QUALITY OF LIFE THERAPY

Applying a Life Satisfaction Approach to Positive Psychology and Cognitive Therapy

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Quality of Life Therapy depends upon the use of the Quality of Life Inventory or QOLI® to assess clients initially, plan interventions, and chart clients' progress during treatment/intervention. To get started using the QOLI®, order the "Hand-Scoring Starter Kit" by telephone by calling Pearson Assessments at (800) 627-7271 (8 A.M.–6 P.M. U.S. Central Standard Time) or write: Pearson Assessments Ordering Department, P.O. Box 1416, Minneapolis, MN 55440, USA.

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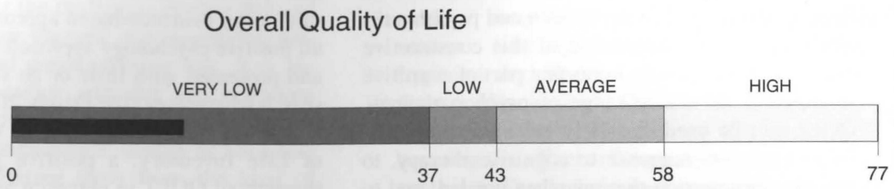
INTRODUCTION

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.

(Raw Score: -1.9)
T Score: 15
(%ile Score: 1)



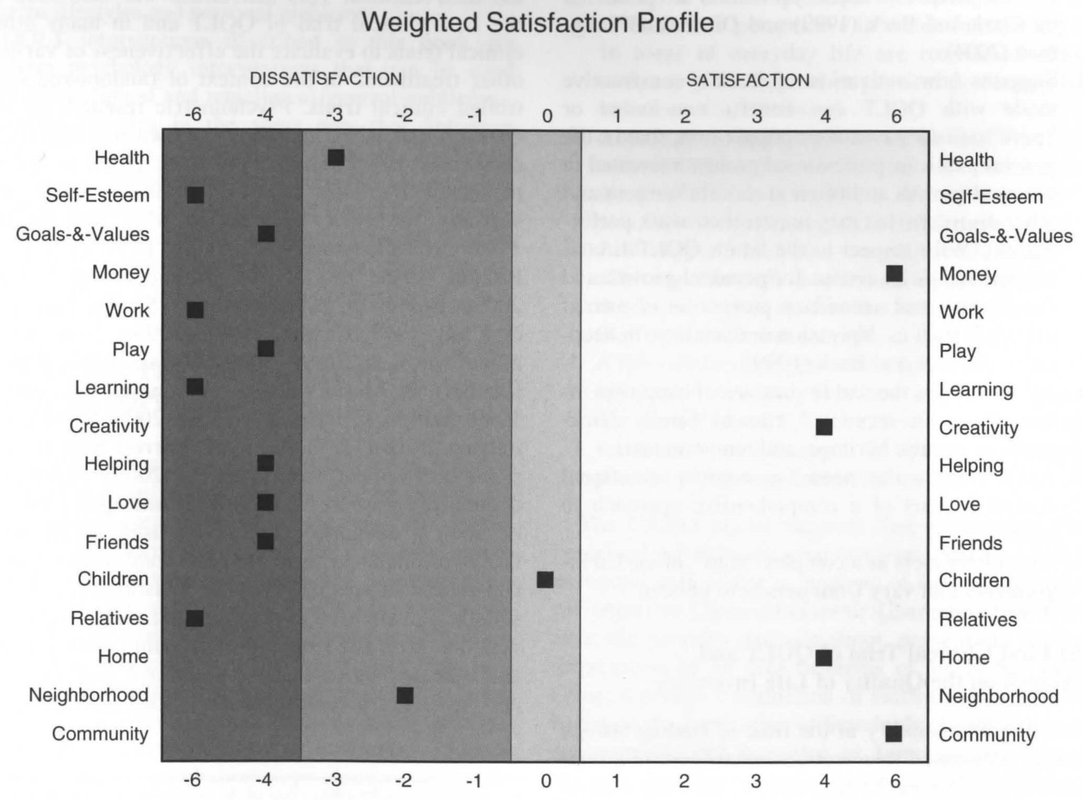


Figure 1.1 Tom's pretreatment QOLI Profile. *Source:* ©2006, 1994, Pearson Assessments and Michael B. Frisch. All rights reserved. Reprinted with permission.

