# Part One
# INTRODUCTION AND THEORY

CHAPTER 1

# *Quality of Life Therapy (QOLT): An Introduction*

## WHY QUALITY OF LIFE THERAPY[1] (QOLT)? THE BENEFITS OF HAPPINESS AND LIFE SATISFACTION

Why do we put happiness and satisfaction ahead of money as life goals (Diener & Oishi, in press)? Certainly, feeling good, that is, being happy and satisfied with life, is its own reward. Other more tangible rewards accrue to the generally or consistently happy. For example, the generally happy in Western societies appear to have more rewarding and longer-lasting marriages, more friends, higher incomes, superior work performance, more community involvement, better mental and physical health, and even greater longevity relative to their less-happy peers (see review by Lyubomirsky, King, & Diener, in press).

Greater happiness and contentment lead to greater success in life, better health, and more rewarding relationships; clients need not be unhappy to benefit and grow from a positive psychology program like Quality of Life Therapy (QOLT) since *any* growth in happiness can affect these outcomes and make individuals more satisfied with life. This is the rationale for QOLT with nonclinical or *pure positive psychology clients* such as the professional groups of lawyers, teachers, businesspeople, physicians, clergy of all stripes and persuasions, university student life professionals, quality of life researchers and their students from around the world, and police or probation personnel who make up half of my positive psychology practice.

### QOLT for Boosting Acute Treatment Response and Relapse Prevention in Cognitive Therapy

QOLT may also be seen as a way to boost the acute treatment response of clients undergoing evidence-based cognitive therapies for *DSM* disorders, in part, because of QOLT's hypothesized activation of the constructive mode, a necessary part of successful cognitive therapy. According to the latest formulation of cognitive theory expanded now to include most psychopathology and not just clinical depression (Clark & Beck, 1999—also see details in Chapter 3). QOLT also has a role to play in relapse prevention. Just as schema work used to be considered relapse prevention work in cognitive therapy and just as mindfulness training is often now seen in this way (interestingly, mindfulness training is also a part of QOLT—see Chapters 7 and 10). QOLT is viewed as a new, comprehensive, and *positive psychology-oriented approach to relapse prevention* in cognitive therapy that goes well beyond the very simple and limited interventions of Fava and his colleagues (Fava & Ruini, 2003) who pioneered the approach of enhancing relapse prevention in cognitive therapy with positive psychology or so-called well-being

[1] A simpler exposition of QOLT for the layperson can be found in the companion book and CD to this book authored specifically for clients and the general public titled, *Finding Happiness with Quality of Life Therapy: A Positive Psychology Approach,* © 2006 by Michael B. Frisch, Woodway, TX: Quality of Life Press. Foreword by Ed Diener; E-mail contact: michael_frisch@baylor.edu.

Interventions described in this book are positive psychology interventions that can be used with both clinical and nonclinical/general public/professional samples in the same way that Seligman (2002) has begun to apply his *Authentic Happiness* interventions to both groups. Interventions aimed at nonclinical groups are sometimes referred to as "coaching"; the term and acronym *Quality of Life Therapy* and *QOLT* encapsulates both types of interventions, that is, *Quality of Life Therapy and Coaching.*

interventions. QOLT tries to represent the current state-of-the-art and *totality* of what positive psychology has to say about improving human functioning. Much of this knowledge was simply unavailable at the time of Fava's pioneering work. In contrast to Seligman's (2002) approach to positive psychology training that was written for a lay audience, QOLT is geared more to practitioners, is more life satisfaction-oriented, and more directly interconnected to Beckian cognitive theory and therapy than *Authentic Happiness.* The specific mechanisms of action for relapse prevention in QOLT are presented in Chapter 22 on *Relapse Prevention and Maintenance.*

## The Birth of QOLT: A Journey from Cognitive Therapy to Positive Psychology and Back Again

This book—and a simpler companion book for clients and the general public entitled, *Finding Happiness with Quality of Life Therapy: A Positive Psychology Approach* (Frisch, 2006)—represents a new approach to positive psychology and, to a lesser extent, a new approach or addition to cognitive therapy. My primary mentor in cognitive therapy was John Rush who graciously supervised my work and taught me not to trust authors who wrote about therapy without having a passion for doing it themselves. Other influences include Aaron Beck, Art Freeman, and Robin Jarrett.

