by Adrian McInman

Pathways to Happiness

Group Therapy Without the Tears

The principles of positivistic psychology can be used to conduct group therapy programs with elderly clients—programs that ensure the seniors do not feel they are in therapy, while still offering the benefits of more traditional psychological approaches.

The author instituted a happiness group therapy program in a New York City nursing center, and offers advice on how to build a program and how to overcome the cognitive obstacles some seniors face.

Call me "Mr. Happy."

After all, that's what I'm called by the staff and senior residents at Saint Elizabeth Ann's Health Care and Rehabilitation Center, Staten Island, N.Y., part of Saint Vincent Catholic Medical Centers.

The nickname is probably due to the 30-session, 10-week group therapy program I conducted there, called "Pathways to Happiness." Or, it might result from my leisure-seeking Australian and New Zealander values. Or it may simply be because, even if they cannot understand my accent, they do understand a smile and a laugh when they see one.

The program differs from more traditional psychological approaches in that it does not focus on the negative. Historically, psychology has preoccupied itself with misery. Group therapy programs addressing anxiety, depression, anger management and stress management are the norm. Programs focusing on joy, contentment, pleasure and happiness are, alas, not common.

Upon hearing about this program, the initial reactions of some staff members were optimistic and encouraging, while others were more skeptical. Some were initially amused that such a "fluffy" topic would be pursued. However, perceptions changed from fluffy to legitimate when I presented the latest research on happiness done by eminent researchers such as David Myers, Daniel Nettle and Martin Seligman.

Building the Program

Pathways to Happiness stems from emerging research in an area some call "positivistic psychology." Although the focus is on happiness, techniques from both cognitive behaviour therapy (CBT) and motivational interviewing are incorporated. For instance, one session uses the CBT skills of disputing dysfunctional automatic thoughts. Likewise, two sessions are based on motivational interviewing's theories of stages and processes of change.

The program has three major components.

- First, there is a substantial focus on happiness, with sessions devoted to the things that most impact a person's happiness: being extroverted, having an internal locus of control, having high self-esteem, having little anxiety, etc.
- Second, relaxation is emphasized, along with teaching and constant rehearsal of relaxation techniques (diaphragmatic breathing, meditation, progressive muscular relaxation and body awareness exercises).
- Third, the importance of positive, functional thinking is stressed. A number of psychological techniques—disputing dysfunctional thoughts, thought stoppage, mental imagery, goal-setting, etc.—are taught and practiced every day. Clinical psychology skills such as disputing dysfunctional thoughts are

interwoven with the latest skills from sports and industrial psychology (e.g., mental imagery, goal-setting). A substantial number of communication skills (I-messages,* summary statements, complimenting the work of others) are also taught and rehearsed.

What's In It for the Provider?

A major advantage of focusing on happiness is the inherently pleasant nature of the topic. The same psychological and relaxation techniques that would be implemented in more traditional programs can be used. However, everything is framed in a more optimistic and pleasant tone. As Seligman suggests, using the traditional psychotherapy approach is akin to starting at minus-five and moving forward, whereas a happiness approach starts at zero, if not higher. The health professional does not have to dwell in misery.

Issues relevant to elderly populations (grief, depression, suicide, motivation, alcohol misuse and abuse) can all be addressed, but with a less threatening tone. Another advantage is that happiness is a central and fundamental goal in our lives. Try asking your clients: "What is it you want more than anything else in life?" You will probably find the most common answer is "happiness."

According to Alison Malone, Saint Elizabeth Ann's director of recreation therapy, the program complemented existing programs, but also helped overcome a difficulty her staff often face—their elderly clients' reluctance to change their routines.

"The residents had a really great reaction," Malone says. "Even the few staff that went along found it all positive. They were asking me, when is he coming back? [Certain residents] are hard to engage … It's very difficult to get them out of their routines."

What's In It for the Seniors?

The happiness approach can work with many populations. Malone likes the "life skills" flavor of the program, where clients learned skills they could use in everyday life, and the fact that "any one can benefit from it," including the more alert seniors;

* I-messages begin with the word "I" and help a person take ownership assertively. For instance, instead of "You need to check in with me more often," you might say, "When I'm not kept informed, I get worried and start imagining you're having problems that are not being solved."

clients with AIDS; neurobehavioural patients; clients with cancer, diabetes or gastro-intestinal disorders; hospital patients; and even multiple sclerosis groups. Malone believes that among the resident seniors, those with greater cognitive abilities gained more from it, but everyone gained an increased quality of life, even if it was only transitory due to short-term memory loss.

