Integrating Positive Psychology Into Family Therapy: Positive Family Therapy

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Abstract
The article provides an overview of positive family therapy that combines family therapy and positive psychology to develop a nonpathologizing, growth-oriented, strengths-based, relationship-focused model of intervening with families. The theoretical roots from both family therapy and positive psychology are described. The unique feature is the mechanism of change, broaden and build theory from positive psychology. Examples of techniques are provided that foster strengths, virtues, approach goals, and positive affect. In accordance with the counseling psychology tradition, we argue that positive family therapy is culturally sensitive, growth oriented, and hope enhancing.

Keywords
prevention/well-being, psychotherapy, children/adolescents, adults

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In this article, we present a succinct overview of the essential “ingredients” of positive family therapy (PFT) and the major developments since the model’s inception (Conoley & Conoley, 2009). Whereas evidence from multiple unpublished case studies supports the process, validation of the entire approach remains wanting. In essence, the model represents an elaboration on many of the more limiting aspects of solution-focused therapy (SFT; De Shazer, Dolan, & Korman, 2007), which has preliminary support from studies on a number of populations and conditions (Bond, Woods, Humphrey, Symes, & Green, 2013). The ultimate goal of our elaborations has been to reshape SFT techniques and concepts into a format that supports a broader use of positive psychology research in family systems for improving clients’ quality of life by encouraging them to pursue healthy goals and behaviors. We hope that by formally summarizing and disseminating the precepts of PFT here, we may galvanize increased interest among researchers and practitioners, and thus encourage additional empirical research on its deployment and outcomes.

Leo Tolstoy claimed that “Every happy family is alike, but every unhappy family is unhappy in their own way” (Tolstoy, 1878/1960, p. 1). Although we clearly would not agree that any family is indistinguishable from another, our belief in the efficacy of PFT rests on the observation that there are specific and syncretic qualities that distinguish happy families from less happy families, or families with members who have lower subjective well-being. In distilling, reproducing, and enhancing those qualities, this approach offers a unique contribution to the field. When skillfully executed, PFT is capable of both respectfully acknowledging the infinitely varied reasons that bring a family to therapy and of moving beyond those initial challenges to fortify the family with the core skills and qualities that consistently produce positive, functional, and sustainable relationships.

In the following pages, we outline the theoretical underpinnings of PFT, summarize the hallmark techniques, and illustrate through examples how most of the common interventions may be put into practice. Contextual and multicultural considerations are addressed, as are future directions for research. We begin with an overview of PFT’s essential purpose, principles, and benefits, with a focus on the attributes that render it distinct from similar therapeutic approaches.

**PFT**

The primary features that separate PFT from more traditional forms of systemic family therapy are the application of broaden and build theory, an expressly strengths-based intervention design (Fredrickson, 2001), and an emphasis on approach rather than avoidance goals (Elliot, 2008). Precisely because PFT is a strengths-based, forward-facing method, there is little focus on the etiology or
development of presenting problems, which are conceptualized more as opportunities for growth than traps from which the clients require assisted release. Because many clients appear in therapy with preexisting biases toward a problem-focused process, a considerable portion of PFT involves redirecting clients to a solution-focused mind-set. This focus is typically accomplished through treatment that prizes the attainment of both full and partial goals, considering each new success not only as a laudable step toward attenuation of the presenting problem but also as a valuable contribution toward the more important accomplishment of creating a high-functioning family.

The crux of PFT’s rationale of change lies in the broaden and build theory (Fredrickson, 2001), and consequently favors a cumulative perspective of family functioning. It is cumulative in that repeated emphasis on minor instances of positive affect and mutually enhancing interaction eventually coalesce into comprehensive growth for the entire family unit, and promote increased occurrence of facilitative interactional patterns. In tandem with PFT’s focus on approach goals and identification of strengths and virtues, families in this treatment system will optimally complete therapy with more than just a sense of resolution from the presenting problem: They will come away with an improved and expanded recognition of their own capacities, as well as a growing appreciation for the potential of their family members, both individually and collectively.

A broad multicultural benefit of the PFT approach is its de-stigmatizing approach to mental health. As numerous studies have indicated, negative attitudes and preconceptions toward mental health issues constitute a prevalent barrier to access—and an inhibitory mechanism during therapy—for many minority populations (Alvidrez, 1999; Meyer, 2003; Nadeem et al., 2007). The traditional problem-focused orientation of orthodox psychotherapeutic techniques may reinforce minority clients’ perception that being in therapy is in itself a sign of defective character or substandard family functioning. Conversely, PFT’s emphatically strengths-based, affirming approach to therapy works concomitantly to celebrate culturally important values while freeing clients from the stressful dissonance precipitated by participation in a culturally suspect process.

We have applied PFT most often with Mexican American and European American families. The application with Mexican American families has occurred most often with presenting problems of child classroom behavior problems, whereas the other families have exhibited a broader range of presenting problems. The SFT, a family treatment model similar to PFT (De Shazer, 1994), provides considerable research supporting family therapy with many of the same PFT interventions (Bond et al., 2013). The similar interventions include miracle question, focusing on solution or goal, exception finding, and interrupting pathologizing conversations.
Generally, positive affect has been an important intervention outcome because of the consistent correlation of positive affect with relationship satisfaction (Driver & Gottman, 2004; Ruvolo, 1998). Our clinical experience demonstrates that PFT consistently increases positive affect in families, in tandem with a host of mutually reinforcing auxiliary benefits. To comprehend how and why PFT accomplishes these outcomes, it is helpful to understand the theoretical framework from which it derives its interventions, as well as the primary principles that guide the processes. These are reviewed in the following section.

**Essential Theories and Principles**

**Broaden and Build Theory**

PFT stands apart from other positive psychology models (e.g., Smith, 2006; Wong, 2006) by focusing on the broaden and build theory as the mechanism of change. Formally introduced to the field by Barbara Fredrickson in 1998, broaden and build theory asserts that positive emotions—even when they are small and brief—can act as catalysts for sustainably enhanced well-being. The “broadening” component refers to the finding that individuals experiencing positive emotions become more inclined to interact with their environment in a creative and open-minded fashion than when positive emotions are not present (Bryan & Bryan, 1991). Essentially, the “broadening” aspect illustrates the enhanced resourcefulness and engagement that positive emotions bring to individuals’ lives, yielding not just momentary pleasure of a positive emotion but also the increased opportunity for global augmentation of an individual’s efficacy. The “building” component refers to the generative aspect that accrues greater knowledge and resources, such as social and coping skills. It includes the growth aspect that is possible following a positive emotion–prompted openness or engagement. The growth increases an individual’s likelihood of securing more positive emotions and the resultant resources in the future (Fredrickson, 2001).

