LIFETRACK THERAPY

Yukio Ishizuka, M.D.

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A new therapeutic approach is presented which is characterized by:
1. Quantifiable definition of Positive Mental Health as a therapy objective.
2. Patients rate themselves daily on a subjective 10 point Scale on a total of 41 parameters.
3. Visual (graphic) feedback by a personal computer during therapy sessions.
4. Active advocacy role for Positive Mental Health by the therapist.

Benefits of Lifetrack Therapy include:
1. Comprehensive, up to date, and accurate data becomes available.
2. Psychological Feedback reinforces positive therapeutic gains.
3. Patients learn to think more positively and improve rapidly.
4. Clearer grasp of the path to recovery with graphic display on a computer screen.
5. Patients gain the means of monitoring and improving themselves.

Important clinical research findings with Lifetrack method include:
1. All patients go through typical ups and downs in the course of improvement.
2. Breakthroughs that follow setbacks often lead to higher peaks of improvement.
3. Improvement itself seems to provoke a setback in most patients.
4. Resources mobilized against defense determine breakthrough or stagnation.
5. See-saw like sequential breakthroughs are needed in couple therapy.

Lifetrack Therapy represents a new concept and method characterized by:
1. A quantifiable definition of Positive Mental Health as objective of therapy.
2. Patients rating themselves daily on a subjective 10 point scale involving 41 parameters.

3. Visual (graphic) feedback by a personal computer, during therapy sessions.
4. An active advocacy role for the Positive Mental Health by the therapist.

INTRODUCTION

Over the years, psychiatry and psychology have worked towards a better definition and understanding of mental illnesses. However, we have not paid enough attention to the definition of Positive Mental Health, or wellness state. As a clinician in private practice in New York working with American, European, and Japanese executives, and their families, as principal clients over the years, I have faced an acute need for a positive and practical definition of a therapeutic objective against which daily progress in therapy can be measured.

The efforts to develop a clear and quantifiable objective of therapy that can withstand the challenges of sophisticated and demanding clients, resulted in a practical definition of Positive Mental Health, using 41 parameters that seem to adequately define the total psychological adjustment of the individual.

The structured and quantifiable definition of Positive Mental Health offers a practical conceptual model of the therapeutic objective for the patients through distress and wellness. The distressing symptoms, such as, anxiety, anger, physical symptoms, depression, and psychosis, can be defined as defensive reactions or warning signals, that are mobilized when the brain is faced with challenges that exceed its current ability to cope. The symptoms themselves become the dominant preoccupation of the patient, replacing the real trigger, as if to protect the individual from further danger.

Once the positive state of mental health is defined as the objective of therapy, against which daily progress can be measured, the therapist can become an active advocate to help the patients achieve the well state, which will, in turn, make the symptoms less necessary.

This approach has been developed over the years into the Lifetrack Therapy concepts and computer assisted patient tracking and visual feedback (Psycho Feedback) system. The purpose of this paper is to briefly present the Lifetrack Therapy concept and method, with its clinical implications.

LIFETRACK CONCEPTS

In 1958, M. Jahoda17,18 produced a monograph entitled
“Current Concepts of Positive Mental Health”, reviewing the then existing literature and research on the subject. This included contributions to the literature looking at the concept of Mental Health\textsuperscript{5,21,29} Normality,\textsuperscript{5,10,24,25,27} Happiness,\textsuperscript{19,20,26} and Self-Actualization\textsuperscript{1,22}. Based on her extensive review, she offered six conditions for evaluating the criteria of Positive Mental Health:

1. The idea that there can be one single criterion of Positive Mental Health should be abandoned. Good mental health cannot be reduced to one simple concept and a single aspect of behavior is not an adequate indicator.

2. As the terms we use to describe mental health have tended to be abstract, we should now strive to more scientifically define our operating procedures and methodologies. There is a need to have scales and measures for each criterion.

3. Each of the criteria should be thought of as a continuum since there are unhealthy trends for an otherwise healthy person.

4. These criteria should, at any point in the individual's progress, serve either to define the state of the individual, or to indicate trends towards wellness or disease. Implicit in the criteria is the concept of gradients of mental health.

5. The criteria are regarded as relatively enduring attributes of a person — not just functions of isolated situations the individual finds himself in at a given time.