Participants don't feel like they are participating in therapy. Instead, they view it more like a philosophical or educational discussion. Louis Delfino, one of the residents, felt that the objective was "to reach our goals and to make us learn." He thought the program was "worth going to. I got something out of it. We talked about self-esteem. A lot of different things. I remember the questions that you asked." At no time did Delfino suggest that therapy was involved. Instead, he considered me more a "teacher" than a health care professional, though he knew of my training in psychology.

Though she did not believe the focus of the program was "therapy," one senior client told me the happiness orientation was therapeutic for her: "You were helping bring me out."

Recreation Therapist Patty Abi-Saab says, "No one was perceiving you as a scientist, or felt that they were being interviewed and having notes taken on them. They were not on a couch. They were not being evaluated by a psychologist. They were just having a visitor and that made a difference."

Difficulties

The working environment at St. Elizabeth Ann's is receptive to such a program. Attempting such a "fluffy" topic in a more conservative establishment, however, would clearly be more difficult. Nevertheless, selling the proposal need not be impossible. An important point to stress is that although such an approach is theoretically sound, it is only a skeleton to base therapeutic change around. The use of group therapy factors, including, but not confined to, the instillation of hope, imparting information and the development of socializing techniques, which occur with any good program, are what usually causes change.

One major key to happiness is having an internal locus of control, that is, perceiving that you have control in your life, instead of believing that events happen just because of luck, fate or powerful others.

Other difficulties are common to all group therapists working with an elderly population. For instance, clients fall asleep during the sessions. This should not be viewed negatively, as it means you have created a safe environment where the client feels secure. Likewise, the timing of sessions around medication times, meal times and health care professionals' schedules is also problematic.

Having a sense of humor is definitely important if you want to be happy as a therapist or a senior. Perfectionism, however, is not so useful. For instance, the perfectionist would have difficulty teaching meditation if he or she insisted all seniors practice with a straight back, especially those in wheelchairs.

Likewise, not taking yourself too seriously is important. One client stopped me in the foyer one day and said "I really liked your session yesterday."

"Why?" I asked.

"You know, the one about meditation."

"But why?"

"Oh, I liked it so much that I taught Tom and Jerry how to do the meditation."

"That's great," I said, only to discover later that Tom and Jerry (names changed) were voices only he could hear!

One problem with a senior population is the frequent short-term memory problems many seniors suffer, as the program is relatively cognitive. As one client said to me: "I really like your session. It's just a shame I don't remember any of it." Hence, sessions need to be incremental and build on one another, with a great deal of revising and recapping.

Creating a Happiness Program

A useful start is to focus on the major differences between happy and unhappy people. For instance, happy people, compared to unhappy people, tend to have healthier bodies and be fitter; have realistic goals and expectations; have more positive self-esteem; feel in control (high internal locus of control); are optimistic; are outgoing and more extroverted; have reduced anxiety; have supportive friendships; have warm relationships with a partner; have challenging work and active leisure, interspersed by adequate rest; and have a positive, focused belief in something.

One of the major killers of happiness is anxiety; both trait anxiety and state anxiety.* Hence, an integral component of a happiness program should include techniques to reduce anxiety, predominantly relaxation and psychological techniques to change the client's thinking style.

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* Trait anxiety refers to personality—the degree to which a person is anxious most of the time. State anxiety is anxiety felt at a specific moment.

mental imagery, thought stoppage and more mainstream therapy techniques found in CBT, along with solution-focused therapy and motivational interviewing.

Clients will not become happier if they are not ready to become happier. It is important to discuss the stages people go through when they decide to change their behavior. Similarly, as change is an everyday fact of life, and stress can occur whenever we must adapt to change, I recommend teaching stress-management techniques. Linking stages and change with stress management is highly effective.

Because the happiness approach is nontraditional, it is important that your program be based on research evidence. There are a number of excellent resources. I recommend four books in particular: David Myers' *The Pursuit of Happiness*, Michael Argyle's T*he Psychology of Happiness*, David Lykken's *Happiness: The Nature and Nurture of Joy and Contentment* and Daniel Nettle's *Happiness: The Science Behind Your Smile*.

A happiness orientation has the advantage of focusing on an inherently pleasant topic while addressing specific issues relevant to elderly populations, such as grief and depression. Dr. Anne Fatone, a New York psychologist who served as an advisor during construction of the Pathways to Happiness program, suggests, "The happiness orientation provides a positive approach to a therapeutic intervention, as opposed to those focusing on issues and problems. It offers people an alternative view of their life and their future."

The life skills flavor of the program allows any population to achieve gains, with the added benefit of participants not feeling as if they are participating in therapy due to coping inadequacies on their part. As Fatone noted: "I think it offers practical training, for example, relaxation and thought-stopping, as well as theory. It offers people possibilities, something they may not have considered as applying to their lives before, and that is very important for maintaining both mental and physical well-being."

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