OVERALL QUALITY OF LIFE CLASSIFICATION

The client's satisfaction with life is Very Low. This person is extremely unhappy and unfulfilled in life. People scoring in this range cannot get their basic needs met and cannot achieve their goals in important areas of life. This person 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. The client should be assessed and treated for any psychological disturbances.

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:

Area	Weighted Satisfaction Rating
Self-Esteem	**-6**
Work	**-6**
Learning	**-6**
Relatives	**-6**
Goals-and-Values	**-4**
Play	**-4**
Helping	**-4**
Love	**-4**
Friends	**-4**
Health	**-3**
Neighborhood	**-2**

OMITTED ITEMS

None omitted.

End of Report

Figure 1.1 *Continued*

ory, including its integration with the latest formulation of Beck's cognitive theory/therapy (Clark & Beck, 1999).

Background

Tom is the pseudonym used for a 22-year-old college student undergoing QOLT. Tom was drawn to the work of tortured artists such as Kurt Cobain and Sylvia Plath whose book *The Bell Jar* presaged her own suicide. He also immersed himself in the writings of existentialists whose emphasis on inner angst and the inherent meaninglessness and absurdity of life mirrored his own inner experience. All of his energy seemed to go into maintaining a high average in premedical undergraduate courses. His Type-A lifestyle seemed to reflect a core belief—depressogenic schema—that he was only worthwhile when he was achieving near-perfect levels of performance in school.

Tom occasionally overeats and abuses alcohol to self-medicate his depression. When feeling deeply down and depleted, alcohol helps Tom to forget his problems and to feel more confident in approaching women. He feels guilty about several furtive one-night stands, which, at the time, seemed to relieve his depression momentarily by providing him with some level of intimacy.

He felt guilty later, however, for violating his personal moral code and values by using women in this way and by pretending he was close to the person and interested in a committed relationship when he was not.

For a while, Tom was able to function as a "workaholic." A depressive crisis developed insidiously, however, because he increasingly had no time for anything but school work. For example, he started using any free time for more schoolwork. He often went to the library to read all of the latest research articles that he could to impress his teachers. There was no sense of moderation or balance in his life. In QOLT terms, he put all of his "emotional eggs" in one basket which was work, making him vulnerable to deep unhappiness should anything ever go wrong in this area of life.

Application of CASIO Theory of Happiness to Tom

In terms of the CASIO model of life satisfaction and happiness, Tom's overall satisfaction plummeted as he put more and more time into his work/schoolwork, completely neglecting other valued areas such as *Friends, Spiritual Life,* and love life—all areas of deep unhappiness. This unbalanced lifestyle failed to render even his schoolwork satisfying. In CASIO terms, Tom's S or Standards for fulfillment in work were perfectionistic and impossible to meet on a consistent basis. He was dissatisfied with anything but an "A" on an assignment and constant signs of approval from all of his professors. Since he evaluated his performance as substandard most of the time, he did not really enjoy or feel satisfied with his work, even though he had an A average at pretreatment!

The CASIO model in Figure 3.1 shows overall life satisfaction as the additive sum of satisfactions in all valued areas of life. Since Tom neglected all valued areas except for his school-*Work,* his pretreatment satisfaction in non-Work areas was quite low, contributing to a very low overall level of QOL as seen in his pretreatment QOLI profile shown in Chapter 1, Figure 1.1.

Application of Beck's Cognitive Theory of Depression to Tom

As seen in Figure 3.2, psychopathology, in this case, major depression, comes about when significant stressors or unpleasant life events activate negative core beliefs or schema, hurling clients into an all-encompassing primal mode of thinking, feeling, and behaving. For Tom, the stress—or stressors—of trying to maintain a perfect "A" average in all of his academic work on the one hand, and an increasingly impoverished lifestyle of academic drudgery with little or no pleasure or fun, on the other hand, activated "ghosts from the past" or negative core schemas that led directly to Tom's depression (see "Schemas That Drive You Crazy" in the Toolbox CD for a listing of many core schemas). In other words, his frustration in meeting his goals for perfect work and his dissatisfaction with other areas of life that he cared about but ignored seemed to serve as stressors in Tom's case; more than discrete and obvious stressors like the end of a relationship or losing a job (Clark & Beck, 1999).