Whereas most theoretical approaches endorse increased positive emotions as an outcome goal, PFT adds a focus on positive emotions as a process goal. Under the broaden and build system, even minor instances of positive affect stimulate increased receptiveness in the client to new experiences, thoughts, and behaviors, which in turn augments the strength and diversity of a client’s psychological repertoire as a whole. As the techniques described within this article attest, PFT uses broaden and build theory specifically as an interventional schematic, guiding the therapist in the complex and demanding work of expanding a client’s foundation of positive experiences, abilities,
and willingness to take risks. By deliberately and thoughtfully fortifying the client’s cache of positive emotions (e.g., warmth, optimism, pride, curiosity, joy), the therapist can initiate and then reinforce a positive feedback loop in which every added experience expands the client’s capacity and openness for more growth and positive emotions. Following successful treatment in PFT, a client should possess a well-established repertoire of abilities that serves as both an incubator and an amplifier for future positive experiences.

**Approach Goals**

The approach orientation, in contrast to an avoidant orientation, is a hallmark of PFT. In the effort to move beyond a pathologizing or problem-focused diagnostic approach, PFT helps clients identify what they want to achieve rather than the things that they want to avoid. The basic premise of the approach-goal orientation is that clients will be more optimistic, creative, and motivated in their efforts to make changes in their lives if they are working toward the attainment of a positive goal than if they are seeking to reduce a worrisome state or condition.

Numerous laboratory studies support this assertion. Researchers evaluating comparative behavioral differences in goal- versus avoidant-focused task completion have found that the former yields increased persistence (Elliot, McGregor, & Gable, 1999; Grant & Dweck, 2003); enhanced creativity, flexibility, and resourcefulness (Friedman & Förster, 2001); and heightened motivation and energy (Goetz, Robinson, & Meier, 2008). Research results that reveal that approach-goal orientation has therapeutically helpful qualities beyond the orientation toward a desirable outcome underscore the importance of the approach- and avoidant-goal orientation.

The approach-goal format also facilitates multicultural sensitivity at the foundation of the intervention by providing clients with a dedicated forum to identify the qualities and conditions that are uniquely meaningful to their family. In a more general sense, approach goals enhance multicultural competence by bypassing the culturally imperialistic pitfall of the avoidant orientation, which implicitly suggests that the therapist’s view of a family is both the singular correct view and the indisputable force majeure behind therapeutic success.

In practice, adopting approach goals often requires active involvement on the part of the therapist because of clients’ proclivity for a problem-reduction thought process. Many—if not most—families enter therapy with the stated goal of reducing or eliminating a specific problem. Through the interventions outlined in this article, a substantial part of the therapist’s work lies in reorienting client conceptualizations from a problem-focused mind-set toward the embrace of an approach-goal framework.
For example, a common topic in family therapy is conflict between “rebellious” adolescents and their parents. Many parents begin the dialogue by stating that they want their teenager to be less argumentative, confrontational, or generally recalcitrant (i.e., an avoidant goal). Such a statement explicitly condemns the teenager’s character and suggests that a fundamental change must occur on the part of the teenager alone to achieve parental acceptability. A more positive and empowering unstated wish exists that implicitly illustrates the parents’ fondness for their child, their faith in the teenager’s ability to be a more cooperative member of the family, and their desire for a warmer, more pleasant relationship with their teenager. The parents could be helped to fashion an approach goal that clearly expresses these positive aspects producing a statement that is consequently more agreeable and incentivizing to their child. For example, “We really want to figure out how to talk with Declan in enjoyable ways so that we know each other better, even have enjoyable times together.” If the therapist can guide the parents in restating their agenda as an approach goal that emphasizes such positive outcomes and expectations, the teenager may not only feel less threatened but also motivated to collaborate creatively with the parents in producing a more pleasant atmosphere for all involved.

**Strengths**

A fundamental tenet of positive psychology is the focus on strengths to promote growth, well-being, and happiness. The interventions utilized in PFT take a strengths-based approach, as focusing on strengths can lead to multiple therapeutic benefits, including the creation of positive emotions in session, identification of approach goals, tools for accomplishing goals, and enhancement of the therapeutic alliance.

Multiple conceptualizations of strengths exist, ranging from perspectives that view strengths as limited to a finite list (Hodges & Clifton, 2004; Peterson & Seligman, 2004) to perspectives that consider the nature of strengths to be developmental, rather than inherent and individualized (Biswas-Diener, Kashdan, & Minhas, 2011). For purposes of application, we conceptualize strengths broadly and as deliberately inclusive of many different perspectives. Utilizing a broad conceptualization to identify client strengths can lead to increased therapeutic outcomes beyond the scope of similar therapy that lacks identification of client strengths (Flückiger & Grosse Holtforth, 2008).

The specification of strengths has evolved since the original presentation of PFT (Conoley & Conoley, 2009). Strengths are more recently operationalized as helpful personal assets or qualities that can fall under four categories, namely (a) abilities such as creativity, athletic, professional, and humor; (b)
accomplishments such as health, knowledge, and relationships; (c) attitudes or emotions such as love of others, hope, and enjoyment; and (d) virtues such as kindness, courage, and honesty. This list is designed to be both substantial and straightforward, to facilitate the therapist’s ability to identify strengths quickly during a session. Most of the PFT interventions require immediate recognition and identification of client strengths. The operational definition of strengths has provided guidance for content analysis in psychotherapy process research of the interventions (e.g., Conoley, Pontrelli, Oromendia, Bello, & Nagata, in press).