After exploring the issues of quality of life assessment and intervention in the 1980s, I presented a little noticed paper in 1989 at the World Congress on Cognitive Therapy at Oxford University. In this paper, I described my work in developing an early version of the Quality of Life Inventory or QOLI (Frisch, 1994; Frisch et al., 2005; Frisch, Cornell, Villanueva, & Retzleff, 1992). I was attempting the classic exercise of many cognitive behavior therapies taught to me by Tom Stampfl of the University of Wisconsin-Milwaukee by applying findings from the experimental laboratory to the clinical enterprise. In this case, I wanted to synthesize and apply the vast literature on subjective well-being or happiness in nonclinical populations to the understanding, assessment, and treatment of clients with depression and related disorders. I was also interested in assessing and promoting life satisfaction and a better quality of life in nonclinical groups such as older persons and the unemployed, using community psychology interventions and social programs. I found encouragement and inspiration in these efforts from the vast subjective well-being literature, in general, and the work of Ed Diener, Alex Michalos, John Flanagan, Angus Campell, Hans Strupp, and others, in particular.

I hoped that the QOLI could help in carrying out the under-elaborated problem-solving component of cognitive therapy by assessing problems in living as well as strengths or assets. Robin Jarrett allowed me to work with her research group at the University of Texas Southwestern Medical School in Dallas; for a time, Dr. Jarrett used the QOLI (Frisch, 1994) to train cognitive therapists in assessing problem areas of life. Dr. Beck (Aaron T. Beck) encouraged me to continue elaborating traditional cognitive therapy tools, and develop new ones based on the happiness literature. He also encouraged me to share my ideas with Art Freeman, who published my work in his *Comprehensive Casebook of Cognitive Therapy* (Frisch, 1992). The need for measures of problems in living or quality of life concerns was raised in this chapter along with the need to consider these concerns in cognitive therapy case formulations. More recently, Jackie Persons and her colleagues have raised these issues again, bemoaning the scarcity of measures like the QOLI that allow for problem assessment and, therefore, adequate case formulation in cognitive therapy (Persons & Bertagnolli, 1999; Persons, Davidson, & Thompkins, 2001). According to Dr. Persons and her colleagues, cognitive therapists in training often miss crucial problems in living or quality of life concerns without use of a formal assessment instrument aimed at assessing these concerns and problems in living.

With the encouragement of Alan Kazdin and Ed Diener, I continued my work in quality of life assessment and intervention, culminating in several papers and a revision of the QOLI (Frisch, 1994, 1998b; Frisch et al., 1992, 2005). While pursuing a program of research on the psychometrics of the QOLI, including the development of a nationwide normative sample, I continued to develop my own approach to positive psychology intervention for clinical and positive psychology applications (Frisch, 1998b). Additional testing and refinement with clinical and nonclinical or *positive psychology* clients has led to the intervention approach described in this book. Along the way, QOLT has also been refined and updated based on the most current positive psychology literature—research findings and theories. As a *Founding Fellow* in Dr. Beck's Academy of Cognitive Therapy, I have tried to represent current cognitive theory and therapy accurately, using my clinical practice to develop some elaborations of venerable cognitive therapy techniques like the thought

record and activity schedule—see Chapter 10—as well as some new approaches such as the *Five Paths* rubric and exercise for problem solving and enhancing quality of life in *any* area of life (see the accompanying Toolbox CD and Chapter 10). To gain some firsthand experience in mindfulness training and to learn about the current state of affairs in various spiritual traditions, I attempted to gain an understanding of mindfulness and mediation approaches as part of a study of contemplative practices of diverse religions, including Christianity, Judaism, Buddhism, and Islam. The Reverend Barbara Kohn along with Drs. Peg Syverson and T. Flint Sparks, psychologist and founder of the Austin Zen Center, were invaluable in this regard as were ministers, priests, and rabbis in the Waco and Woodway area, especially the Reverend Dr. Jimmie Johnson, Reverend Mike Toby, Rev. Dr. W. Winfred Moore Sr., and Rabbi Seth Stander.