This barren and bleak lifestyle seemed to potentiate all of Tom's negative core beliefs or depressogenic schemas. He could not always get "As" on assignments and tests. He could not always make professors like him. In his private world of twisted logic, this was

"proof" that he was somehow a defective person, unworthy of love and care. Here we see the interplay of schemas of perfectionism, approval, and what Dr. Judy Beck (1995) calls unloveability.

Other diverse schemas and complex cognitive processing characteristic of Beck's loss/deprivation primal mode took hold of Tom. Tom was certainly *deprived* of self-respect and a rewarding daily life. This deprivation *mode,* a full body and mind experience of misery that goes beyond simple cognitive schemas alone (see Clark & Beck's, 1999, exposition of *mode theory* for details), colored Tom's consciousness every waking minute, leading ultimately, to the diagnosis of Major Depressive Disorder (American Psychiatric Association, 2000). The pervasiveness of the deprivation mode is captured in Tom's metaphors. He said it was like being possessed by a "Mr. Hyde personality." He also referred to the experience as "my personal Auschwitz."

In terms of key schemas, Tom believed that he was basically an unlovable, flawed, and defective person. His academic achievements were a smoke screen that, as he saw it, hid his rotten inner core, keeping those he cared about from abandoning him completely. Indeed, he was sure that friends would reject him if they ever got to know him. Tom was ruthlessly critical of himself in order to keep his performance perfect and to jump on any mistake or interpersonal problem that might arise. If a problem came up, he wanted to "nip it in the bud" and effect "damage control," before rejection, abandonment, or criticism took place. If he was not eternally vigilant and successful in staving off failure or big mistakes, others might see what a loser he was and abandon or reject him. In this vein, his online conscious experience was like that of the spider-like machines in the *Matrix* movie whose only purpose was to sniff out problems (as in human beings) and destroy them before they could do any serious damage (see Wells & Papageorgiou, 2004). This depressive rumination and generalized anxiety-type worry maintained and intensified Tom's depression as he endlessly focused on and analyzed his negative feelings, looking for mistakes he made and convincing himself that any dysphoria or bad feeling whatsoever was a sign of deep psychopathology or "craziness" (McMillan & Fisher, 2004).

A detailed case conceptualization of Tom can be found in the Toolbox CD (ACT model worksheet).

Poor Little Rich Boy: The Childhood Etiology of Tom's Schemas

How did Tom's negative core schemas develop? To begin with, Tom was an unwanted child born into a materially wealthy family. His father took sadistic pleasure in reminding him that he was an "accident" and that his mother wanted to take him to an orphanage when he was born. For his first 9 years, his parents basically ignored Tom. His mother was working on becoming a prominent socialite in the community and his father was building a medical practice; they simply had no time for the boy. After coming home from day care all day, he would be left alone as his mother pursued her community volunteer work and his father worked in the evenings. The pain and confusion from being ignored and rejected by his own parents was intensified by their constant fighting. Tom blamed himself for their fights, believing that he was flawed, defective, and the extra burden that caused his parents to fight. Tom also blamed himself for his parents divorce when he was 9. His mother really didn't want him to live with her, fearing that living with a single mother would make him gay. Instead, Tom lived with his father from ages 9 to 17. For the most part, Tom was lucky if he saw his father for 15 minutes a day over dinner. From the age of 6 to 13, Tom was sent away to summer camp for 11 weeks where he was always the last child to be picked up by his parents, an experience that haunts him to this day. His father did not handle the divorce well; he withdrew further from Tom except to scold or beat him for such egregious offenses as leaving an apple core on the kitchen table. In anger he would tell Tom what a "rotten little shit" he was and how his mother never wanted him. The few times in which Tom's father was not scolding, berating, or ignoring him involved sexual molestation. Tom was "rescued" by his mother at the age of 17 when she heard of Tom's abuse. Older and wiser, his mother now resolved to try to make up for the years of neglect and abuse that Tom had experienced.

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Date: *January 1, 2525*

Client Name: *Thomas* (Last) *"Tom"* (First) *T.* (MI)

Age: *22* Gender: *Male* ID#: *1234654*

Ethnicity: *White* Marital Status: *Single* Religious Preference: *Methodist*

Setting:

Clinician's Name:

Reason for referral and presenting problems or areas for growth: *Sad, blue, life has no meaning, burned out, lonely, shut down and can't work anymore.*

STEP 1: COMPLETE PROBLEM ASSESSMENT

Key Questions: What's wrong?
What does **D.A.P.T.** (STEP 1 A-D) assessment reveal?