**Systems Theory**

The processes important to understanding therapeutic family dynamics are described in systems theory, communication theory, and social constructionism. According to general systems theory, originally proposed by Ludwig von Bertalanffy (1976), living things exist within varied and recursive systems. When one part of the system acts, the consequences are recursive, and all other system elements are affected. In PFT, we apply this theory to the human system defined as a group of people who interact together in moderately predictable ways (von Bertalanffy, 1976). The predictable actions or reactions affect all the members who act or react: The terms act or react often define blame, and their interpreted meanings depend on where the interaction is thought to begin in a particular systemic sampling (Boscolo, Cecchin, Hoffman, & Penn, 1987). In the family system, all members mutually influence one another, underscoring the importance of focusing attention on each family member during PFT not simply the person in the family identified as having the problem. Some family members, such as parents (depending on the family context and culture), have more power than other members to influence the system. The power dynamic is critical to consider in session because the therapist typically lends attentional priority to dynamically powerful family members, while continuing to distribute attention to all individuals.

Because of the recursive nature of systems, there are many ways a system can reach its current state, and a multitude of factors influence the system’s continuity or change over time. This principle of equifinality, stating that many possible routes could have led to the existing troubles rather than a single identifiable route, highlights the unnecessary nature of blame in family therapy as the improbable ability to identify a single or even a certain cause (Bertalanffy, 1976). Moreover, many ways exist for the family to proceed toward their goals. We promote the broaden and build model, with the incorporation of strengths and approach goals as primary interventions, to
facilitate family members in proceeding toward their goals. In considering processes of facilitating family growth as well as enjoyable relationships, PFT attends to communication issues.

**Communication Theory**

Human systems definitively interact via communication; therefore, communication theory tenets are foundational to PFT. Four of the Palo Alto group’s (Bateson, Jackson, Haley, & Weakland, 1956; Watzlawick, Beavin, & Jackson, 2008) key tenets are especially useful to consider in the practice of PFT, including (a) communication in relationships is always occurring; (b) everything done and said (or not done or said) in a relationship communicates something; (c) once communicated, a communication cannot be rescinded; and (d) ignoring or rejecting one individual’s perspective communicates that the individual is not an important or significant member of the family system (which can ultimately be counterproductive in working toward positive goals).

The influence of the communication tenets on PFT appears in the therapist’s choice of content, decision to disrupt maladaptive communication, and maintenance of neutrality. Communication tenets highlight how family therapy is dissimilar to individual therapy where almost anything can be said and explored in a safe and confidential environment. Defining neutrality and identifying maladaptive content are described in the following sections.

An example of maladaptive content for family therapy is the discussion of whether to divorce even if the therapist is certain that the parent will not really decide to leave the children. In individual therapy, a parent could express the desire to abandon the family for a more liberating life. The counselor would follow-up the statement by perhaps asking the parent to envision a life without a family and how it would be different from the current life. The client may respond positively, imagining a life where all personal needs may be put before those of the others. Then the counselor might follow up by asking how the client would feel losing his or her family. The client could respond with sadness and feelings of incredible loss. Eventually the client could come to the conclusion that abandoning the family is not desirable in the end.

In family therapy, however, the same content could have devastating and irreversible effects on a child or spouse, as the desire to abandon them cannot be uncommunicated, even when the ultimate conclusion is to stay. The therapist must always be cognizant of how therapeutic content affects each individual in the family. The family therapist interrupts potentially destructive conversations and guides the communication toward approach goals that are
relevant to the content, so as not to inflict psychological harm on any family member through careless communication. If the content uncovered in family sessions is judged important yet destructive to the family’s growth, individual sessions may be added.

Another less dramatic example of destructive communications that a PFT therapist would attempt to block and transform into an approach goal is a parent expressing shame or anger toward a child (or other parent). For example, a parent might state that the child’s grades and behavior in school are humiliating and embarrassing to the parent. The child is ruining the parent’s life, and the parent is extremely angry at the child. The content is destructive because the communication harms the relationship between the parent and the child. As soon as the PFT therapist understands the content of the communication, the parent is interrupted with an alternate message that the therapist believes is acceptable to the parent in accomplishing the ultimate goal. The therapist could interrupt saying,

Let me be clear. You would like for your daughter to do better in school because you would really like to be able to brag about her when your neighbors are bragging about their daughter. Is that what you want? What would that be like? What would you like to say about Maria?

The therapist solicits the parent’s desire to be proud and happy with the child. Instead of allowing the original destructive communication to unfold, the PFT therapist facilitates a parental invitation to be in a warm relationship that could facilitate growth.

Therapist neutrality is an important construct derived from communication theory. To remain neutral, the therapist must establish and maintain rapport with each person without being viewed as having a favorite person or perspective. The therapist communicates interest in each family member’s perspective, while simultaneously acknowledging other members’ perspectives (Boscolo et al., 1987; Cecchin, 1987). Because avoiding or ignoring an individual’s experience communicates that the individual is unimportant and insignificant in the family system, care must be taken to include all family members’ perspectives in therapy. Members who feel excluded from the conversation might feel excluded from the family itself, which can lead to counterproductive behaviors that hinder the attainment of goals. Inclusion of all perspectives facilitates the therapist’s cultural competence. The therapist gains important culturally relevant information by attending to the transactional interaction of each individual’s perspective with the family system as a whole. Therapist neutrality does not mean that equal time will be given to every person or perspective. However, every person would be invited to share
a perspective with no expectation that agreement should occur. Family members who are used to talking more will probably say more by the end of the session. However, parents are typically asked to say the most because of their leadership position.

**Social Constructionism**

Theories of both constructionism and social constructionism are centered on the idea that individuals create their own realities by ascribing meaning to various external and internal events. We take a moderate view in the ensuing, greatly simplified interpretation of constructionism and social constructionism. For an in-depth discourse, see Wong (2006). Constructionists believe that individuals create meaning through internal processes such as perceptions and beliefs (Rudes & Guterman, 2007). Social constructionists, however, propose that individuals create meaning through interpersonal interactions, and therefore, others are vital in shaping reality (Bruner, 2004; Gergen, 1997). PFT primarily ascribes to the facet of social constructionism that views language as creating reality, especially in the context of the family communications. Because of this, the therapist helps a family adopt a more positive conversational style to create not only healthier relationships but also healthier self-concepts for the family members.

