Transforming Voice and Communication with Transgender and Gender-Diverse People

AN EVIDENCE-BASED PROCESS

Adrienne B. Hancock, PhD, CCC-SLP
Linda L. Siegfriedt, MEd, CCC-SLP

5521 Ruffin Road
San Diego, CA 92123

Email: information@pluralpublishing.com
Website: https://www.pluralpublishing.com

Copyright © 2020 by Plural Publishing, Inc.

Typeset in 11/13 Garamond by Flanagan's Publishing Services, Inc.
Printed in the United States of America by Integrated Books International

All rights, including that of translation, reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, recording, or otherwise, including photocopying, recording, taping, web distribution, or information storage and retrieval systems without the prior written consent of the publisher.

For permission to use material from this text, contact us by
Telephone: (866) 758-7251
Fax: (888) 758-7255
Email: permissions@pluralpublishing.com

Every attempt has been made to contact the copyright holders for material originally printed in another source. If any have been inadvertently overlooked, the publishers will gladly make the necessary arrangements at the first opportunity.

Library of Congress Cataloging-in-Publication Data:
Names: Hancock, Adrienne B., author. | Siegfriedt, Linda, author.
Title: Transforming voice and communication with transgender and gender-diverse people : an evidence-based process / Adrienne B. Hancock, Linda Siegfriedt.
Description: San Diego : Plural Publishing, [2020] | Includes bibliographical references and index.
Identifiers: LCCN 2019017792| ISBN 9781635500899 (alk. paper) | ISBN 1635500893 (alk. paper)
Subjects: | MESH: Speech Therapy | Voice Training | Voice Quality | Communication | Transgender Persons | Case Reports
Classification: LCC RC423 | NLM WM 475.3 | DDC 616.85/500867--dc23
LC record available at https://lccn.loc.gov/2019017792

CONTENTS

Preface *vii*
Acknowledgments *ix*
Reviewers *xi*
Terminology Used in This Book *xiii*

PART I. Start Smart

Chapter 1. The Mindful Provider **3**
Chapter 2. Cultural Considerations **25**
Chapter 3. Practical Planning **71**

PART II. Press On

Chapter 4. Assessment **97**
Chapter 5. Intervention Phase 1: Get Ready . . . **139**
Chapter 6. Intervention Phase 2: Get Set . . . **193**
Chapter 7. Intervention Phase 3: Go! **259**

PART III. Finish Strong

Chapter 8. Facilitating Progress **301**
Chapter 9. Completion and Connection **337**
Chapter 10. Important Voices **345**

Index *363*

PREFACE

This book is not about the larynx. It is about people in a transformation process. Clients who wish to transform their voice and communication navigate physical, mental, and emotional work. As a guide for this process, whether you are a speech-language pathologist or voice teacher, your role is to inform and facilitate transformation. We designed this book to help you do just that.

We share our knowledge and experience with the hope that you will understand our approach well enough to develop your own. Our evidence-based guidance for the practitioner is presented here in chronological progression, from personal and practical preparations through rationale and instructions for techniques and ending with troubleshooting and maintenance strategies.

The first section, "Start Smart," begins with a chapter about developing and monitoring the provider's self-awareness because we believe a mindful provider is crucial for the safety and success of the process. Information about the populations is provided next to develop the provider's cultural humility and sensitivity. This section closes with practical considerations for working with marginalized populations and ways to mitigate barriers to their accessing care. Real examples of inspirational colleagues demonstrate how this work can be done well with thoughtful planning.

When you are ready to "Press On" through the collaborative stage of this process with the client, the second section of the book will guide you through the best practice standards for gender-related voice and communication services. Assessment is tailored to the client's circumstances and needs, and extends beyond basic vocal function assessment. Intervention is presented in stages of "Ready, Set, Go" to highlight the importance of taking time to establish a collaborative, informed, and evidence-based plan ("Get Ready") and prepare the client's body and mind ("Get Set") before launching into direct voice work ("Go").

Endurance in this process must continue through the end to "Finish Strong." This final section acknowledges that the process involves unique challenges. Several real case examples illustrate how application of evidence-based strategies fosters completion of the client's program. Intentional planning for generalization and independence leads to an affirming send-off—although there are valuable ways to stay connected, too. Finally, the last chapter features personal reflections from people who have experienced transformations already.

This text is intended for an audience with basic knowledge of voice and communication mechanisms and clinical and/or instructional methods. However, because we routinely receive requests for information from providers at all levels of voice experience for more information and guidance about how to

go about working with these populations, we have provided some fundamental information within each training area to be more inclusive to all providers called to do this work. We encourage students and new providers to refer to voice textbooks and references as needed to further develop more comfort and confidence in working with voice in general.