6. The criteria are intended as indicators of the optimum of mental health. They are not to be regarded as absolutes — and the minimum standard for any individual to achieve has yet to be determined, and may indeed change with age. Each person has his own limits, and no one reaches the optimum in all criteria. Still, we assume that most people can achieve the optimum.

The following six criteria were offered by Jahoda as empirical indicators, or a sort of recipe, for Positive Mental Health:

1. Positive attitudes toward the self.
2. Growth, development, and self-actualization — including utilization of abilities, future orientation, concern with work, and so on.
3. Integration, as in a balance of psychic forces, the unifying of one's outlook, and resistance to stress and frustration.
4. Autonomy, as in self-determination, independent behavior, and, when appropriate, non-conformity.
5. A true perception of reality.
6. Environmental mastery, meaning adequacy in love, work, and play, adaptation and adjustment, and the capacity to solve problems.

Twenty years later, H. R. Spiro,\textsuperscript{30} in 1980, in his review of the evolution of concept of Positive Mental Health, observed that regrettably little investigations followed Jahoda's work during the ensuing decades, citing only several related contributions:

"Campbell" examined responses to a series of questionnaires intended to evaluate positive affect, life satisfaction, and perceived stress. Bradburn,\textsuperscript{3} Andrews, Withey,\textsuperscript{1} all attempted to develop scales that measure social indicators of psychological well-being.\textsuperscript{22}

"Campbell's initial results suggested that factors in a life cycle explain much of the variance in the index of positive affect and life satisfaction scales.\textsuperscript{4} Positive affect and life satisfaction scales vary together with the most positive results appearing among married persons with children six years of age and older. Responses are far more negative for divorced and separated persons. Positive affect shows the lowest scores among the widowed, the divorced, the separated, and young people who are not married. The results seem to indicate that family status is the most important single variable in Positive Mental Health. Occupation, education, religion, race, and sex contribute very little to the variance."

In 1980, a survey of a large number of Americans on happiness conducted by Friedman\textsuperscript{18,29} produced similar findings to those of Campbell. Friedman reported that the single most important predictor of happiness was the presence of a loving close relationship with someone, followed by satisfaction at work. Friedman also found that the objective level of success, wealth, independence, and freedom had little predictive value of happiness of the individual, while more subjective elements, such as sense of confidence in his life values, sense of purposefulness and meaning in his life, and sense of mastery of his fate etc., were more important determinants of one's happiness.

Building on the above and other concepts\textsuperscript{9} of Positive Mental Health, integrating various therapeutic schools of thought, but most importantly learning from the patients in my private practice, I have developed a structured model of Positive Mental Health, that has lead to the development of Lifetrack Therapy.

In way of developing our working concept of Positive Mental Health, it is also helpful to remember the well known Social Readjustment Scale, developed by Holmes and Ray.\textsuperscript{11} Their 43 stressful life events can be categorized into the following three spheres: Intimacy (death of spouse, divorce, marital separation, death in family, marriage, marital reconciliation, etc., 21 items), Achievement (21 items), and Self (7 items). When the weight given to each event on their 100 point scale, are added, Intimacy sphere receives 50% of the total points, Achievement 40%, and Self 10%.\textsuperscript{13}

These three spheres are partly converged on each other and are dynamically interactive with one another (see Figure 1). Building on the above, and other concepts of Positive Mental Health, integrating various therapeutic schools of thought but, most importantly, learning from the patients in my private practice, whose clinical condition must be continuously monitored at least daily, I have developed a structured model\textsuperscript{12} of Positive Mental Health, in which Self, Intimacy, and Achievement spheres are further defined in three dimensions and nine elements each, meeting all six conditions of criteria for Positive Mental Health proposed by Jahoda, in 1958.
INTIMACY

The intimacy sphere can be broken down into Intellectual-Social, Emotional, and Physical-Sexual dimensions.

The Intellectual-Social dimension consists of acceptance of one's partner as he is, being able to trust and depend on the partner, and how willing and able one is to let the partner depend on him.

The Emotional dimension consists of giving and receiving of concern, affection and love.