Many individual therapies take a constructionist stance by focusing on changing individuals’ cognitions about external events and consequently changing their realities. Most family therapies, however, ascribe to a social constructionist model, concentrating on how recursive communication affects each individual family member. In family systems, the ways in which various family members speak to and understand each other shape each individual’s concepts of self and reality (Gergen, 1997; White & Epston, 1990). The focus of family therapy, then, is to change patterns of communication within the family by changing how various members are spoken to and treated, as well as changing each individual member’s reactions to other members.

Families become stuck in problems when the family conversations revolve only around the problem, which perpetuates current communication patterns and the corresponding current realities of each individual family member (Anderson & Goolishian, 1988). In PFT, shifting the conversation to focus on possible solutions and approach goals allows new patterns of communication to be formed, helping all members to arrive at a more positive outcome. For conversations in therapy to be productive, the new patterns of communication must extend beyond the therapy session. Because parents typically interact frequently with their children, are emotionally invested in them, and
control a large proportion of family activities and conversations, family theories support the presence of the parents in session as well as the sustained leadership role of the parents in perpetuating more positive communication patterns at home. Put simply, a common goal in family therapy is to make the parents their own family therapists, allowing them to become long-term collaborators in promoting their children’s well-being and mental health.

The theories and principles outlined in the previous sections form the foundation for PFT interventions. Although not all of the interventions are described in the following section, the interventions are designed to develop a family’s approach goals, strengths, positive emotions, and supportive communication patterns, while concomitantly working to enhance a sense of pride, investment, and satisfaction in the family unit as a whole.

**Interventions**

**Capitalization**

Capitalization refers to the inter- and intra-personal dividends yielded when an individual discloses good news to a confidante, who then actively celebrates the news with the discloser (Langston, 1994). Drawing upon broaden and build theory, capitalization optimizes and extends the positive affect of an event because the disclosing person feels more positive emotions, values the revealed accomplishment more, and enhances the relationship with the person celebrating the disclosure. Recent findings suggest that even the confidant who celebrates the disclosure feels more positive emotions as a result of the process (Conoley, Vasquez, Carmen Bello, Oromendia & Jeske, under review; Vasquez, Lee, & Conoley, 2012), a direct reflection of both the process and power of social constructionism. Research on capitalization across a variety of domains, from romantic to professional, suggests that its effects include both intra- and inter-personal benefits for individuals in widely varying contexts; capitalization can have positive results even between total strangers (Ilies, Keeney, & Scott, 2011; Reis et al., 2010)! The positive self-discloser can benefit from capitalization through increases in life satisfaction and heightened positive affect. In expressly dyadic scenarios, capitalization efforts appear to increase the self-discloser’s overall sense of trust, intimacy, and satisfaction in the relationship while reducing the likelihood of conflict (Gable, Reis, Impett, & Asher, 2004). A critical facet of successful capitalization is a shared belief by both the discloser and confidante that the celebration is genuine (Vasquez et al., 2012).

Capitalization also demonstrates the application of systems theory and communication theory through its ability to positively reshape recursive
communication styles. Because many families exhibit a default reaction of neutral, passive, or even explicitly negative response patterns to positive news (Gable et al., 2004), helping members develop authentic capitalization skills is an important step in disrupting existing destructive patterns of communication and introducing more productive ones. Consequently, therapist modeling and client homework assignments of practicing capitalization help enhance an individual family member’s self-efficacy and relational closeness, instigating an individual change that will affect the family system as a whole. For example, the therapist may encourage a client to try a capitalization exercise in session:

Therapist: Alright, now let’s try out a little capitalization exercise. How would you respond if your daughter told you that after winning her most recent high school Slam Poetry competition, she had been invited to perform in a regional event, and that she was excited but also very concerned about the fierce competition coming up?
Mother: Well, I guess I would tell her that there’s no shame in losing when she’s already worked hard, and that we will love her no matter how the regional competition turns out.
Therapist: Alright. I’m noticing that you are doing a great job of expressing your unconditional love for your daughter while acknowledging her fears, but how about also taking a moment to celebrate her win? Can you try that out?
Mother: Okay. How about . . . Wow, how exciting—that’s fantastic news! What an honor for you to make it to regional, you worked really hard on your poetry and you have every reason to be proud of this accomplishment. We should go out for ice cream tonight to celebrate your victory.
Therapist: Excellent! Don’t forget to try it out with her next time she shares something positive with you.

Encouraging members to practice acts of capitalization independently offers the additional benefit of increasing the family’s focus on positive events in a framework that privileges the members’ unique interpretations of what constitutes a “positive event”—a crucial point in ensuring the intervention’s multicultural sensitivity.

Paraphrasing

Paraphrasing or restatement involves a literal reassertion of the client’s words in which the therapist selects highlights from longer responses and offers
them back to the client as a sort of check-in to verify the accuracy of the therapist’s understanding (Hill, 2009). On a more subtle level, paraphrasing offers the therapist a chance to select expressions of strengths, goals, or solutions that have been quickly brushed past by a client’s problem-focused thought process and clearly present them back to the client for further discussion. In contrast to positive empathy (Conoley et al., in press), which requires insight into a client’s latent hopes and creative conceptualization of approach goals, paraphrasing is intended to be a strategic restatement rather than a hypothesis of the client’s deeper desires potentially expressed within the original statement. Whereas paraphrasing might be deployed every one to three sentences on average, it is especially warranted to highlight the client’s strengths and refocus the session toward client-initiated approach goals.

Fitting within systems theory and social constructionism, paraphrasing can also support the therapist’s intent to be neutral by simultaneously demonstrating support for both involved parties and showing that the therapist is attentive to the goals of the client who is speaking but also cognizant of, and affirmative toward, the client who is the (identified patient) subject of the speech. This is accomplished through the careful selection of positive statements regarding the identified client that parallel approach goals, allow the speaker to feel understood, and communicate an appreciation of the positive attributes of all involved parties.