A. Diagnosis/Symptoms

List all psychological and physical symptoms and diagnoses verified by clinical interview, chart, symptom checklist, significant others, testing, and history. Skim *DSM* list of disorders (American Psychiatric Association, 2000) for disorders to include, exclude, or explore further.

Major Depressive Disorder, Recurrent

Perfectionism and Workaholism parts of subclinical Obsessive Compulsive Personality Disorder

Depressive rumination and worry that could relate to subclinical Generalized Anxiety Disorder

Subclinical and occasional binge eating and alcohol abuse

Subclinical social anxiety symptoms

B. Assets and Areas for Growth

List the client's strengths, skills, assets, and resources. List areas of satisfaction on the quality of life tests like the Quality of Life Inventory (QOLI) as well as any positive personal characteristics, skills, strengths, or resources. For pure positive psychology cases with no current area of dissatisfaction in life, list areas identified for growth or greater satisfaction by clients such as work in which the client is doing well but would like to do better.

Tom is very bright and is motivated to feel and function better.

Tom's QOLI profile shows that he feels satisfied, that is, his needs are being met in the areas of "Money," "Creativity," "Home," and "Community." He chooses not to try and improve satisfaction further in these areas so he has no "areas for growth" in a pure positive psychology sense.

More specifically, Tom's profile and written comments in the QOLI narrative section suggest that Tom is comforted by the following assets and strengths: clear religious beliefs, financial security, ability to get good grades, creative ideas, close friends that he has not seen lately, and involvement in a local church and service club. He also feels safe, comfortable, and stimulated by the university community and likes his "home" or apartment complex.

Figure 6.1 Case example of QOLT conceptualization and treatment (intervention) plan.

C. Problems in Living or Quality of Life Problems

List any real-life practical problems faced by the client. For example, list and describe areas of dissatisfaction on the QOLI.

His QOLI Profile reveals that Tom is deeply dissatisfied (Weighted Satisfaction Score is −4 or −6) with Self-Esteem ("I feel flawed and defective . . ."), Work ("I'm driven to perform well and worry too much about school work."), Play ("I have no time to 'goof' around, exercise, and hang out with my friends 'cause of school."), Goals-and-Values ("I don't live my values about a balanced, kind, spiritual life and feel guilty about some one night stands I've had—I don't like leading women on . . . Some of it has been weird. For example, a friend watched me have sex with his girlfriend when I had been drinking and I felt really weird afterward."). Relatives said I was abused as a kid. I'm still trying to prove I'm not a bad person by doing good in school." and Love ("I have chosen to isolate and not date. I couldn't attract the kind of girl I'd like.") He is also dissatisfied with his Health ("I'm out of shape, drink too much, and eat too much. At times I want to 'make the world go away.' I can't get motivated to exercise. I don't play b-ball anymore with 'the guys.'").

D. Theory-Based Problems and Concepts

"Translate" the client's problems or symptoms into the language of any theory or theories that you wish to apply. Keep this brief, putting details in the upcoming Step 2: Conceptualization of Problems.

Cognitive Therapy Examples: Stressors, Negative Core Beliefs/Schemas, Coping Skill Deficits, Childhood Abuse/Neglect, Genetic Predisposition, Deactivation of Constructive Mode Functioning, and Activation of Primal Modes—loss/deprivation in depression, threat in anxiety, victim in anger.

QOLT Examples: Areas for Growth, Low Quality of Life or Life Satisfaction, Inability to get needs met in valued areas of life (specify areas), CASIO factors—Unrewarding Life **C**ircumstances, Negative **A**ttitudes about an Area of Life, Unrealistic **S**tandards of Fulfillment in Valued Areas of Life, Poor Priorities in What Is Deemed **I**mportant—Undue Emphasis on Dissatisfying or Uncontrollable Parts of Life, Unbalanced Lifestyle—**O** in CASIO, Lack of Goals or Purpose, Self-Hate (or Negative Self-Evaluation), Hopelessness, Low Self-Esteem, Low Self-Efficacy, Excessive Self-Blame, or Criticism, Excessive Self-Focused Attention and/or Performance Fears, Self-Medication (through drug abuse), Lack of Social Support, Poor Social Skills Needed for Developing Mutually Beneficial Relationships, Poor Coping Skills for Dealing with Stress and Frustration including Poor Emotional Control, Problem-Solving, or Time Management Skills. Life Management Problems as in Difficulty in Setting and Following Priorities, Difficulty in Setting Challenging but Realistic and Attainable Goals.