The Physical-Sexual dimension covers three elements: how one is able to enjoy being together with the partner, how one desires to touch the partner (sensual), and how one is able to experience sexual excitement.

ACHIEVEMENT

Productive and creative activities such as are involved in one's work and career, can be seen as a sublimated (socially acceptable) way of following one's quest for closeness with others, as all achievement-oriented activities seem to be ultimately designed to achieve acceptance, respect, and admiration by others through sublimation and self-sacrifice. The achievement sphere can also be defined in three dimensions, i.e., Task, Self, and Interpersonal dimensions.

Task adjustment, or one's ability to cope with demands of realities in achievement activities, can be broken down to elements such as, how well one can set objectives and maintain priorities, mobilization of resources to achieve objectives, and effectiveness with which one gets things done.

Self dimension in the Achievement sphere consists of how well one grasps realities, how well one is able to experience satisfaction and fun in achieving, and how well one can control his thoughts, feelings, and actions under pressure of achievement.

The interpersonal dimension of achievement includes elements, such as, how personally close one can feel towards his colleagues, how professionally appropriate and productive such relations are, and how well one controls such relationships and keeps them within proper boundaries.

LIFETRACK THERAPY APPROACH

Using the above structured definition of Positive Mental Health or Wellness State as an objective of therapy, recognizing that the patients' subjective inner experience of life — rather than objectively measurable external elements — determine their wellbeing, the patients are instructed to use the Lifetrack Total Adjustment Sheet (see Table 1) to track their dynamic psychological and physical condition daily.

In order to capture often rapidly changing states of distress and wellbeing, even in the course of a single day, the first portion of the sheet documents the negative psychological peak experiences of anxiety, anger, physical symptoms,
<table>
<thead>
<tr>
<th>PSYCHOLOGICAL STATUS</th>
<th>(-) PEAK</th>
<th>(+) PEAK</th>
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</thead>
<tbody>
<tr>
<td>-1. ANXIETY</td>
<td></td>
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<tr>
<td>-2. ANGER</td>
<td></td>
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<tr>
<td>-3. PHYSICAL SYMP</td>
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<td>-4. DEPRESSION</td>
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<td>-5. PSYCHOSIS</td>
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<tr>
<td>(+) PEAK</td>
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<tr>
<td>+1. PEACE</td>
<td></td>
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<tr>
<td>+2. FRIENDLINESS</td>
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<td>+3. PHY WELLBEING</td>
<td></td>
<td></td>
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<tr>
<td>+4. HAPPINESS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+5. MASTERY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I. (SELF)

A. IN TOUCH
1. POSITIVES
2. NEGATIVES
3. PERSPECTIVE

B. AT PEACE
1. POSITIVES
2. NEGATIVES
3. INTEGRATION

C. IN CONTROL
1. DECISION
2. ACTION
3. MONITOR/CONTROL

II. INTIMACY

A. INTELL-SOCIAL
1. ACCEPT
2. DEPEND
3. LET DEPEND

B. EMOTIONAL
1. CONCERN
2. AFFECTION
3. LOVE

C. PHYSICAL-SEXUAL
1. TOGETHERNESS
2. SENSUALNESS
3. SEXUAL EXCITEMENT

III. ACHIEVEMENT

A. TASK ADJUSTMENT
1. OBJECTIVES
2. MOBILIZATION
3. EFFECTIVENESS

B. SELF DIMENSION
1. REALITY GRASP
2. SATISFACTION
3. SELF CONTROL

C. INTERPERSONAL
1. PERS. CLOSERNESS
2. PROF CLOSERNESS
3. SELF CONTROL

PHYS. COND. (-) PEAK
-1. ILLNESS/INJURY
-2. ABUSE (le, FOOD)

PHYS. COND. (+) PEAK
+1. PHYS. HEALTH
+2. PROPER USE

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depression, and psychosis. Positive peak experiences, or
wellness, is likewise measured by peaks of peace, friendly
feelings, sense of physical wellbeing, happiness, and sense
of mastery.