## DEFINITION OF POSITIVE PSYCHOLOGY AND QOLT

Diener (2003) defines the good life and the *positive* in positive psychology as the relative predominance of happiness (i.e., "subjective well-being" or "well-being," a pleasant or "positive" affect) over unpleasant/negative affective experiences (e.g., anxiety, depression, anger) in our conscious experience. He emphasizes happiness and life satisfaction over other positive affects (see Lazarus, 1991, for a discussion of these) perhaps because these are associated with fulfillment and accomplishment of personal goals in the areas of life that we value. To avoid moral relativism and the celebration of happy psychopaths, he further emphasizes happiness achieved in an ethical manner without harming others. Finally, he defines positive psychology as a loose confederation of those interested in studying happiness and other positive human strengths and virtues and in helping people achieve a better quality of life. *Quality of Life Therapy* (QOLT) defines positive psychology similarly as *the study and promotion of human happiness, strengths, and a better quality of life for all.* As one of many positive psychology approaches to enhancing human happiness and quality of life, QOLT advocates a life satisfaction approach in which clients are taught a theory, tenets, and skills aimed at helping them to identify, pursue, and fulfill their most cherished needs, goals, and wishes in valued areas of life. In order to preserve relationships and social harmony, this pursuit should be an ethical one in which the legitimate rule of law is not violated and in which harm to others is minimized and avoided. QOLT attempts to incorporate the most current theory and research with respect to happiness, positive psychology, and the management of negative affect along with insights from my clinical and positive psychology practice.

## QUALITY OF LIFE THERAPY AS A "PURE" POSITIVE PSYCHOLOGY APPROACH WITH NONCLINICAL POPULATIONS

QOLT consists of an approach to increasing happiness or to *positive psychology intervention* (see Seligman (2002) or Snyder (Cheavens, Feldman, Gum, Michael, & Snyder, in press) for a different approach). QOLT can be applied to clinical and nonclinical clients. Nonclinical clients are defined here as groups without a psychological or psychiatric disturbance as defined by the presence of one or more *DSM-IV-TR* disorders (American Psychiatric Association, 2000a). For example, QOLT has been shared with nonclinical professionals—physicians, lawyers, clergy, university professors or academics, quality of life researchers and their students, university student life professionals, police personnel, psychologists, and other mental health professionals as well as undergraduate and graduate university students. In the context of professional training and instruction, QOLT has been joined with the American Psychological Association's Ethics Code principle of *competency* and the related constructs of impaired performance, burnout, professional/personal growth, and self-care (American Psychological Association, 2002); in this context, QOLT aims to increase professional self-care or "inner abundance" (Chapter 3) and to prevent burnout. It has been estimated that 50 percent of ethical lapses on the part of psychologists stem, in part, from personal problems and unhappiness at the time of the infraction (Koocher & Keith-Spiegel, 1998). Similar rates of unhappiness are likely involved in sub-standard care and service in other professions. If so, some ethical lapses could be prevented or minimized with QOLT which is aimed at boosting happiness by addressing problems of fulfillment in all valued areas of life (while at the same time, invoking evidence-based treatments for any psychological disturbance that may also be present).

It is likely that personal problems and unhappiness lead to reduced competence, impaired performance, and sub-standard care by preoccupying, isolating, and clouding the judgment of professionals who otherwise are not prone to the self-serving "cognitive distortions" so often seen in professional misconduct and unethical behavior (Koocher & Keith-Spiegel, 1998). In QOLT, self-caring is equated with Inner Abundance and is defined as feeling deeply calm, rested, centered, loving, alert, and ready to meet the challenges of your day and your life after caring for yourself in a thoughtful, loving, compassionate, and comprehensive way. It is assumed that such self-caring attitudes and behaviors will, by themselves, and in concert with other QOLT interventions, improve professionals' quality of life while at the same time protecting them from the kind of burnout, ethical lapses, and professional errors born of harried lifestyles and personal problems.