Tom is a "Type A workaholic" who puts all his energy into work which he doesn't currently enjoy and which keeps him from getting satisfaction from other parts of life like Play and Love which he values but neglects in favor of work. His standards of fulfillment (CASIO model of life satisfaction) are so high for Work that he never fulfills them, feels frustrated, and has no time for anything else. Also shows signs of Depressionogenic Schemas of self-hate, perfectionism; Childhood Abuse/Neglect, Deactivation of Constructive Mode Functioning and Activation of loss/deprivation Primal Mode; Very Low Quality of Life or Life Satisfaction, Inability Unrewarding Life Circumstances, Negative Attitudes about Play and Friends which are completely ignored and neglected for Work that has perfectionist and Unrealistic Standards of Fulfillment; Unbalanced Lifestyle—O in CASIO, Poor Coping Skills for Dealing with Stress and Frustration including overeating and alcohol use. Poor Emotional Control and Life Management Skills.

Figure 6.1 *Continued*

STEP 2: CONCEPTUALIZATION OF PROBLEMS OR AREAS OF GROWTH

Key Questions: What are the most important problems?
What factors caused the problems?
What factors maintain the problem (or area for growth) or keep it going now?
(Answer only if these factors differ from those that caused the problem in the first place)
How do the different problems interrelate to each other?
What Theory-Based Problems and Concepts (1D) apply here? List them for a conceptualization.
Apply your preferred theory or theories if you wish to be eclectic, integrationist, or diathesis-stress-oriented, and so on.

Cognitive Therapy Examples: Low self-esteem (predisposition) from an abusive/neglectful childhood interacted with the stress of rejection in love or failure at work (stress) to activate depressogenic schemas to produce depression that is self-medicated with alcohol abuse (illustrates Beck's latest cognitive theory, a diathesis-stress model).

QOLT Examples: Client is dissatisfied in love because of her unrealistic standards for husband and her marriage (S in CASIO) and her exclusive devotion to the marriage over other valued areas of life like friends, work, and play that are being woefully neglected. Depression and overeating over her unhappiness with love and generally poor quality of life or low life satisfaction may get worse until progress toward her life goals as shown on Vision Quest is realized. (List specific areas of dissatisfaction such as learning and see also QOLT Examples in Step (1D).

*In cognitive therapy terms, the stress—or "stressors"—of trying to maintain a perfect A average in all of his academic work on the one hand, and an increasingly impoverished lifestyle of academic drudgery with little or no pleasure or fun, on the other hand, activated negative core depressogenic schemas—unlovable/defective self, perfectionism, approval—that led directly to Tom's depression. He has felt as if in a fog, as this "full body" deprivation mode seems to take over his body and mind. In QOL theory terms, Tom's **S**tandards of Fulfillment (CA**S**IO model of life satisfaction) for Work are so high that he never fulfills them, feels frustrated, and has no time for anything else, resulting in impoverished and unfulfilling Circumstances in the areas of Friends, Play, and Love. Tom lacks confidence in dating. Tom self-medicates his depression with occasional and alcohol abuse, overeating, and furtive one night stands which he feels guilty about later.*

STEP 3: ESTABLISH TREATMENT AND INTERVENTION PRIORITIES AND PLAN

Key Questions:

A. Based on your conceptualization, the urgency of a problem (e.g., suicide risk, resistance to treatment, imminent divorce), the client's and referral agent's priorities or agenda for change, and/or desire to provide immediate relief for easily treated problems, rank order the problems and areas for growth you need to treat to have a positive treatment outcome. Rank the top priority goal #1, the second priority goal #2, and so on.

B. Specifically name and define each problem or area for growth.

C. State a long-term or termination goal(s) for each problem or area for growth, saying how you'd like the client's thoughts, feelings, behaviors, and circumstances to be different if treatment is successful. Be specific and offer a time line to check and see later if the goal is accomplished. Make sure *Goals* are measurable and observable to others. For example, in 15 sessions aim for a subclinical BDI-II score of less than 15 or aim for a *DSM* interview in which the client no longer meets the *DSM* criteria for Major Depressive Disorder. For positive goals aim for an overall QOLI T score within one standard deviation of the nationwide nonclinical mean, therefore, a score of 41 or greater. Include goals for specific areas for growth such as "find and form a second close friendship (to supplement my relationship with my husband) with a woman at work with whom I can be totally open and can visit with daily or weekly."