The definition of each of 41 elements (see Table II) is
also provided to the patients to help them remember the
meaning of each parameter they are to rate. It is explained
to the patients that the self-rating exercise is not simply
an act of passive accounting of how they might have been
during that day, but also is an active exercise in which they
must reflect on how they can think, feel, and act in such
a way as to improve on each of the positive parameters,
since improvement on their scores is the objective of the
therapy. The patients are actively coached how to think,
feel, and act, so that they can better take the following four
key steps for successful adjustment on each of the 41
parameters:

1. Accurate observation and recognition of realities around
   and within oneself.
2. Putting perceived realities into a positive perspective.
3. Making proper choices and decisions.
4. Acting in a manner consistent with the decision made.

The patients are introduced to the tracking sheet during
the first session as the therapist takes the patient through
the sheet, explaining each element while scoring the patients'
condition with them, as part of the initial diagnostic
evaluation.

The patient is also given computer data entry cards to
be marked, based on his/her daily scoring on the sheet,
and is instructed to return for the next session with his sheet
filled with columns of numbers (usually one scored at the
end of each day) and a stack of properly marked computer
data entry cards. At the beginning of each session, these
cards are fed into the personal computer through an optical
card reader. The patient and the therapist can then, together,
examine the daily records of the patient during the previous
week via the colorful graphs on the computer screen.

Scoring is made on a 10 point scale with 0 as minimum
and 10 as maximum. The patients are encouraged to score
at least once at the end of each day, but also score when
there are significant fluctuations in their condition, capturing
the peaks and valleys as they occur during the day.

Optionally, the Total Adjustment Sheet can be scored
in three columns as a unit. Instead of just the patient rating
himself, a second column rating his observed condition of
his partner, such as a spouse, and the third column represen-
ting the patients' perception of his partner's evaluation
of him.

The analysis of scores on the Total Adjustment Sheet
alone is quite helpful, providing clues to a wealth of material
for further exploration and interpretation during the therapy
session. In fact, the author practiced for several years using
the sheet alone, with considerable benefit. However, when
these scores are visualized on the computer screen, the
impact became more potent, often making the therapeutic
interactions more interesting, dynamic, and productive, both
for the patients and the therapist.

The visualization of the patient's subjective state gives
him a sense of confidence as he can understand and track
his subjective experiences, and eventually control and im-
prove them. From a strategic point of view, the quantification
and visualization of the patients' condition makes it possible
to help them overcome their negative and decremental
cognitive bias and to develop more positive and incremental
cognitive, emotional, and behavior patterns.

While Lifetrack approach has been used for a wide range
of problems, both for out-patients and in-patients, over the
past 12 years in the author's private practice. The computer-
aided therapy for practically all patients started about three
and a half years ago, and, to date, 300 patients have been
treated with highly satisfying results. The following two cases
are presented to illustrate some of the characteristic ex-
periences in Lifetrack therapy.

CASE 1.

Mrs. A, a 53-year-old female executive with a six month history
of worsening anxiety, agitation, multiple physical symptoms and
preoccupations, depression, and the psychotic delusion that she
was about to die with malignancy.

She became overwhelmed by her work, feeling unappreciated
and undermined by her boss. She felt unfulfilled in her relationship
with her husband of over 30 years, despite their recent move into
their "dream house" in the suburbs after many years of repeated
movements, due to her husband's frequent transfers.

She had been a dynamic and successful person, though with
a history of three previous treatments for anxiety and depression.
The first episode came when she married and started having
children. Later, as her children were growing up, she received
psychotherapy at a family unit.

When first seen, she was anxious, restless, appearing almost
prostrate and "suddenly aged" as she had been nauseated and unable
to eat. She was preoccupied with various physical symptoms, such
as discomfort in the throat, esophagus, and stomach, where she
thought she had a malignancy. She also had sleep disturbance and
an inability to concentrate. Although she denied suicidal thoughts,
his thought content and affect were clearly depressed.

She was treated with daily psychotherapy sessions initially (the first 10 days), due to the extreme volatility
of her condition and her refusal to consider hospital treatment.
In order to improve their intimacy at the same time as she overcame
her symptoms, she was given Amitriptyline Hydrochloride and
Lorazepam, and was treated in couple therapy sessions with her
husband, as often as he could participate. She responded to therapy, and
the frequency of sessions were decreased to once weekly. (Total
number of sessions = 22; Total hours = 30.) She had regular
treatment for two months with a decreasing frequency of sessions,
and three further follow-up sessions spread over an additional three
month period.

