work dissatisfaction. Similarly, interventions from the relationship chapter of the manual are designed to help in enhancing relationship satisfaction or in finding a new love relationship or friendship where none presently exists. In fact, QOLT can best be summarized in these terms; that is,

Brainstorm possible solutions under each CASIO strategy, or, in other words, by listing attitudes or actions for managing or solving the problem.				
C	A	S	I	O
Changing Circumstances	Changing Attitudes	Changing Goals and Standards	Changing Priorities or What's Important	Boost Satisfaction in Other Areas not Considered Before
Basic Strategy:	Basic Strategy:	Basic Strategy:	Basic Strategy:	Basic Strategy:
Problem solve to improve situation.	Find out what is really happening and what it means for you and your future.	Set realistic goals and experiment with raising and lowering standards. What new goals and standards can you come up with?	Re-evaluate priorities in life and emphasize what is most important and controllable.	Increase satisfaction in any areas you care about for an overall boost to happiness.
I need to decide whether to make peace with Ashley and accept her overtures or keep "blowing" her off.	My folks taught me garbage I don't have to listen to like I'm "no good." I think they were "no good" as parents. No kid is inherently bad!	Try for a B in my class for one week and see if "the sky falls."	Feed my soul with reading a novel, making friends, and going to Temple. Without some Inner Abundance, I'm no good to anybody.	Walking the mall brings me to people and is the best "antidepressant" I got!
	Just 'cause Stan (husband) wants to sit around and "watch" the grass grow, doesn't mean I can't travel to see the kids and grandkids.	Try to just be kind and connect with a "hello" to folks/potential friends as I make a String of Pearls or a "string" of positive connections each day with folks I see.	Quit beating my head against the wall. I can't change Stan (husband). Stop trying and "do your own thing" more.	

Figure 27.2 Five (CASIO) paths to happiness (or problem solving) exercise: excerpt with client examples.

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QOLT aims at boosting clients' level of well-being, happiness, meaning in their lives, quality of life, and positive goal success by matching clients' goals with interventions in one of the "sweet 16" areas of life said to comprise human happiness and meaning. In addition, QOLT interventions can be applied to any and all "sweet 16" areas of life that are valued as important to clients, understanding that *overall* happiness and meaning will be increased to the extent that any or all *specific* areas of life are enhanced. QOLT is made more manageable for clients by focusing on only two to five areas of life at a time. Additional areas can be targets for intervention when very small, "doable" changes can boost satisfaction with an area as when a client begins to skype with a distant but dear friend once a month.

Making an Intervention Plan Based on a Well-being Assessment

Once clients are versed in the rationale for QOLT, a domain-based well-being assessment is administered. The QOLI is a measure of satisfaction with life specifically suited for use in QOLT (Frisch et al., 2005; Frisch 2009). The QOLI consists of 16 items selected to include domains of life that have been empirically associated with overall life satisfaction or happiness (see Table 27.1). Respondents rate how important each of the 16 domains is to their overall happiness and satisfaction (0 = not at all important, 1 = important, 2 = very important) followed by rating of how satisfied they are in the area (-3 = very dissatisfied to 3 = very satisfied). The importance and satisfaction ratings for each item are multiplied to form weighted satisfaction ratings ranging from -6 to 6. A "Weighted Satisfaction Profile" akin to an MMPI profile of well-being (versus ill-being) is generated which gives a comprehensive overview of clients satisfaction with life, see Figure 27.1). The overall life satisfaction is computed by averaging all weighted satisfaction ratings with nonzero importance ratings; the total score thus reflects one's satisfaction in only those areas of life one considers important. Respondents can also indicate what problems interfere with their satisfaction in each area on a narrative section of the QOLI test booklet.

The graphic portion of QOLI results for a client are displayed in Figure 27.1. Overall Quality Of Life or well-being is depicted at the top of the page in terms of a nationwide US standardization sample. Results for each of the "sweet 16" areas of life which make up the Overall Quality of Life are depicted in the Weighted Satisfaction Profile in the lower half of Figure 27.1, with areas on right-hand side of the graph denoting strength, fulfillment, and satisfaction and areas on the left-hand side denoting areas of dissatisfaction in which important needs, goals, and wishes are *not* being fulfilled.