QOLT interventions described in this book are positive psychology interventions that can be used with both clinical and nonclinical/general public/professional samples in the same way that Seligman (2002) has begun to apply his *Authentic Happiness* interventions to both groups. Interventions aimed at nonclinical groups are sometimes referred to as "coaching"; the term and acronym *Quality of Life Therapy and QOLT* encapsulates both types of interventions, that is, *Quality of Life Therapy and Coaching.*

## TWO-TRACK THERAPY: QOLT WITH CLINICAL POPULATIONS

QOLT is about teaching clinicians how to incorporate the latest in positive psychology into their "negative" or traditional mental health treatments. The QOLT approach to positive psychology or increasing happiness is combined with evidence-based Beckian cognitive therapy for various *DSM-IV-TR* disorders when clients present with a *DSM-IV-TR* diagnosis (American Psychiatric Association, 2000). The goal here is a seamless integration of cognitive therapy and positive psychology that is consonant with the latest formulation of Beck's cognitive therapy and cognitive theory of depression and psychopathology, as expressed in the book he coauthored with David A. Clark of the University of New Brunswick, entitled *The Scientific Foundations of Cognitive Theory and Therapy for Depression* (Clark & Beck, 1999).

### Characteristics of QOLT

Some of the unique characteristics or emphases of QOLT include:

1. A Whole Life or Life Goal perspective in which each phase of intervention is related to clients' overall life goals in valued areas of life so that clients see a direct connection between an intervention or homework assignment and the fulfillment of their most important needs, goals, and wishes (although developed independently, Lyubomirsky, Sheldon, & Schkade, in press, review evidence—e.g., Sheldon & Elliot, 1999—supporting the usefulness of this strategy in boosting the effects of happiness-enhancing interventions). Similarly, assessment and conceptualization of clients' problems and strengths assume a Whole Life perspective in which functioning in 16 areas of everyday life are considered along with any psychological or physical problems, disorders, or disabilities.
2. A therapy of meaning in so far as QOLT is concerned with helping clients find out what is most meaningful to their happiness and well-being both now and over the course of their lifetime.
3. A therapy of awareness- and skill-building aimed at giving clients the understanding and skills that they need to gain satisfaction in areas of life that they most value and cherish.
4. A life satisfaction approach to the positive psychology goal of increasing happiness and contentment.
5. The Five Path or CASIO rubric or model of life satisfaction as a blueprint for quality of life and positive psychology interventions.

The CASIO model suggests that satisfaction (the perceived gap between what one wants and has) with a particular area of life is made up of four components: the objective **C**ircumstances or **C**haracteristics of an area; the person's **A**ttitude about, perception, and interpretation of an area in terms of his or her well-being; a person's evaluation of fulfillment in an area based on the application of **S**tandards of fulfillment or achievement; and the value or **I**mportance a person places on an area for overall happiness or well-being. These four components, combined with a fifth concerned with **O**verall satisfaction in other areas of life that are not of immediate concern, make up the CASIO model for increasing satisfaction and happiness.

6. A blueprint for bringing positive psychology theory and interventions to traditional clinical or "negative psychology" practice. Specifically, QOLT offers an integration of current positive psychology findings and the QOLT theory of life satisfaction with Beck's cognitive theory of psychopathology and depression. For example, QOLT can be used in the clinical context of cognitive therapy to activate the constructive mode in Beck's latest model of depression and psychopathology, in general. Activation of this constructive mode is now seen as an important part of cognitive therapy for the entire range of psychopathology. QOLT can be used clinically to augment clients' *acute treatment* response to cognitive therapy, to provide *continuation therapy* when needed, and to prevent relapse—*relapse prevention* as predicted by Clark and Beck (1999) and Diener and Seligman (2004).
7. Suggests how activation of Beck's constructive mode with QOLT can benefit *nonclinical* or "pure" *positive psychology* populations, that is, the general public or professional groups interested in personal growth and often at risk for burnout and other disorders that may impair their work performance. With respect to the latter, QOLT is conceptualized as an avenue for personal growth and for primary and secondary prevention of mental disorders such as depression and anxiety, in keeping with Clark and Beck (1999).
8. Acknowledges the real limitations of happiness interventions in terms of clients' family backgrounds, genetic heritage, and temperament.
9. Acknowledges the need for *negative* emotional control as part of a comprehensive approach to happiness.
10. Views happiness as a complex "stew" of varied ingredients that vary from person to person.