Her course in therapy was characterized by repeated set backs,
typically preceded by periods of improvements, and followed again
by breakthroughs. She gradually improved over the two months
period, in all three principal spheres of life — Self, Intimacy, and
Achievement.

She was treated with the help of a Lifetrack computer aided
monitoring program based on her daily self ratings. Twenty-six
<table>
<thead>
<tr>
<th>NAME</th>
<th>MO/DAY/WD</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LANDMARKS</strong></td>
<td></td>
<td>Notable events that may account for changes in scores</td>
</tr>
<tr>
<td><strong>PSYCHOLOGICAL STATUS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(+) PEAK</td>
<td>Negative peak experiences within a given rating period</td>
<td></td>
</tr>
<tr>
<td>- 1 ANXIETY</td>
<td>Thoughts, feelings, and actions that signal anxiety, nervousness, tension, worry, and fear</td>
<td></td>
</tr>
<tr>
<td>- 2 ANGER</td>
<td>Thoughts, feelings, and actions that are angry, unfriendly, hostile, and mean</td>
<td></td>
</tr>
<tr>
<td>- 3 PHYSICAL SYMPTOMS</td>
<td>Any and all physical symptoms and feeling of illnesse</td>
<td></td>
</tr>
<tr>
<td>- 4 DEPRESSION</td>
<td>Thoughts, feelings, and actions that are negative to the point of being beyond your control</td>
<td></td>
</tr>
<tr>
<td>- 5 PSYCHOSIS</td>
<td>Thoughts, feelings, and actions that signal inconsistency, confusion, inappropriateness, ambivalence or paralysis</td>
<td></td>
</tr>
<tr>
<td>(+) PEAK</td>
<td>Positive peak experiences within a given rating period</td>
<td></td>
</tr>
<tr>
<td>+ 1 PEACE</td>
<td>Feelings of peace, relaxation, and safety</td>
<td></td>
</tr>
<tr>
<td>+ 2 FRIENDLINESS</td>
<td>Friendly, positive feelings toward those around you</td>
<td></td>
</tr>
<tr>
<td>+ 3 PHYSICAL WELLBEING</td>
<td>A sense of physical well-being; a feeling that you are healthy and strong</td>
<td></td>
</tr>
<tr>
<td>+ 4 HAPPINESS</td>
<td>Feelings of happiness and contentment; a feeling of being wanted and fulfilled</td>
<td></td>
</tr>
<tr>
<td>+ 5 MASTERY</td>
<td>Confidence and optimism; a feeling that you are master of your own fate</td>
<td></td>
</tr>
</tbody>
</table>

I. (SELF) | How well you are in touch, at peace, and in control of self |
| A IN TOUCH | How well you are in touch with your thoughts, feelings, and actions |
| 1. POSITIVES | The extent to which you are aware of happy or optimistic thoughts, feelings, and actions |
| 2. NEGATIVES | The extent to which you are aware of pessimistic or unpleasant thoughts, feelings, and actions |
| 3. PERSPECTIVE | The extent to which you have a balanced perception of your positive and negative experiences |
| B AT PEACE | How well you are at peace with your thoughts, feelings and actions |
| 1. POSITIVES | The extent to which you accept, appreciate, and feel comfortable with positive thoughts, feelings, and actions |
| 2. NEGATIVES | The extent to which you can accept, and come to peaceful terms with negative thoughts, feelings, and actions |
| C IN CONTROL | How well you integrate your positives and negatives, while maintaining self-justification |
| 1. DECISION | Your ability to make choices and decisions |
| 2. ACTION | Your ability to act on decisions once they are made |
| 3. MONITOR/CONTROL | Your ability to be flexible, and to modify your thoughts, feelings, and actions |