D. Choose specific treatments, interventions, and techniques that will allow you to achieve each Termination Goal. Try and reference interventions with specific books, treatment manuals, studies, and/or theorists.

Figure 6.1 *Continued*

Problem (or Area for Growth) #**1:**

Major Depression

Measurable Termination Goal:

Tom will no longer meet the DSM criteria for Major Depressive Disorder and will have a BDI-II within the functional or nonclinical range (that is, within one standard deviation; Kazdin, 2003; Ogles, Lambert, & Masters, 1996) according to college norms.

Interventions:

1. *Quality of life therapy (Frisch, 2006), including Beck's cognitive therapy of depression and positive psychology interventions for valued areas of life with which Tom is unhappy right now.*
   Note: This entry by itself can be a sufficient treatment plan. If the reader wishes to consider each problem in more detail, this problem 1 entry can be expanded to the following problems and interventions.

Problem #**2:**

Low Self-Esteem and Self-Hate

Measurable Termination Goal:

Movement to within one standard deviation of functional sample on Rosenberg Self-Concept scale.

Interventions:

1. *QOLT Self-Esteem interventions from both professional and client handbooks.*
2. *Traditional cognitive therapy schema work.*
3. *Self-schema work via QOLT Goals-and-Values' Life Script Technique and Tenets of contentment.*

Problem #**3:**

Work/School Dissatisfaction

Measurable Termination Goal:

Movement to within one standard deviation of nonclinical functional sample on College Adjustment scale.

Interventions:

1. *QOLT Work interventions esp, Good Not Great Technique for perfectionism.*
2. *QOLT Learning interventions that relate specifically to the school problems that Tom is having.*
3. *Readings in books **Mind Over Mood** and **Feeling Good** on perfectionism and achievement schemas.*

Figure 6.1 *Continued*

Problem #**4:**

Play and Health Dissatisfaction

Measurable Termination Goal:

Meeting target—30 minutes per day of aerobic physical activity on behavioral exercise log.

Interventions:

1. *QOLT Play interventions such as Playlist.*
2. *Habit Change Program to increase physical activity and exercise for their antidepressant and anxiolytic properties.*
3. *Time management via Happiness Pie and activity scheduling—QOLT's Daily Activity Plan—to plan for daily recreation activities and exercise which is Health as well as recreational concern for Tom.*

Problem #**5:**

Relatives Dissatisfaction

Measurable Termination Goal:

1. *Movement to within one standard deviation of functional sample on Dyadic Adjustment scales.*
2. *Interacts weekly with mom and both report in session that the relationship is mutually supportive and satisfying.*
3. *No longer reports guilt about limited relationship with father that is totally one sided as dad discusses his suicidal ruminations with Tom!*

Interventions:

1. *QOLT Relationships/In General and Relative interventions such as Surrogate Family Technique, Take-a-Letter # 1and 2.*
2. *Emotional Honesty and QOLT Relationship Tenets and Skills for setting boundaries with dad and sharing specific hurts and needs with mom.*

Problem #**6:**

Addictions or subclinical and occasional overeating, alcohol abuse, and one-night stands

Measurable Termination Goal:

1. *Each behavior moves to within target goal range on behavioral log/Habit Control Diary in QOLT.*
2. *Movement to within one standard deviation of non-clinical, functional sample on Addiction Severity Index with norms available in Ogles, Masters, & Lambert, 1996.*

Figure 6.1 *Continued*

Interventions:

1. *These "self-medication" practices should cease once Tom's depression starts to remit.*
2. *If intervention #1 is not successful in 10 weeks, the Health chapter's Habit Change Program will be invoked.*

Problem #**7:**

Depressive rumination and GAD-type worry which seem to be equivalent (Papageorgiou & Wells, 2004)

Measurable Termination Goal:

1. *Movement to within one standard deviation of nonclinical functional sample on Response Styles Questionnaire (Luminet, 2004)*

Interventions:

1. *QOLT "Guide for Worry Warts" protocol from Toolbox CD*
2. *QOLT Emotional control techniques (Chapter 10) that overlap with cognitive therapy techniques with the same purpose*
3. *New cognitive therapy techniques of McMillan & Fisher (2004)*