## The First Clinical Trial of QOLT and Research on the Quality of Life Inventory

Given the impossibility at the time of finding enough "purely" depressed volunteers, adequate control groups were not possible in the first and, so far, only clinical trial of QOLT (Grant, Salcedo, Hynan, & Frisch, 1995). Although all depressed clients in the study were no longer depressed and showed clinically significant gains in quality of life and life satisfaction at posttreatment and follow-up assessments, the results of this trial must be viewed as preliminary when applying the highest standards of clinical trial outcome research (Kazdin, 2003). That is, the use of QOLT for acute, continuation, maintenance/relapse prevention phase treatment of depression and other *DSM-IV-TR* psychological disturbances—as well as the use of QOLT for nonclinical, "pure" positive psychology populations—requires further efficacy and effectiveness studies to "prove its salt" as an evidence-based approach. Of course, almost all positive psychology approaches have been published and presented with little or no supportive outcome research whatsoever (see Frisch, 2000, for review).

The cornerstone of QOLT is the QOLI® or Quality of Life Inventory, a positive psychology test used throughout QOLT in planning and evaluating individual interventions. This instrument was also used in the first clinical trial of QOLT and in many other clinical trials to evaluate the effectiveness of various other treatments in the context of randomized controlled clinical trials. Psychometric research on the QOLI is extensive, including my own research (e.g., see Frisch, 1994; Frisch et al., 1992, 2005) as well as *independent* studies and evaluations by other researchers at other laboratories (e.g., Ben-Porath, 1997; Crits-Christoph & Connolly, 1997; Crowley & Kazdin, 1998; Eng, Coles, Heimberg, & Safren, 2001a; Heimberg, 2002; Horowitz, Strupp, Lambert, & Elkin, 1997; Kazdin, 1993a, 1993b, 1994, 2003; Mendlowicz & Stein, 2000; Moras, 1997; Ogles, Lambert, & Masters, 1996; Persons & Bertagnolli, 1999; Rabkin, Griffin, & Wagner, 2000; Safren, Heimberg, Brown, & Holle, 1997; Forrest Scogin, personal communication, August 22, 2005). Figure 1.1 depicts the pre-intervention/treatment QOLI profile of Tom, a disguised case study used to illustrate QOLT throughout this book; both Tom's overall score and profile of specific areas of satisfaction and dissatisfaction are used in planning and evaluating interventions after the example of Kazdin (1993a, 2003) and others.[2] Notice the non-pathology, positive psychology items, overall score, and QOLI profile. These

[2] In keeping with the ethics code of the American Psychological Association (2002), the cases discussed in this book have been disguised and altered to protect the confidentiality of clients. Personally identifying information has been removed and, at times, fictionalized as in the person's name, gender, city, or occupation to further protect the privacy of clients.