Areas of dissatisfaction typically become targets for goal-setting and intervention in QOLT. This is the essence of a case conceptualization and intervention plan shared with clients along with their pre-intervention QOLI results (Frisch 2006). To wit, since their overall contentment is made up of the sum of satisfactions in valued areas of life, interventions will be "prescribed" for their areas of dissatisfaction. According to the theory, boosting satisfaction in specific areas of dissatisfaction will also increase their overall contentment and well-being. Once clients understand and accept this rationale, they collaborate with the therapist/coach in deciding when and how to address their areas of dissatisfaction.

Goal-setting, Self-care, and Making Time for Change Efforts

Next, clients set goals for areas of life they value and put in place some self-care ("Inner Abundance") practices to support their efforts to build a life of greater meaning and happiness. This includes some daily time set aside for relaxation and reflection on their QOLT efforts. Collectively, these steps are called the "Three Pillars" of QOLT.

Controlling Negative Affect and Time Management

QOLT teaches clients basic mood control and life management skills aimed at controlling negative affect and organizing their lives in the service of striving for personal goals in valued areas of life. Since Diener and others (see Diener, Suh, Lucas, & Smith, 1999) defined happiness as a preponderance of positive over negative affective experience, it stands to reason that both coaching and clinical clients must learn skills aimed at controlling negative emotions lest negative affect vitiates or cancels out increases in positive affective experience. Negative emotions are an inevitable part of human experience even for the so-called "chronically" (Lyubomirsky, Sheldon, & Schkade, 2005) or very happy (Diener & Seligman, 2002). For example, when goal pursuits are thwarted, clients may be expected to experience anxiety, depression, and/or anger. Feeling bad is good if it gives us a wake-up call to find a new or different path to getting our needs met, as when unhappy lovers realize their irreconcilable differences and find someone more suitable. Feeling bad often and for long periods of time is not good, however. For this reason, skills in mindfulness, postponement of worry and problem solving, and cognitive restructuring are offered as ways to help clients manage their negative affects constructively, that is, in a way that minimizes their intensity and keeps them active in pursuing positive life goals. Without such skills in "(negative) emotional control" (Frisch, 2006), clients' level of negative affective experience can nullify gains in positive affect, immobilize clients, interfere with relationships, impede advanced social problem solving in postmodern societies, and even lead to addictive or risky behaviors (Witkiewitz & Marlatt, 2004). Clinical clients are especially in need of such skills as they are prone to chronic problems such as "negative affect syndrome" (Barlow, Allen, & Choate, 2004), neuroticism, or negative affectivity.

Matching Goals to Area-specific Interventions in the "Sweet 16"

Aside from use of the generally applicable Five Paths intervention, Quality of Life Therapy intervention consists of matching clients' goals for coaching, therapy, and life with interventions in one of the "sweet 16" areas. The procedure is the same whether the venue is coaching, organizational psychology, mental health, or behavioral medicine. The manual for QOLT (Frisch, 2006) provides step-by-step instruction and case illustrations of assessing well-being, planning and tailoring interventions, and monitoring progress, outcome, and follow-up with the the Quality of Life Inventory. The interventions include a compendium of "state of the art" (Diener, 2006) positive psychology interventions such as gratitude and strengths exercises along with more innovative interventions based upon the integrative theory discussed here, and the author's positive psychology coaching, therapy, and supervision practice of twenty years (Furey, 2007; Sirgy & Wu, 2009). Many of the interventions are summarized in the form of a convenient client checklist, called the "Positive Psychology Practices Questionnaire (P3Q)" in the Appendix.

Reassessment, Fine-tuning, and Follow-up for Relapse Prevention

The Quality of Life Inventory is re-administered every three weeks or so during intervention to gauge progress in areas of life that are targets for intervention. Intervention is fine-tuned or changed when new patterns or problems emerge in assessment results (e.g., see Kazdin, 1993, 2003).

Illustrative Clinical Case: Case of B or "Black Sheep"

As the following case illustrates, adding QOLT to a clinical or therapy practice can be as simple as administering a 10-minute assessment to a client, developing positive life goals for valued areas of life, and applying a few area-specific interventions to accomplish these goals (this is a

disguised case history designed to protect the anonymity of the client; B felt rejected by her family of origin who saw her as the "black sheep" in the family).

"Dr. James, this is Jack Sprat. I am in trouble. My supervisor and internship training director (aka B) is "coming on" to me. Our supervision sessions have moved to eight o'clock at night at her apartment with a candlelit dinner! I am afraid to do anything since she is evaluating me and must write a letter of recommendation for any job I get after completing my internship." After an intervention to remove B from any supervisory authority over Jack's work, she was referred to the author for therapy.