Paraphrasing also offers a diplomatic means to interrupt a client engaging in an excessively lengthy problem-focused description. By interjecting with the stated purpose of ensuring comprehension, the therapist is able to signal respect for the client’s thoughts and feelings while gently redirecting the client to a more constructive approach. This is a direct application of communication theory, as the therapist uses the paraphrase to interrupt a train of thought that may be damaging for a partner or family member to hear, before it is communicated. For example,

Husband: She just never makes any time for us to relax together anymore and I miss that a lot. She’s always fussing with the kids or gossiping with her friends and it feels like she just doesn’t want to hang out and chat with me like we used to. I really wish we could get to that place again. I know she can be a caring person, but even when we do talk these days, she just complains about work. I hate it when she has the evening off and just decides . . .

Therapist (interrupting): So it sounds like you are saying that you know she is a caring person [smiles at wife] and you really want to be able to make time together to relax and enjoy each other’s company. Is that correct?
In this way, the therapist simultaneously supports both parties by acknowledging the husband’s stated but not focused on approach goals while also actively affirming the wife’s positive qualities and value in the relationship. Just as importantly, the therapist is able to subtly maneuver the husband’s negative remarks to the periphery of the conversation while bringing those aspects of the comment that reveal his appreciation of his wife to center stage.

**Therapeutic Positive Empathy**

Therapeutic empathy, or an ability to understand and step into a client’s world, has long been considered a cornerstone of working alliance development and positive client outcomes in clinical practice (Elliott, Bohart, Watson, & Greenberg, 2011; Wynn & Wynn, 2006). In addition to fortifying the therapeutic alliance by helping the client feel understood and accepted, empathy expands opportunities for accurate and profound insights. As Carl Rogers (1959) first emphasized, the essential importance of therapeutic empathy more than half a century ago and its conceptualization and operationalization have been frequently reimagined in both literature and practice (Neukrug, Bayne, Dean-Nganga, & Pusateri, 2013). PFT prizes empathy as an expressly positive mode of sharing and sensing the client’s world. Thus, although classic definitions of empathy often promote therapist commiseration with the hurt and anger behind a client’s statement, positive empathy focuses on the hopes and desires that typically lie beyond the more negative and accessible features of client descriptions. At the crux of positive empathy is an ability to extract a deeper, unstated yet implied hope or desire from basic client statements, and to then reflect it back to the client in a way that communicates a therapist’s comprehension and support while exposing an approach goal or opportunity for growth (Conoley et al., in press). The skillful integration of positive empathy provides a unique opportunity to enhance the multicultural competence of the intervention strategy, allowing the therapist to specifically seek out and affirm strengths, desires, and qualities that are meaningful to the members themselves (as distinct from the potentially culturally biased preconceptions that the therapist may inadvertently bring into session). Therapeutic positive empathy has developed considerably since it was first introduced (Conoley & Conoley, 2009). Focusing on unspoken desires has been found to increase the number of approach goals and strengths stated by the client as well as increase the probability of eliciting positive emotions (Conoley et al., in press). The focus of conversation occurring because of positive empathy fits within the theory of social constructionism by creating ongoing conversation leading to a therapeutic reality.
Consider an example in which a client complains that every day when she arrives home from work, she is frustrated and angered to find that her house is in a state of disarray and her children are either quarreling or watching TV. The children ignore their homework and family obligations completely. In a traditionally empathic response, the therapist would likely respond by uncovering more deeply the mother’s disappointment in coming home to a chaotic and distracted household. A therapist might respond, “I sense the pain, anger, and perhaps disappointment that you feel when your children do not meet your expectations.” Although this would likely succeed in making the mother feel heard and understood by the therapist, it risks alienating the other members of the family while also perpetuating the problem-focused mind-set that contributes to the family’s dissatisfaction.

Using positive empathy, the therapist might respond by highlighting the mother’s desire to connect with her family in a pleasant and comfortable environment. By drawing attention to the mother’s affection for her children, as well as her sense of yearning for a household that is welcoming and enjoyable, the therapist can help the other members decide whether the mother’s desire could become a family goal. The PFT therapist might say, “I sense your desire for wanting to feel happy to see your children as you come in the door and wanting to compliment them on keeping the house so nicely.”

Circular Questioning

Circular questioning is a process through which therapists create change by reintroducing family members’ ideas and feelings back into the family system and conversation. This intervention applies systems theory and communication theory by affecting the system through the modeling of new communication processes and allowing for the perspective and input of all family members. In addition, circular questioning is a prime example of the application of social constructionism, as the therapist prompts each individual to
consider other family members’ positive experiences of them and reflect on how that makes the individual feel. In circular questioning, therapists use information previously given by individual family members as a basis for their next question to another family member. This circular process of reintroducing information back into the family system allows the therapist to focus the conversation on important, relevant, and positive information, whereas family members learn more about their significant others (Boscolo et al., 1987; Scheel & Conoley, 1998; Tomm, 1988). Therapists select and reintroduce information that includes strengths, compliments, and approach goals, and edit out negative emotions, blaming, and criticism. The following example incorporates paraphrasing, circular questioning, and positive empathy:

Mother: It really frustrates me that David has just stopped applying himself in school. I feel like he is wasting his intelligence and I know he can do so much better if he just tried.

Therapist: So you have confidence in David’s intelligence and his ability to apply himself. Correct? (Paraphrase)

Therapist (turning to David): David, did you know how intelligent your mom thinks you are and how certain she is that you can apply yourself in school? (Circular Question)

David: Well, she just gets mad at me for doing things other than school-work now but she never seemed happy before when I would do my homework.

Therapist: How would you like her to celebrate your accomplishments in school with you? (Positive Empathy)

David: When I was younger we used to talk at dinner about the things that went well during the day and then I would tell her about something I did well in school, and she would be happy about it. Now she doesn’t even seem interested . . .

Therapist (interrupting the beginning negativity and turning to Mother): That’s wonderful! Mom, did you know how much those conversations helped David to feel good about his accomplishments? (Circular Question)

Mother: I didn’t know it meant that much to him, I would love to have those conversations again.