Figure 6.1 *Continued*

beyond the theory-neutral *DSM*. Some basic CASIO model musings on Tom are listed here in preparation for the fuller conceptualization of Tom's case that is in the next section of the ACT worksheet. The conceptualization of Tom's case also draws on Beck's latest cognitive theory summarized in Chapter 3 and diagrammed in the Toolbox CD as the *Beck Theory Diagram*. Finally, a straightforward treatment/intervention plan is offered to Tom based on QOLT. The plan could stop with the listing of only problem 1 and prescribed intervention/treatment: Depression, and the prescription of QOLT, understanding that QOLT in this case would also include Beck's cognitive therapy for depression. Nevertheless, six more problems and associated interventions are presented to give readers a flavor of a more detailed and comprehensive treatment/intervention plan using the QOLT approach. The detail of an intervention plan is only limited by the time available to "flesh out" such a plan in the ACT format.

Sharing the Case Conceptualization with Tom

At the second and third meetings, the therapist and Tom went over a copy of Tom's ACT Model Worksheet and discussed the results of the various assessments used to diagnose Tom's problem. The process made Tom feel understood and enhanced his confidence in the therapist who not only accurately described Tom's problems in terms of QOLT and cognitive therapy, but who also had a specific and clear plan of attack (i.e., treatment/intervention plan) for addressing these problems. The therapist discussed Tom's particular *DSM* symptoms before introducing the ACT worksheet.

In explaining Tom's QOLI profile to him, the therapist first shared the CASIO diagram from the Toolbox CD and mentioned the CASIO theory, which states that a person's overall happiness is made up of the satisfaction he feels with particular areas of life that he or she personally values.

Tom's QOLI profile (Figure 1.1 in Chapter 1) was explored collaboratively with his therapist, the author. Tom could see that the CASIO theory was illustrated in the way the QOLI was scored and in how the QOLI profile was laid out in terms of overall score followed by the underlying profile of satisfactions and dissatisfactions in valued areas of life. He understood that his QOLI score was very poor relative to the standardization sample (his score placed

him in the 15th percentile), putting him at risk for future health problems in addition to his current depression and other problems.

Tom was reminded of his assets and strengths on the QOLI by going over areas of *satisfaction* such as Money and Surroundings in his QOLI profile (see Chapter 5 for detailed instructions for interpreting QOLI results). Likewise, his problems in living were discussed in terms of areas of *dissatisfaction* on the QOLI (as well as Problems That Get in the Way in the narrative or "write in" section of Part II of the QOLI, which is not shown in Figure 6.1).

After sharing the ACT model of case conceptualization, the therapist presented Tom with a straightforward QOLT treatment/intervention plan that would address seven identified problems. Once again, Tom felt cared for, understood, and hopeful about a clear-cut intervention plan specifically tailored to his particular assets and problem areas.

Tom, We Hardly Knew Ye: Implementation of ACT and Outcome

Tom was willing to "play with," to experiment with all manner of QOLT ideas and techniques in order to gradually sculpt a life that fit his truest, most personal goals and values—and less so the one's foisted on him by his parents and teachers. He quickly separated the "wheat from the chaff" in terms of techniques that were clearly helpful to him and his circumstances and those that were not. The specific cognitive therapy treatment techniques found useful by Tom included the classic activity schedule, thought record—in this case the *Lie Detector,* and schema change techniques as presented here along with techniques unique to QOLT such as the *Five Paths* approach to problem solving—see Chapter 8 for excerpts from Tom's many *Five Paths* exercises completed during his daily Quality Time. Weekly QOLI profiles and scores helped to determine the current focus of treatment whether it be on dealing with work/school/achievement issues, planning for recreation, or dealing with dating or familial relationship problems.

After 15 sessions of therapy, Tom would talk at length about how he had taken up rollerblading and was zipping through the campus at frenetic speed at all hours of the day and night—he also moved to a safer neighborhood where he could walk and rollerblade without fears of getting mugged. Furthermore, he was extolling the gospel of rollerblading to many of his uptight friends who seemed to think that graduate school was all that mattered in life. Besides rollerblading, Tom would play, re-create, and recharge himself by volunteering through his church at a local food bank. The food bank work was very renewing as predicted by Lyubomirsky et al. (in press) and allowed him to lose himself in the *flow* of interacting with and helping others (Csikszentmihalyi, 1997). The food bank and church also did wonders for his subclinical social anxiety problems and added to the web of relationships in his life, a prominent aspect of the lives of the "very happy" (Diener & Seligman, 2002; also see *Tangled Web Tenet*). On weekends, Tom took up sailing, a love from his youth that he had almost forgotten.