B was a 55-year old European-American single woman. B described Jack as "the perfect man" and "God's gift to womanhood." Jack had movie star looks, impeccable manners, and a quick wit. He was a gourmet cook, and loved to discuss "chick" flicks and books. B came to "know and love" Jack during long bus rides to a rural practicum site some distance from the the medical center in Waco, Texas which served as the primary internship site.

After a successful course of cognitive therapy for major depressive disorder related to the end of her relationship with Jack Sprat, B, while asymptomatic, reported feeling "blah." She no longer felt bad, but did not feel particularly *good*. Specifically, while B's level of negative affect was in the tenth percentile at post-treatment, her level of positive affect experience was also very low (seventh percentile) as measured by the Scale of Positive and Negative Experience (Diener et al., 2010). While her Beck Depression Inventory-II was in the nonclinical or low range at post-treatment, her overall score on the Quality of Life Inventory, was also in the low range, signifying a lack of fulfillment in some highly valued areas of life; B's QOLI test results are presented in Figure 27.1. These assessment results brought to mind David A. Clark's (2006) rationale for adding positive psychology to traditional psychotherapies, to wit:

In some respects, clinical psychology and psychiatry have exhibited a depressive thinking style in their theories, research, and treatment of psychological disorders. We have tended to focus exclusively on the negative. Our preoccupation has been the relief of suffering, the alleviation of negative emotions, the restructuring of negative cognitions and dysfunctional schemas, and the modification of problematic behavioral responses ... As psychotherapists, we have ignored the "half-full" side of the equation. That is, we rarely address issues of happiness, contentment, and quality of life. At last psychologists like Ed Diener, Martin Seligman, and Michael B. Frisch have begun to readdress this imbalance in our perspective on human emotion ... *Treating negative mood will not automatically lead to happiness and life satisfaction in our patients. Instead a new and expanded therapeutic perspective is needed that directly addresses issues of positive affect, life satisfaction, and contentment.* (Clark, 2006, p. ix, italics added)

Based on this rationale, QOLT was instituted in an effort to boost B's positive affect experience and satisfaction with life (QOLT can also be implemented *concurrently* with a psychotherapy and/or pharmacotherapy; see Furey (2007) and Frisch (2006) for guidelines on how to do this). B was excited and motivated by the prospect of learning ways to be happier and more enthusiastic about her life. She also was intrigued by the part of the rationale that promised a prophylactic effect from QOLT. After five episodes of major depressive disorder, B was eager to learn an approach that would also reduce her risk of relapse.

B's overall quality of life score was broken down into the "Sweet 16" areas of life—see Weighted Satisfaction Profile in Figure 27.1; while satisfied and fulfilled in areas of life such as, money, work, and home, she was *dissatisfied* the areas of health, self-esteem, learning, helping, love, relatives, and community.

Clark and Beck (1999) identify the pursuit of positive goals as key to activating the "constructive mode" of well-being and to "lasting" therapeutic change. Positive goal pursuit is also a core intervention in the QOLT. For example, B identified *positive goals* for each of her six areas of dissatisfaction (i.e., work, relatives, play, creativity, and friends) in contrast to the more negative, symptom-oriented goals characteristic of her first phase of treatment

(These initial goals were aimed at reducing symptoms of sleep and appetite disturbance, suicidal ideation, fatigue, and depressed mood; B also secured services such as adult day care for her frail elderly mother with major neurocognitive disorder due to Alzheimer's disease in this first cognitive therapy phase of treatment). Interventions from the chapters in the QOLT manual corresponding to B's five areas of dissatisfaction were discussed with B as a way to plan and prioritize interventions.

In an effort to not overwhelm B, only two of her areas of dissatisfaction were targeted for *sustained* intervention, that is, helping and love. With the help of her therapist and the Five Paths Exercise, B did, however, choose some simple "Happiness Habits" to boost her satisfaction with four additional areas: health, self-esteem, relatives, and community. For example, her concern about health ("I'm overweight and out of shape") was addressed by visiting a local YMCA each weekday morning before work to attend an exercise class where she accrued the added benefit of making new friends and serving or helping the community by supporting a nonprofit agency that she believed in. She pursued the "Do not Ask Path" to self-esteem, by viewing self-esteem as a meaningless abstraction and learning to mindfully ignore self-downing thoughts when they would arise. She also expected a boost in self-esteem as she made progress toward her goals in other areas of life like helping or love (the "Success Path" to self-esteem). With respect to relatives, B set up a weekly time to visit her two estranged sisters from California via Skype or Facetime; they read books together and even bingewatched shows on Netflix contiguously, commenting on an episode via phone as if they were in the same room.