II. (INTIMACY) | Level of closeness within your most important relationship |
| A INTELL-SOCIAL | How close you are in the intellectual-social dimension |
| 1 ACCEPT | Your willingness and ability to accept your partner |
| 2 DEPEND | Your willingness and ability to trust and depend upon your partner |
| 3 LET DEPEND | Your willingness and ability to let your partner depend upon you |
| B EMOTIONAL | How close you are in the emotional dimension |
| 1 CONCERN | Your thoughtfulness and concern over your partner's wellbeing |
| 2 AFFECTION | Your willingness and ability to feel and express affection |
| 3 LOVE | Your willingness and ability to feel and express love |
| C PHYSICAL-Sexual | How close you are in the physical-sexual dimension |
| 1 TOGETHERNESS | The extent to which you want to be (and enjoy being) together |
| 2 SENSUALITY | The extent to which you desire and enjoy touching, holding, kissing and caressing |
| 3 SEXUAL EXCITEMENT | The extent to which you desire and enjoy giving and receiving sexual excitement |

III. (ACHIEVEMENT) | Your level of adjustment at work and in activities like sports & hobbies |
| A TASK ADJUSTMENT | Your willingness and ability to cope with tasks and realities |
| 1 OBJECTIVES | How well you can set objectives and maintain priorities |
| 2 MOBILIZATION | The enthusiasm with which you handle tasks and realities |
| 3 EFFECTIVENESS | How effectively you get things done |
| B SELF DIMENSION | Views of yourself within the context of achievement |
| 1 REALITY GRASP | How accurate is your grasp of realities around you (and within you) |
| 2 SATISFACTION | How much satisfaction and fun you get out of achievement |
| 3 SELF CONTROL | How well you can control your thoughts, feelings, and actions related to achievement |
| C INTERPERSONAL | Your views on interpersonal relationships within the context of achievement |
| 1 PERS Closeness | How genuinely close you feel to colleagues on a personal level |
| 2 PRO Closeness | The extent to which such closeness is professionally acceptable and workable |
| 3 SELF CONTROL | Your willingness and ability to keep such relationships within proper boundaries |

PHYS. COND. (+) PEAK | Your positive peak physical condition within the rating period |
| - 1 ILLNESS/INJURY | The presence of any illness or injury |
| - 2 ABUSE (ie. FOOD) | The extent to which you used food, alcohol, drugs, or tobacco improductively |

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color graphs on screen were routinely used in each therapy session to help analyze how she was evolving during the therapy in various spheres and parameters as listed in the Total Adjustment Sheet. This daily tracking and regular use of Psychological Feedback was invaluable in the course of treatment of this volatile and demanding patient, since she could see for herself that she was progressively achieving higher peaks over time, despite repeated setbacks that totally demoralized her each time, making her skeptical of the value of therapy.

Figure 2 is a sample of one of the 26 standard graphs used in daily therapy. Initially, her state of acute distress is indicated in the marked elevation of the (−) Peak Average line (or average scores of 5 Negative Peak experiences — Anxiety, Anger, Physical Symptoms, Depression and Psychosis — reached high levels, emerging above the (+) Peak Average line (or average scores of 5 Positive Peak Experiences — Peace, Friendliness, Physical Wellbeing, Happiness, and Mastery).

The dramatic and repeated fluctuations of the (−) and (+) Peak Average shows the volatile clinical condition. By the midpoint of the graph, or about one month into therapy, her (+) and (−) Peak Average lines show progressive and clear separation with (+) line emerging above (−) line. By the second month of therapy, the (+) Peak Average was reaching and stabilizing around 9 (on a 10 point scale), though still showing some ups and downs. This improvement was achieved and maintained despite a serious car accident suffered by her husband seven and a half weeks into her therapy (three weeks before termination of her regular sessions), requiring hospitalization and repeated surgery. The (−) Peak Average also declined progressively, coming down to the level of 2 by one month, and less than 1 by the second month.

This marked improvement represents a 100% (from 4.5 to 9) improvement in (+) Peak Average, and more than 700% (from 7 to below 1) improvement in (−) Peak Average (or symptoms), over the 2 month period of therapy.

Figure 3 is another graph example, showing the Total Average (Average scores of Self, Intimacy, and Achievement spheres representing an average of 21 elements) going from 4.5 to 9, a 100% improvement in 2 months.

The graphs also showed several setbacks reflected in the deep valleys of the (+) line with corresponding spikes of the (−) line (see Figure 2). Similar ups and down are clearly shown in the Total Average line (Figure 3).

CASE 2.