By continually reintroducing positive information in the form of a question, the therapist maintains neutrality, for each person to feel supported (and pushed) by the therapist. In addition, the circular questions simultaneously facilitate positive communication, growth, and the discovery of a potential solution.
Success Finding

Once an approach goal has been articulated, an attainable route to accomplishing it may be rapidly identified through an intervention called success finding. This process adapts the structure of a well-established intervention in SFT known as exception finding, in which the client is encouraged to describe prior instances when the difficulty under discussion was avoided or resolved, while the therapist helps elucidate the strategies that contributed to taming the challenge (De Shazer et al., 2007). Exception finding is well suited to resistant populations, among others, perhaps due to its relatively immediate sense of gratification in recalling prior conquests, as well as its respect for and acknowledgment of existing client strengths (Corcoran, 1997). Furthermore, exception finding has been found useful in redirecting the focus from blame and aggravation of the problem to recognition of positive qualities and assets within the system (Melidonis & Bry, 1995). Consequently, the exception finding process and results are readily adapted to the affirmative, strengths-based model of PFT through adjustments to the framing of the intervention.

Success finding aims to reorient the intervention to an approach focus by inquiring expressly about instances in which the goal was either wholly achieved or brought nearer to actualization in contrast to the original formulation of exception finding that explores scenarios in which the problem was defeated or subdued (De Jong & Miller, 1995). Essentially, this is a shift from the original prompt of “Tell me about the last time that [the problem] didn’t feel so bad” to the PFT-adapted update of “Tell me about the last time you accomplished [the goal], or came close to accomplishing it.” The therapist then uses the resulting description to call attention to the strengths and qualities that contributed to the accomplishment, which may then be parlayed into future successes. Ideally, this intervention serves simultaneously to foster pride and appreciation for past successes while increasing a sense of empowerment and hopefulness toward future ones. This approach, in addition, reinforces the multicultural competency of the intervention by locating and affirming those abilities that are most important and salient to the client, rather than those that the therapist may mistakenly assume to be preferred based on culturally rooted preconceptions of strengths and competencies.

Visualizing Success

The visualization of successful outcomes in family therapy can significantly increase the motivation and likelihood that individual family members will carry out positive behaviors oriented toward approach goals. The imagined representation of an event or visualization increases both the individual’s confidence that
the outcome will occur and the probability of it actually occurring (Pham & Taylor, 1999; Taylor, Pham, Rivkin, & Armor, 1998). Several factors in the process of visualization increase the probability of performing the goal. One element is to include the steps leading up to the goal behavior as well as the action steps of the goal behavior (Pham & Taylor, 1999; Ratcliff et al., 1999). For example, to increase the performance of capitalization celebrations, the lead-up visualization could contain the detailed components of attending to the strengths of another family member and then the action steps of the goal behavior of animatedly complementing the other person’s behavior.

Another element of visualization that can enhance the motivation to achieve a desired outcome (e.g., playing nicely with a sibling) occurs by imagining the outcome itself (e.g., dad responding with smiles and compliments). Practicing visualization with family members offers dual benefits in that it facilitates success while allowing opportunities for the therapist to assess the clients’ developmental suitability for the intervention. The ease of visualizing a successful goal accomplishment is correlated to the likelihood of goal attainment (Hansen & Wänke, 2010).

Past research has found that matching the immediate affective state with the affective state of accomplishing the goal increases the ease of visualizing goals and the perceived plausibility of achieving them (E. J. Johnson & Tversky, 1983; Risen & Critcher, 2011). For instance, it is difficult for a child to imagine a goal of enjoying an interaction with his or her mother when the child is currently angry. However, if positive emotions are facilitated in the therapy session, the same child’s thought processes might be broadened, leading to the successful visualization of the goal.

Visualization may fit into the theoretical framework of PFT in two ways. Visualization may create a social construction of the family dynamics facilitative of the family approach goals. In addition, visualization may create a positive emotion that could fuel “broaden and build” toward the accomplishment of the approach goals.

Encouraging realistic visualizations that focus on imagining all aspects of the goal behavior (the steps prior to action, the action itself, and the outcome), while matching present emotional states, enhances the probability of successfully achieving a goal. The miracle question is a visualizing success technique that does just that.

**Miracle Questions**

The premise of the miracle question is that a miracle occurs that completely liberates the family of its problem. Through visualizing such a circumstance, family members explore how they would interact and feel as a result of the...
problem’s absence. Taken from SFT (De Shazer et al., 2007), the intervention allows family members to focus on all the minute details of a family life without the problem, and reinforces the use of approach goals while applying broaden and build theory, circular questioning, and visualization techniques. This technique is one of the most distinctive exemplifications of PFT’s co-option of systems theory principles, in that the visualizations proceeding from the miracle provide alternate positive constructions that can then be interpolated into the family’s recursive communications and behaviors, producing a useful and pleasant adjustment to the essential interactional pattern of the family system. The therapist implements the miracle question after establishing an approach goal relevant to a problem acknowledged by all family members (Conoley et al., 2003). After the introduction of the miracle, the family members carefully visualize every detail of the new and improved situation. Clients imagine their reactions, feelings, and behaviors, as well as how they would communicate with each other and how they might continue to live in the different family system. Because believability has such a significant influence on the outcome of visualizing success, clients are asked to act out their interactions, demonstrating to each other that they have the necessary qualities to accomplish the goal. Clients are also asked to carefully imagine every step of the living in phase of the accomplished goal, as step-by-step visualization increases the individuals’ confidence that they can accomplish imagined goals, as well as the likelihood that outcomes will be achieved. Last, because we are asking family members to imagine a positive outcome situation, and visualizing success requires affective states to be matched, positive affect must be present. The therapist can instigate this by introducing the miracle question in a playful and fun manner, continuing to facilitate positive conversation regarding the miracle conditions through circular questioning and emphasis on the strengths of each family member to maintain the desired outcome. The following exemplifies the implementation of the miracle question with a father and son:

Therapist (sounding playful and turning to both father and son): Okay, now something crazy and wonderful is about to happen . . . . Are you both ready for it?? An amazing miracle is going to happen tonight . . . . When you wake up in the morning everything will be fixed, just like that!! Pretty amazing, right?? (Making eye contact with everyone). Okay, so a miracle happens tonight. What is the first sign that it has happened, that your problem is gone when you both wake up tomorrow??