B found helping or altruism/prosocial activities to be her "favorite antidepressant." That is, when feeling down, she called or skyped her two sisters from California or friends from an Alzheimer's support group to visit with them, inquire about how they were doing, and encourage their efforts in dealing with problems. She also sent homemade greeting cards and e-cards to these people. Contacting local people also led to deepening friendships and dates for coffee, lunch, and dinner.

B's most ambitious helping project involved all the steps of establishing a "Helping Routine" in order to form an Alzheimer's disease support group where none existed in her community. Initially, B felt too shy and overwhelmed to consider this project. She spoke with numerous "Expert Friends" in the community about the idea and invoked QOLT skills pertaining to relationship skills and time management to make this dream a reality. For example, B broke down the project into simple, 15-minute tasks such as calling her mother's physician and the US Alzheimer's Association for guidance and advice. Eventually, she asked others take over the leadership roles for this group.

Using QOLT relationship skills such as role-playing and "Making Conversation" and tenets like "Find a Friend, Find a Mate," B found a boyfriend whom she later married, in spite of admonitions from friends that "all the good men are taken or dead" in late middle age. A key for her was an online dating website and meeting men at the "cultural hub" of Waco, that is, a Barnes and Noble bookstore.

In terms of self-care and emotional control, B found a "Relaxation Ritual" helpful when she felt overwhelmed or frustrated in carrying out her "happiness project." Her favorite ritual from the manual consisted of quietly reading over the client handout called "Tenets of Contentment," which summarizes much of the philosophy, attitudes, and skills that make up QOLT. While reading, she gained inspiration from tenets she thought might apply to her "happiness project" as she called it. In her words, "I read the Tenets like a self-help book in a comfortable, quiet place or the bath." B also found it helpful to postpone worries and problem solving to a time of day when she felt calm, centered, and unrushed ("Guide for Worry Warts" exercise). At other times, she would try to distract herself from worries via "Mindful Breathing," which is based on Jon Kabat-Zinn's and the Austin Zen Center's approach to meditation and mindfulness throughout the day.

B's 12 weeks of well-being interventions led to a sense of *élan vital* and flourishing reflected in increases on the SPANE (Positive Affect subtest score at the eighty-third percentile) and Quality of Life Inventory. The latter score moved to the average range of the standardization sample.

B reported feeling good as if she really "had a reason to get up in the morning," although she would still become upset for days at a time when her goal pursuits were thwarted. At a two-year follow-up, her Quality of Life Inventory scores moved into the high range, according to B, who had taken to assessing her own "emotional temperature" with the Quality of Life Inventory every three or four months (this well-being test and others can be directly obtained and used by clients and laypersons themselves. Periodic self-administration of well-being tests can aid clients like B in preventing relapses into happiness-depleting thoughts, behaviors, and activities.

Future Research and Applications

Research on QOLT and its companion assessment, the Quality of Life Inventory, are still in their infancy. It is hoped that this chapter may inspire talented researchers to further explore the efficacy and effectiveness of QOLT for various populations and disorders as well as its ability to prevent relapse and significantly add to the effects of established treatments for DSM-5 disorders. In one study to date, the QOLI significantly predicted academic retention one to three years in advance in a university setting (Frisch et al., 2005). The theory-based prediction that low QOLI scores may also predict health, work, and relationship problems needs the same rigorous testing, including large cross-validation samples.

The "dismantling strategy" for randomized controlled trials may be employed to establish which components or elements of QOLT are most efficacious. For example, the additive effects of positive versus negative affect interventions on of positive and negative affect as well as satisfaction with life, DSM-5 symptoms and functioning bears scrutiny given the complex interrelationships among these constructs. For example, David Barlow and his colleagues (Carl, Fairholme, Gallagher, Thompson-Hollands, & Barlow, 2014) found that anxiety and depression symptoms decrease positive affect reactivity and increase the downregulation of positive affect. Positive and negative affect are inextricably intertwined like the red and white stripes of a peppermint stick. It is time that we heed the clarion call for simultaneously attending to both constructs in clinical work (Wood and TARRIER, 2010; Gilbert, 2012; Carl, Soskin, Kerns, & Barlow, 2013).