Mr. B a 50-year-old businessman with a three months history of easy tiredness, nasal discomfort, stiff shoulder, numb and dull feelings in the head. He also reported difficulty with falling and staying asleep, and early morning awakening. His appetite and sexual potency remained intact, however. He noted a general lack of enthusiasm and initiative, lack of concentration, patience, memory, a diminished ability to think, and an increasing tendency to shy away from interpersonal contacts.

He had been a successful executive with a solid technical background and two previous overseas assignments. He had held a position with over 100 subordinates, before transfer to New York to be one of the senior officers of a U.S. subsidiary of a major multinational company. In New York, he found his work to be more political and difficult, due to the differences between New York and home office business practices. He also felt poorly supported by his boss, while the head office expected unrealistic results. His subordinates in New York had more technical experience in U.S. operations, than he, and this made him feel inadequate and useless, as he had little routine work of substance to perform.

He had previously functioned alone in New York for 14 months, without many symptoms of distress. However, three months after his wife and three children joined him, he started having the aforementioned depressive symptoms.

He was treated as an out-patient with once weekly psychotherapy with his wife, for 3 months. Each session consisted of 3 to 5 hours, typically one hour spent with him alone, another hour with his wife alone, and then the remainder of time with both of them together. (A Total of 12 sessions; total time = 48 hours; average session duration 4 hours; and duration of therapy = 3 months.)

Initially, he was given Amitryptyline, but was switched to Desipramine in the third week due to excessive side effects “numbness” and a feeling of a tight “ring” around the head. Desipramine caused urinary retention and premature ejaculation, and was discontinued after two weeks.

During the ninety one days of therapy, his condition improved rapidly, reaching and exceeding the best previous level of adjustment in Self, Intimacy and Achievement spheres. He was happy and confident, much closer to his wife, and enjoyed working in the same work environment that had appeared hopeless only three months before.
He and his wife were followed with the Lifetrack computer patient tracking program, which allowed us to closely follow daily changes in all 41 parameters, and to analyze and interpret the dynamic and complex process of change, as therapy progressed. The 26 standard graphic displays were used to demonstrate progress being made with both the patient and his wife, often sharing each other's graphs in joint couple sessions.

His wife was an exceptionally capable and independent person who had her own successful career before moving, and was not happy about the move to New York. Initially, his wife was surprised that her husband had been in such distress without her knowledge. However, she was encouraged in the course of therapy, to recognize that she had defenses against closeness and that she really wanted to be closer with him. She strenuously resisted for nearly six weeks, although she did come in and participated in each session. However, by the sixth week she was beginning to make a breakthrough. By that time her husband had already recovered to a level significantly better than his best previous level of adjustment, with scores exceeding 10. Interestingly, as she finally started feeling closer towards him, he had a setback, with his scores slipping in all three spheres. It was explained to him that his defense against closeness with his wife was now being mobilized as she had overcome hers, and that it was vital that he overcome his and reach a higher level of closeness now that she was available for a closer and more satisfying relationship with him.

This seesaw-like mechanism was seen at least three times during the course of their therapy. First, his wife rejected her husband when he was reaching out in distress; and the second time around the sixth week in therapy (as described above); and the third time at eleventh week, when his wife again had another breakthrough (rapid improvement) in her sense of closeness towards her husband, when he had another significant setback.

Figure 4 shows the Total Adjustment line (average of all 27 scores in Self, Intimacy, and Achievement spheres) and (-) Peak Average (average of 5 negative peak experiences).

Over the three months period of therapy, the patient went from his worst condition (starting point with (-- Peak average -- symptom peaks -- near maximum of 9, Total Average score at low of 5), to premorbid level by the first month (Symptoms (-- Peak average down to 2, and Total Average at a high level of 8). However, most significantly, he went on to achieve higher than his best previous level of adjustment by second month (Symptoms minimum 0, Total Average score at high of 11). By the third month, he reached a level 100% higher than the premorbid level and 200% higher than the starting point of therapy (Symptom 0, Total Average at 18).

Figure 4 and other graphs clearly show the typical pattern of ups (breakthroughs) and downs (setbacks) that characterize the process of improvement. It is extremely reassuring and beneficial to the patients to be able to see visually that setbacks are usually followed by breakthroughs and improvements are usually followed by setbacks. Recognition and prediction of this pattern, in the course of therapy, greatly helps the patient and the therapist to maintain a positive and optimistic outlook in the face of seemingly hopeless situations, such as Mrs. A and Mr. B. found themselves in, in the course of treatment.