Father: I’d get up and Andrew would have taken the trash out like I asked the night before, and he would have cleaned up after his late night snack. Everything would look how I left it when I went to bed.
Therapist: Wonderful! So dad, after the miracle happened, you would see that Andrew cleaned up after himself and did his chores. How would you react?
Father: I’d probably be in disbelief and would be grinning from ear to ear! (Looks at Andrew, grinning).
Therapist: Wow, that’s great! Andrew, look at your dad smiling. How does it feel to have him smile at you like that?
Andrew: It feels good, because he never . . .
Therapist (interrupting before Andrew moves into unhappy or angry problem talk): Great! So it feels good to have your dad happy with you and smiling! What would you be doing, Andrew?
Andrew: I would be feeling good and probably pretty happy to have him react to me like that. I’d probably smile back.
Therapist: Wonderful, so it would feel good and make you happy to have your dad smiling at you because you finished your chores the night before. Right?
Andrew: Right!
Therapist: What were you doing before you saw your dad smiling?
Andrew: Well, the night before I stopped watching TV and took out the trash, and I cleaned up after myself.
Therapist: Wow! So after the miracle happened, you stopped watching TV and did your chores! How did you manage to do that, Andrew?
Andrew: I thought about how he would be in the morning and how angry . . .
Therapist: (Interrupting) Great! So you were thinking about your dad’s actions and feelings in the morning and that led you to do your chores, right? Can you imagine his big smile and how good you’ll feel? Will that help you do your chores?
Andrew: Yeah.
Therapist: Great! Dad, how do you feel about the fact that Andrew was thinking about you and what you wanted? Can you show him and remind him how happy you’ll be?
Father: OK. Andrew, I would be pretty astonished, and I would probably ask if this was actually happening. (Father laughs) I mean, it never . . .
Therapist: Great dad! Try just saying, “I’m going to be so happy with you! Just like this. And give you a big hug!” (Big smile)
Father: Yes! I would say, this is amazing, Andrew! And then I would probably want to give him a hug!
Therapist: Oh wow, Andrew, how does it feel to have your dad react to your accomplishment of doing all your chores this way?
Andrew: It’s weird but I like it!
Therapist: Dad, can you give Andrew a hug to imagine how this result might feel? (Father hugs Andrew and both smile).
Therapist: Wow! Look at how you are both smiling! Andrew, do you think it is possible to make this happen in the future?
Andrew: Yeah, I do, actually.
Therapist: That is wonderful news! What steps would you take to make this happen?
Andrew: I guess I would leave more time to do my chores and think about how my dad feels more.
Therapist: Andrew that is a wonderful goal! Dad, do you think you could react in a similar way as you did just now if Andrew did his chores?
Father: Yes, I would react that way every time he did his chores!!

By exploring the miracle question in detail, family members are able to visualize each step toward goal achievement, as well as their specific contributions to a positive family outcome. The process allows family members to understand the systemic nature of change within the family system and emphasizes that each family member is significantly involved in, and responsible for, a positive change process. Carefully following and orchestrating interactions allows the family to circumvent a common obstacle in the practice of family therapy, which is that each individual typically finds it easy to see the effects of others’ actions but may find it difficult to recognize the power of personal change on his or her own part. Owning one’s personal responsibility and contributions to help move toward a goal is far more agreeable than admitting one’s contributions toward a problem. The miracle question facilitates identification of helpful ways to contribute. By maintaining a positive focus through visualizing a miracle, positive change is made more believable to each individual family member, and is consequently more likely to occur.

**Family Rituals**

PFT views the exploration of family rituals as a relatively untapped resource for helping members recall and celebrate the values and strengths at the foundation of their relationship. Family rituals have generally been shown to enhance pride, stability, and resilience within the system (Fiese et al., 2002). A family ritual may be conceptualized as a recurring, organized gathering for some greater purpose, often featuring a ceremonial component. Although it is important to note, particularly from a multiculturally informed perspective, that many families create or carry out rituals unique to their system, and identification of such rituals may require dexterity and resourcefulness on the part of the therapist; familiar mainstream examples include weddings, reunions,
religious or secular holidays, and birthdays. The distinction between family rituals and the more common family routines is sometimes difficult to ascertain, but the important defining aspect of the family ritual for the purposes of PFT is that it is capable of communicating values.

In many families, the underlying significance of these events has been forgotten or obscured, and the ritual is consequently performed in a perfunctory fashion. Unearthing a family endorsed purpose or meaning for the ritual—and encouraging the family’s attendance to that meaning—serves to both strengthen awareness of the ritual’s power and enhance the family’s mindfulness in preserving its core values. For example, both the repetition and commercialization of the Thanksgiving Holiday have rendered its original meaning opaque to many families. Calling attention to the underlying qualities of gratitude, familial closeness, and abundance engendered by the celebration can help the family to both fully appreciate and conscientiously reinvigorate those assets. The process may be particularly valuable in the cases of family rituals around occasions such as birthdays or anniversaries, where a rediscovery of the celebration’s intended meaning galvanizes a renewed appreciation of relationships and individuals. This intervention includes the exploration of the values embedded in family rituals to expose and emphasize family strengths. Family rituals fit within the theories of broaden and build as well as social constructionism.

**Catching Your Child Being Virtuous**

With a focus on enhancing prosocial child behavior as well as parent–child rapport, this intervention builds on promising research findings suggesting that enhancing virtues is a direct and viable means of attenuating depression and enhancing happiness (Seligman, Steen, Park, & Peterson, 2005). Modeled after the popular practice of “catching your child being good” from embedded instruction protocol (J. W. Johnson, McDonnell, Holzwarth, & Hunter, 2004), the virtue-based approach seeks to reinforce and expand specific positive qualities in the child by increasing the parents’ awareness and recognition of the child’s extant behavior in the selected domains. To initiate this intervention, the therapist assists the parents in identifying a particular virtue that they hope to cultivate in their child. Insisting that the parents (rather than the therapist) select the targeted virtues serves to both enhance parental investment and ensure that the list will reflect culturally appropriate qualities that are valued by the family. This intervention promotes positive family change through the application of systems theory, communications theory, and social constructionism. Working directly with parents, who often possess the preponderance of power in the family system, can increase the probability of affecting positive change. In addition, by catching their child being virtuous, parents...
communicate family values and convey appreciation for the behavior. Social constructionism describes the process as contributing to the child’s reality and self-concept through parental feedback of the child’s positive behaviors.