## 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.

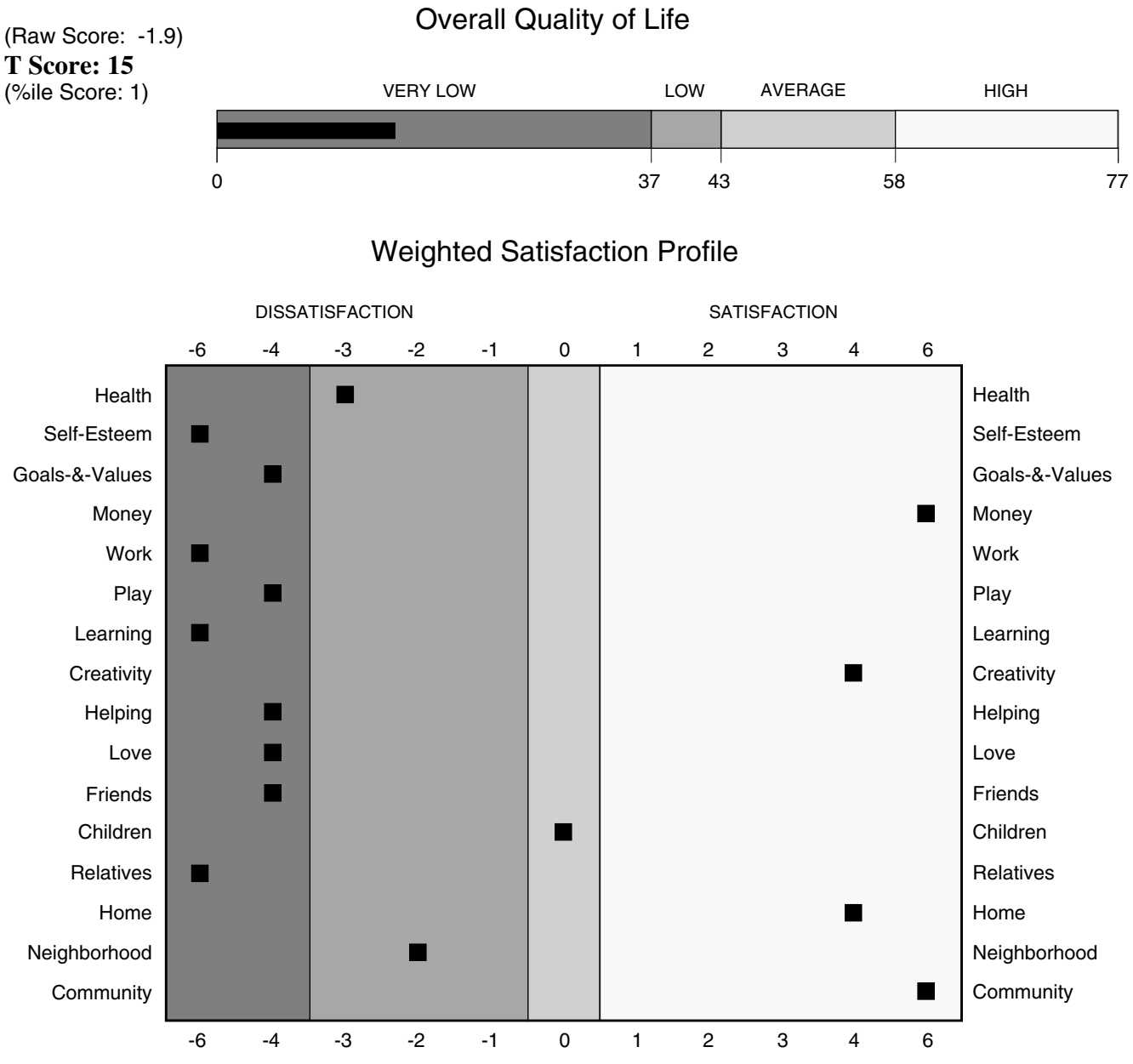


**Figure 1.1** Tom's pretreatment QOLI Profile. *Source:* ©2006, 1994, Pearson Assessments and Michael B. Frisch. All rights reserved. Reprinted with permission.

## 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*

features illustrate the general orientation of QOLT that tries to address all 16 areas of life depicted in the QOLI profile of Figure 1.1.

## PLAN FOR THE BOOK

Part I continues with a discussion in Chapters 2 and 3 of the empirically based theory underlying the positive psychology approach of QOLT. A general understanding of this theory and some of the key terms like positive psychology and quality of life can be invaluable in carrying out QOLT. The theory is also meant to help therapists better understand their clients and to better plan interventions for these clients. Beginning with Chapter 3 and continuing throughout the book, Tom's case is used to show how QOLT, its theory and techniques, can be applied to a particular case; numerous other clinical and positive psychology cases are peppered throughout the book by way of illustration in how to conduct QOLT. Chapter 4 concludes Part I by offering the basic preparatory steps or "nuts and bolts" for conducting QOLT. The structure and format for clinical cases versus pure positive psychology sessions is discussed along with stylistic suggestions such as the use of groups or judicious self-disclosure by therapists or coaches.

To begin QOLT, therapists may simply apply the specific chapters of Part II *in order* to a particular case or group. That is, all of the core elements of QOLT are covered in the proper order of administration in Part II. All chapters in Part II and throughout this book allude to exercises, homework assignments, and mini-lectures/readings that clients can read and explore as part of QOLT; all of these resources such as blank copies of exercises are available for clinical and positive psychology use in the *Toolbox CD* that accompanies this book. The Toolbox CD contains printable Word documents that can be personalized for the therapist's use.