DISCUSSION

While there have been various contributions in the literature on the concept of Positive Mental Health and Wellness, as described in the introductory portion of this paper, this paper presents a direct and systematic application of this concept in therapy in a way that satisfies most, or all, of the 6 conditions of Positive Mental Health suggested by Jahoda in 1958.

The structured model of Positive Mental Health with the specific 41 parameters, allows the patients' subjective self-rating on a frequent basis. This provides sensitive and clinically useful data that can be graphed by computer for analysis and interpretation during the therapy sessions. This approach has significant benefits and clinical implications:

1. The patient and the therapist are able to maintain comprehensive, up to date, and accurate data, for analysis and interpretation, reducing the time required to review and reconstruct the evolving condition of the patient, prior to the session, and focus time and efforts on most important issues.

2. The Psychological Feedback effect helps reinforce positive therapeutic gains, generating high morale and optimism in therapy. Both the patient and the therapist are able to see signs of improvement, clearly and early, so that beneficial changes can be reinforced effectively.

3. Patients treated with this method have rapidly reached, and often exceeded, their best premorbid adjustment level, as rated by the patients themselves. They learn to think more incrementally, rather than decrementally, as typically they did before.

4. A clear grasp of the path to recovery becomes possible with the graphic display of the evolving condition of the patients, helping the therapist to make accurate predictions of the course of therapy, increasing his confidence, credibility, and therapeutic productivity.

5. Accurate monitoring and follow-up of the patients' condition becomes possible, even when sessions occur infrequently, as the patient continues the daily self-rating between sessions.

6. The patients gain the means of monitoring and improving themselves on their own, even after the termination of
therapy. If and when further treatment becomes necessary, the patient and the therapist have an advantage of sharing a consistent framework to communicate with each other.

The following are some of the fascinating clinical findings which emerged during the treatment of over 300 patients with Lifetrack Therapy:

1. Practically all patients go through the typical course of ups (peaks) and downs (valleys), in the process of improvement.
2. Setbacks (downs) are usually followed by breakthroughs, allowing the patient to reach peaks higher than the ones before.
3. Breakthroughs and rapid improvement usually trigger a setback, as if the improvement itself brings on defense against further improvement, essentially manifesting identical symptoms of distress—anger, anxiety, physical-symptoms, depression, and psychosis—as are seen in typical periods of distress.
4. Whether or not a setback can be overcome with another breakthrough depends on whether sufficient resources can be mobilized between the patient, the therapist, and the environment. Stagnation results when defenses are too strong to be overcome with available resources.
5. Seesaw-like sequential manifestations of defense are typically seen in couple therapy, when recovery of the sick partner seems to provoke a setback in the well partner, as if to prevent the fulcrum (level of closeness) of the seesaw from going up. It is essential that this sequence be anticipated by the therapist and the most important other person (spouse or equivalent) be treated with the patient, so that a series of sequential breakthroughs may be achieved, instead of allowing a stagnation of their relationship.
6. A similar seesaw-like phenomenon is often observed among dimensions and elements of the Self, Intimacy, and Achievement spheres of the same patient, as if breakthrough in one dimension or element had to be cancelled by setback in other dimensions or elements. It is essential that this is anticipated and recognized and properly interpreted in sessions, to prevent stagnation of the clinical condition.

Finally, a limitation of the Lifetrack Therapy approach seems to lie in its dependence on close cooperation with the patient, particularly on the patient's ability and willingness to report his subjective experiences honestly and accurately. Thus it requires rapid establishment and maintenance of the therapist-patient alliance, and the method works best in helping the patient, rather than in objectively evaluating them when they are unmotivated or incapable to cooperate.

Further, when the patients' cognitive capacity is impaired, as in acute psychotic decompensations, chemical, environmental, and supportive psychotherapy approaches, may be employed to restore the patient's cognitive function to a sufficient level before the self-rating exercise can be meaningful. The patients with limited intelligence, or marked inability or unwillingness to introspect, are not good candidates for this form of therapy.

REFERENCES