QOLT should also be delivered via the web, including Facebook and smart phone apps, since traditional face to face coaching and clinical delivery systems are not reaching all of those who can benefit from positive psychology intervention and assessment. The use of peer-led support groups emanating from families or groups be they work-, spiritual-, or hobby-based groups can also broaden the exposure of the general public to positive psychology.

QOLT could be tested as a type of training in ethics and emotional competence for health professionals. Fully 50% of ethical lapses are related to unhappiness at the time of the infraction (Frisch, 2006; Koocher & Keith-Spiegel, 2008); this was certainly true in the case of B discussed here. QOLT may prevent burnout and ethical or technical mistakes made by mental health professionals who must learn and practice *emotional* as well as technical competence, according to Pope and Vasquez (2011). How might this be accomplished? Just as Freud and Ellis, tested ideas and techniques on themselves first, clinicians may learn QOLT interventions by first trying them out for themselves. This could boost their well-being at the same time as it schools them in the approach vis-à-vis clients. Professional societies like the British Psychological Society could also offer QOLT training to their members as part of their ethics offerings in continuing education.

In terms of traditional health care, integrated service delivery systems in which well-being assessments and interventions are considered co-equal with and are conducted concurrently

with symptom-oriented assessments and interventions should be developed and evaluated. Since it is the goal of all health care interventions is to maintain or enhance well-being and quality of life in addition to effecting a "cure" for a disorder or disease, the addition of routine well being assessment and intervention procedures to psychology and medicine can be expected to improve clients' and patients' well-being and quality of life. An intriguing possibility raised by Diener and Chan (2011) is that well-being intervention packages like QOLT may improve health directly, that is, impact the symptoms of disorder/disease, even when such interventions are not directly related to the disease or disorder (e.g., chronic pain, heart disease).

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Appendix: Positive Psychology Practices Questionnaire (P3Q)

Name: _____

Date: _____

Instructions: This research-supported powerhouse asks you about happiness practices, attitudes, and skills which you can do at any time to build a life of happiness, meaning, and enjoyable feelings. The questionnaire summarizes the major positive psychology techniques for boosting people's happiness or well-being. Experiment with these in your daily life. Activities and attitudes which reliably boost your mood, contentment, and meaning can be made Happiness Habits to maximize their effectiveness. Those items which become "no brainers" that you engage in daily will do the most to enhance your happiness and meaning. Greater happiness will also lead to better health, relationships, work performance, and service to others and the community. Avoid doing things that are illegal, harmful to others, self-defeating, or that get in the way of your long-term goals in life. Each day, make a plan to practice some of these attitudes and skills. Good luck!

CIRCLE each item that applies; "This past month I ... :

- 1 Visited with friends or loved ones who really love, respect, and believe in me.
- 2 Asked people who know what they are doing, how to handle a problem situation.
- 3 Thought about the many things I am thankful for in my life.
- 4 Made some real progress in achieving my goals in life.
- 5 Used my strengths, skills, or talents to achieve my goals.
- 6 Did something that usually makes me feel peaceful, calm, and content.
- 7 Exercised good self-care or had time to myself to really relax.