The first core technique presented in Chapter 5 is quality of life (QOL) assessment and how this is integrated with traditional assessments of psychological disorders and general medical conditions. A model of case conceptualization and treatment planning is presented and illustrated in Chapter 6 that allows therapists to easily apply the theoretical concepts from Chapter 3 to an actual clinical or positive psychology case. As set forth in Chapter 6, the resulting case conceptualization and treatment/intervention plan is shared with clients in an effort to form a common understanding and close collaborative relationship between therapist and client. The "three pillars" or essential core QOLT interventions of Inner Abundance, Quality Time, and Find a Meaning are presented in Chapter 7.

QOLT offers both *general* CASIO interventions based directly on QOL theory for *any* and all areas of life along with area-specific interventions for specific areas like work or love. Chapter 8 presents these general CASIO interventions, including *Five Paths* (*Five Paths to Happiness*) a highly versatile tool for problem solving and gaining happiness throughout QOLT. The *Tenets of Contentment* in Chapter 9 constitutes an excellent summary of this book in the form of maxims, skills, and proverbs designed to resonate instantly with clients' experience; *Tenets* are easily selected, grouped, and tailored to a particular client's or group's needs using the Toolbox CD.

Unfortunately, positive psychologists often lose sight of the fact that scientific definitions of happiness refer to a predominance in frequency of positive to *negative* affect, neglecting interventions for the latter even though both clinical and nonclinical groups need help in managing negative affect (Diener, 2003) and in managing their lives. In QOL theory, effective goal striving—part of the area called *Goals-and-Values,* requires some basic (negative) emotional control and life management skills in order to achieve fulfillment in valued areas of life. These skills provide a powerful bridge to traditional cognitive therapy and are presented in Chapter 10 because of their importance in QOLT. Cognitive therapists should recognize some skills taught as part of Life Management and Emotional Control Skills in Goal Striving. Indeed this chapter concludes with a quick reference *Primer In Cognitive Therapy* for those who wish to brush up on their Beckian skills as they learn how to combine them with positive psychology interventions.

While general CASIO skills are useful, area-specific techniques add greatly to the power of QOLT. These additional area-specific interventions are presented in Part III with chapters on *Goals-and-Values, Spiritual Life, Self-Esteem, Health, Relationships, Work, Play, Helping, Learning, Creativity, Money,* and Surroundings—*Home, Neighborhood,*

*Community.*[3] Part III closes with a chapter on relapse prevention and maintenance of intervention gains.

Part IV consists of the *Toolbox CD,* some 50 or so growth exercises, maxims, tenets, or potential homework assignments presented as Word documents that therapists and coaches can "legally" download, edit, adapt, personalize, and distribute via e-mail or printing to clients in order to address their unique needs. Toolbox CD exercises summarize or *translate* QOLT concepts into action and into language that clients with little or no education can understand (Therapists may have to present growth exercises orally for those clients with little or no reading skills). Personal growth exercises from the Toolbox CD are designed to be fun and interesting for clients at the same time that they educate and instigate change in positive directions. When done outside of sessions as part of clients' "homework," the growth exercises and tenets of the Toolbox CD are designed to add to the effectiveness of in-session interventions by having clients think about and implement in-session ideas and techniques *between* sessions and even after therapy is over as clients learn how to be their own therapists or personal coaches—the ultimate skill in relapse prevention. Therapists and coaches typically "prescribe," adapt, and tailor Toolbox CD exercises to meet the needs of particular clients.

## A NOTE ON REFERENCES

To reduce the reference density and improve readability, when references are lacking for some assertions, the reader is referred to the following scholarly works on subjective well-being, quality of life, and positive psychology: Csikszentmihalyi (1997); Diener (1984); Diener and Seligman (2004); Diener and Suh (2000); Diener, Suh, Lucas, and Smith (1999); Frisch (1998b); Frisch (2006); Frisch et al. (2005); Kahneman, Diener, and Schwarz (1999); Peterson and Seligman (2004); Seligman (2002); Snyder and Lopez (in press); Suldo and Huebner (2005); and Vaillant (2002). With respect to Beck's cognitive theory and therapy, the reader is referred to Clark and Beck (1999), Judith S. Beck (1995), and McMillan and Fisher (2004).

[3] Areas of life like *Money* are capitalized and italicized throughout the book when referring to the specific theoretical terms and definitions for these areas of life as spelled out in QOL theory and the Quality of Life Inventory or QOLI®—see Chapter 3 and Table 3.1 for the precise definitions of these terms.