The parents must then attentively monitor and be expeditious in catching the child behaving in a way that supports or reinforces the identified virtue(s). Once the child is caught, the parents are encouraged to both actively acknowledge the child’s expression of the virtue and praise the child for incorporating it into the child’s behavior, emphasizing their appreciation of the virtue as an aspect of the child’s personality. This last point underscores the importance of increasing the child’s personal identification with the virtue.

Optimally, a child would be caught at least 2 to 3 times per day, providing a consistent and explicit affirmation that serves as an incentive for the child to initiate behaviors that reflect this virtue more frequently, while also constructing an identity that includes the virtue itself as a salient component. As outlined in the original findings on successful implementation of embedded instructions research, this practice is most effective when it is consistent, unambiguous, and incorporated smoothly into everyday interactions with the child (J. W. Johnson et al., 2004). Recent research using these techniques with elementary-aged children found that the intervention is both effective for the participants and enthusiastically received by the children’s families (Spaventa-Vancil & Conoley, 2012). The performance of virtuous acts can create positive emotions enlisting broaden and build.

The preceding interventions illustrate various aspects of broaden and build theory, systems theory, communication theory, and social constructionism, as well as the principles of approach goals and strengths-finding. Communicating and reinforcing the underlying features of these concepts during therapy increases the family’s ability to put the essential lessons of the interventions into practice outside of their sessions. The following section describes how a PFT counselor can introduce and contextualize this therapeutic process in a way that is clear, multiculturally sensitive, and agreeable to clients, using the example of a first session with a Latina/o family.

**Structuring the Process**

To engage in the interventions presented previously, the therapist must guide the session wisely. Following the clients’ lead in the initial meeting usually evolves into a problem-focused conversation ending in a belief that the therapist will subsequently issue a prescription for a solution. Our recommended alternative involves guiding the session toward getting to know each individual in the family (even the members not present) through their strengths rather than their pathology.
Structuring the process with a Latina/o family, the approach is consistent with the Latina/o values of personalismo and simpatia. Engaging family members in plática or “personable small talk” (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002, p. 116) promotes rapport-building through learning about the family’s strengths, interests, and history. The therapist can communicate the counseling process and structure to dispel any misperceptions and address possible assumptions that could interfere with the counseling process. For example, “some individuals may perceive counseling as going to a medical visit, having a one-time visit, or making a visit whenever needed” (Santiago-Rivera et al., 2002, p. 49). Using the PFT approach, the therapist is also allowed to present the short-term, strengths-based, culturally centered, goal orientation of the family services.

Speaking with each member about favorite activities provides multiple opportunities for capitalization, paraphrasing, empathy, and noting strengths. The family becomes aware of the strengths-oriented perspective of the process and experiences the positive emotions associated with the interventions. In this way, the explicit therapeutic goal of uncovering strengths to achieve approach goals becomes believable to the family members. The therapist’s initial assessment is to gauge the amount and ways of communicating the warmth of relationships and authoritativeness of the parents. Essentially, the process is an opportunity to identify family strengths in communication, which is a more simplified approach to assessment than detailed in the original model (Conoley & Conoley, 2009).

By providing this review of current perspectives, developments, and emerging findings in the application of PFT, we hope to spark interest in the field among researchers and practitioners. We additionally encourage readers who either research or practice in clinical settings to consider how the interventions outlined in this article might contribute to their own work, taking into account what aspects of PFT might be useful and interesting to explore further in other settings. Prominent future considerations for research are outlined in the following section.

**Future Research Directions**

Many processes used in PFT stem from social psychology research. Weaving the constructs into the fabric of PFT appears reasonable but must be empirically supported in the context of therapy. Examining broaden and build in the context of clinical depression, anxiety, and anger provides an initial starting point for this process. Clinical observation in this vein requires further verification. Saliently, no studies of which we are aware have examined the client’s experience of positive paraphrasing. How difficult is the task of using the
correct amount of positive paraphrasing with an upset client? If positive paraphrasing is acceptable to the client, will the process evoke positive feelings, a strength orientation in the process, and uncover approach goals? One study on positive empathy demonstrated that in an analogue condition, the volunteer clients revealed more strengths, approach goals, and positive emotions (Conoley et al., in press). A follow-up study in real therapy is the next logical research investigation. Capitalization has not yet been examined in the context of therapy. When the therapist and client understand that the relationship is professional, will the process of valuing the accomplishment, re-experiencing the positive emotions, and trusting the relationship occur? Whereas research exists on the benefits of exception finding (Corcoran, 1997), does remembering a past success evoke positive emotions? Moreover, the abbreviated assessment of family interactions that direct the interventions should be examined. Is examining the warmth and authoritativeness of these interactions sufficiently complex a formulation for most families? How acceptable are the processes that rely on plática or engaging in informal conversations that reveal the family’s strengths? Are there contexts that make engaging in informal conversations inadvisable?

The theory and techniques presented in this article are relevant to professionals in allied fields such as school psychologists, mental health counselors, marriage and family therapists, psychiatrists, and positive psychology coaches. For example, positive psychology is being applied to educational settings and parents from the perspectives of school psychology (e.g., Sheridan & Burt, 2009) and positive psychology coaching (e.g., van Nieuwerburgh, 2012). Perhaps the applied positive psychology ideas presented here could enrich the application. We would be pleased if other fields could benefit from or add to PFT’s emphasis on cultural considerations.

PFT appears to have done well in dealing with attendance issues that generally trouble the family therapy field (e.g., Ingoldsby, 2010). Family attendance problems are highlighted in the social work (e.g., Gopalan et al., 2010) as well as the psychiatric literature (e.g., E. Johnson, Mellor, & Brann, 2009) revealing premature dropout rates between 40% and 60%. Cooperative research could be mutually beneficial because poor attendance is an important issue that PFT has not experienced in case reports, but larger scale research is imperative.

**Conclusion**

We hope our brief introduction to PFT provides a useful orientation for integrating positive psychology research into family therapy. PFT is built upon components that have been demonstrated as potent in isolation. The modest
multicultural verification of PFT’s interventions performed thus far includes integration of information from the literature and reports from the field supporting use with Mexican American and European American families. Our article reflects an evolution of PFT since it was first proposed (Conoley & Conoley, 2009), and presages the revisions that we hope will continue to emerge from applied insights, theory development, and research contributions.

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References


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