- 8 Did "flow" activities that challenge me, take all my attention, and make me feel great afterwards.
- 9 Felt inspired or motivated by someone or some activity.
- 10 Felt a deep sense of awe or wonder at some time.
- 11 Learned about something that really interests me.
- 12 Did some things that were really enjoyable, fun, or thrilling.
- 13 Did yoga, meditation, or prayed.
- 14 Took pride in someone else's accomplishment.
- 15 Spent time with friends or loved ones who really love, respect, and believe in me.
- 16 Took time to really slow down and enjoy a meal or something beautiful.
- 17 Got seven or eight hours of sleep.
- 18 Ate healthy but delicious food.
- 19 Did thirty minutes of brisk physical activity that got my heart rate up.
- 20 Got thirty minutes or more of aerobic exercise.
- 21 Gave or received love from someone I care about.
- 22 Had at least five positive interactions for every stressful or tense encounter with a close loved one, friend, or co-worker.
- 23 Believed that things will work out for me in life.
- 24 Felt deeply grateful for the good things in my life.
- 25 Really "dodged a bullet" or avoided a huge problem or mishap.
- 26 Bounced back quickly from adversity or something bad that happened.
- 27 Spent time in nature or a green space.
- 28 Believed that I will be successful
- 29 Took some risks to be happier or to try something new.
- 30 Never gave up on some important life goals and values.
- 31 Kept trying despite some failures.
- 32 Believed that I was a good, decent person.
- 33 Believed in myself as a competent and capable person.
- 34 Believed in myself as a person who deserves happiness.
- 35 Believed in myself.
- 36 Called a friend who is down or struggling.
- 37 Helped someone else.
- 38 Did something for another person.
- 39 Served a cause, group, or person I believe in.
- 40 "Soldiered on" or persevered through a tough time.
- 41 Felt optimistic about my future.
- 42 Felt interested and engaged in my daily activities.
- 43 Believed that other people really respect me.
- 44 Told a close friend about problem that I am having.
- 45 Made a close friend or visited with a close friend.
- 46 Applied my strengths to a problem I am having or a goal I am pursuing.
- 47 Spent time with a spiritual community or activity that really gives me comfort and peace.
- 48 Had times of flow during the day when I was totally engaged, challenged, and unaware of the time.
- 49 Engaged in Happiness Habits that I know make me a happier person.
- 50 Made a nice connection with people I saw throughout my day.
- 51 Affirmed someone and told them what a great person they were or what a great thing that they did.
- 52 Laughed out loud.
- 53 Smiled a lot.
- 54 Thought that I really like my work, a hobby, or retirement pursuit.

- 55 Took credit for one of my successes.
- 56 Refused to blame myself entirely for something bad that happened.
- 57 Had fun with my partner or worked toward finding someone to love.
- 58 Had fun with two close friends or worked toward making two close friends.
- 59 Believed that my life had purpose and meaning.
- 60 Forgave myself or someone else for a mistake.
- 61 Expressed myself in a creative way.
- 62 Made something artistic or did something artistic.
- 63 Distracted myself in a healthy way from anger, depression, or anxiety.
- 64 Thought about the great things I have accomplished today, this week, and during my life.
- 65 Believed that I have friends and loved ones who are fun and who really care about me.
- 66 Was kind or helpful to another person.
- 67 Journalled about a problem or about a positive future for myself and loved ones.
- 68 Exercised good sleep hygiene or habits.
- 69 Exercised good eating habits.
- 70 Refused to give up on me and my future goals.
- 71 Smiled at several people throughout the day.
- 72 Asked many people how they were doing.
- 73 Greeted many people with a smile throughout the day.
- 74 Went to a meaningful church/temple/mosque service.
- 75 Visited some pleasant or beautiful surroundings.
- 76 Explored some positive part of my home, neighborhood, or community.
- 77 Did something to make the world a better place.
- 78 Tackled a problem or task that I was avoiding, but that really needed attention.
- 79 Distracted myself from regrets about the past.
- 80 Focused on the present and future instead of the past.
- 81 Waited before expressing extreme anger toward someone.
- 82 Was true to my values.
- 83 Stopped to "smell the flowers" or really luxuriate in a pleasant place or experience.
- 84 Stood up for my principles, ethics, or personal morals.
- 85 Refused to act on my extreme anger, depression, or anxiety.
- 86 Made time for both work and play.
- 87 Refused to compare myself to others and followed my own standards for what I need and want.
- 88 Refused to try to "keep up with the Jones'."
- 89 Organized my time and my life in way that feels good and helps me to get things done.
- 90 Set some modest goals for the day that I was able to accomplish and feel good about.
- 91 Thought about WHAT I WANT and HOW CAN I GET IT.
- 92 Pursued a positive addiction like walking or gardening.
- 93 Got a "second opinion" about a tough problem from a friend or "expert" in the know.
- 94 Refused to get down on myself, criticize myself, or give up on myself.
- 95 Socialized with others whom I enjoy.
- 96 Shared the hurt behind the anger I feel toward someone.
- 97 Celebrated a friend or loved one's success.
- 98 Tried to be kind toward and to connect positively with everyone I interacted with all day.
- 99 Worked on making a "surrogate" family of friends who love, support me, and really believe in me and in my potential to succeed.
- 100 Thanked everyone I could for the things that they do for me.
- 101 Faced a tough problem that I had been "ducking."
- 102 Told someone that I was proud of them.
- 103 Focused on my future goals instead of regrets about the past.