In building his self-esteem, Tom resonated to the QOLT approach that builds self-esteem through small success experiences in *other* areas of life. The major Tenet of Contentment that he used in developing a new philosophy of life and in countering negative schemas was the *Happiness Matters Principle.* Specifically, Tom accepted that, in some ways, depression was a choice for him. Every day he made hundreds of choices that could lead him down the path to either fulfillment or depression. For example, by making time to connect with others and to exercise, rather than indulging in his self-hate ruminations or work worries, he knew that he was choosing a path that was more life-affirming and offered growth. Chapter 12 details Tom's other self-esteem work, including revised self-related schemata and a revised or *New Life Script* as suggested in the Goals-and-Values chapter.

In the area of Relationships, with time and therapy, Tom used skills in Emotional Honesty and *Relationship Enhancement* to become clearly aware or mindful of what he wanted from the people in his life and how he was coming across to them in day-to-day interactions. At my request, Tom's mother attended several therapy sessions with him. He gained from this as well as from the use of the Take-a-Letter Technique in which he first clarified his hurts, feelings, and wants about his mother to himself, and then *carefully* planned how to share these hurts, feelings, and wants in an emotionally honest but considerate way in order to improve the relationship. Tom began to make peace with his mother and to see her as a new-found friend. His father continued to be distant and cruel. In their occasional contacts, his father would speak *ad nauseam* about his own personal problems (including suicidal tendencies) instead of playing the part of a nurturing father who keeps his own worst burdens to himself. When told of his son's plan to abandon medicine and biology for the field of history, his father ridiculed him in public, only to "come begging" in order to share in his son's academic honors, including his admission to a prestigious West Coast university. Also in the area of relationships, Tom used the Surrogate Family Tenet to build a support network of friends in place of that part of his family that he had "lost" or more correctly, never had, as a bastion of emotional support.

In terms of his schoolwork or *Learning,* Tom was able to keep his high grades and have a lot more fun and time for friends by lowering his standards and goals *slightly* via the *Good Not Great* exercise—see Chapter 8 for details of Tom's efforts in this regard.

In terms of his work, after taking career interest tests and after exploring career issues and options via QOLT techniques, Tom settled on a plan for a relatively low-stress, but stimulating and challenging job at a small, liberal arts college when he graduated. In terms of his surroundings, Tom was careful to pick a two-bedroom apartment or *Home* in a safe *Neighborhood* that allowed for him to exercise and rollerblade outside. He found his new university *Community* to be as stimulating, open, and tolerant as Austin had been, which was a relief for him given his fundamentalist upbringing in rural Texas.

When stressed, Tom would take time out from his schedule for *Quality Time* and *Inner Abundance* in the evening to calm down—through meditation, prayer, or moving music that he found touching. He would process problems with a thought record/Lie Detector or *Five Paths* exercise, review his Goals-and-Values, and plan a modest but interesting and challenging schedule or flow for next day. Given enough external stress, Tom could still get depressed and lapse or relapse, but he learned to curtail these episodes by recognizing their *Early Warning Signals*—in his case, problems with sleeping, and diarrhea—and following his *Relapse Emergency Checklist* from Chapter 22 and in the Toolbox CD. Rather than get down on himself for these blue periods, he would "drag himself back on top of the horse" of QOLT and get back to feeling good once he had reestablished his *Happiness Habits*—see Tenets.

Outcome

By the end of treatment, Tom no longer met *DSM-IV* criteria for major depression or alcohol abuse. His occasional binge eating episodes had ceased. Reductions in anxiety were reflected in scores on the Trait Anxiety Scale of the State Trait Anxiety Inventory that moved to within one standard deviation of a nonclinical sample; the same result was evident on the BDI (see Ogles et al., 1996, for graphs of reliable change used for both measures). Tom's pretreatment QOLI score soared from a T score of 29 to a T score of 60, a clinically significant move to within one standard deviation of the nationwide nonclinical sample (Ogles et al., 1996). Tom's treatment gains were maintained for 2 years that included several booster sessions or maintenance therapy sessions during times of stress including the breakup of a romantic relationship.