In our experience journeying alongside clients, we have found a world of possibilities we could not otherwise imagine. We are cisgender women and were surprised as anyone when we found ourselves together with a caseload of clients about which we knew very little. Since then, we have felt great satisfaction and sensed the importance of serving these populations, each within our own unique skill set and inspired desires. As gender-diverse people gain greater access to healthcare, information, and the right to choose their own path, all of us will be privileged to receive their talents and gifts.

ACKNOWLEDGMENTS

We are grateful to transgender and gender-diverse clients and research participants over the years; they are our best teachers and our motivation to educate and advocate for their benefit. We would especially like to thank Aeva, Ali, Dena, Grace, Lizzy, Morgan, Reana, and SJ for their trust and for sharing their deepest experiences with us. There are also many clinicians who forged a space for this practice in the field of speech-language pathology and the international community of transgender healthcare professionals, and we are particularly in awe of Richard Adler and Joan Regnell. We are grateful for the encouragement, support, and patience from our colleagues and students in the Department of Speech, Language, and Hearing Sciences at The George Washington University in Washington, D.C. We thank Julia Donovan and Stephanie Ferreira for their assistance preparing this book. Over a decade ago, students started us on this journey with gender-diverse people; today, students are still our hope for progress.

From Adrienne:
It is my privilege to contribute through teaching, research, and writing. I appreciate my mentors in this, including Dr. Leonard "Chick" LaPointe, who first taught me what a person-centered philosophy felt like, and Dr. Shelley Brundage, who has a talent for elevating both skill and spirit of others. I am grateful for Linda Siegfriedt, my collaborator in aims of work and life, whose attention to wholeness enriched this book as well as my experience. My deepest gratitude goes to the people who have allowed me to listen to or be a part of their transformation stories.

With love, I acknowledge and thank my husband Jeremy for his steadying support and grace, and precious Elizabeth for her focus on family fun. I appreciate my parents, Bob and Sue Blanchard, and family for making loving others be such a standard part of life. Finally, in all things, I acknowledge Jesus as my Lord and ultimate model for serving marginalized people.

From Linda:
I am grateful for the opportunity and privilege to contribute as a clinical provider, instructor, and coauthor. With appreciation, I acknowledge my clients whose strength and purpose have inspired me to listen with my soul and give with my heart. I am thankful for my coauthor and friend Adrienne Hancock who has been a joy and has shown me how to be a force in the expression of inner passion and dedication.

I would like to thank my parents Leo and Lucille Abdelahad and my siblings Sandy and Michael for their love and support, and my friends and relatives for their incredible enthusiasm, all of which gave momentum to the evolution of this book. In acknowledgment of her gracious presence and insight, I thank my dear friend Cathy Burgess. And most significantly, in recognition of his amazing light I thank my husband Klyde whose love and inspiring words supported me to express my truest self.

REVIEWERS

Plural Publishing, Inc. and the authors would like to thank the following reviewers for taking the time to provide their valuable feedback during the development process:

Eric R. Bronner, MM, MS, CMVT-MT, CSVW-III
Voice Faculty, Roger Williams University
Master Teacher, McClosky Institute of Voice
Voice Practitioner, Private Studio

Matthew L. Garrett, PhD
Associate Professor, Choral Music Education
Interim Director, University Center for Innovation in Teaching and Education
Case Western Reserve University

Tracy R. Grady, MM, BM
Voice Faculty, Baldwin Wallace University Conservatory of Music
Cofounder and Director, Cleveland Transgender Choir

Amy J. Hadley, EdD, CCC-SLP
Associate Professor
Communication Disorders
Stockton University

Grace Hao, PhD, CCC-SLP
Professor
Communication Disorders
North Carolina Central University

Wanda A. Kapaun, MS, CCC-SLP
Founder/Provider
Home Speech Therapy, PLLC

Ciara Leydon, PhD
Sacred Heart University
Blair Menn, MA, CCC-SLP
Kaiser Permanente Medical Center

Gwen L. Nolan, MS, CCC-SLP
Assistant Clinical Professor
Department of Communication Sciences and Disorders
University of Missouri

Loraine Sims, DMA
Associate Professor
Edith Killgore Kirkpatrick Professor of Voice
Louisiana State University

Wendy Vastine, BFA-Theatre, MA-SLP
Transformative Voice

Josie Zanfordino, MA, CCC-SLP
Say It Proud Speech Therapy

TERMINOLOGY USED IN THIS BOOK

Words matter. As more of society recognizes that, appropriateness of terminology changes frequently. This evolution of language is normal and healthy, but the current pace requires vigilance! We accept the responsibility to use words carefully so more people are made visible and protected. Consensus regarding terminology is increasingly difficult due to the variety of voices included in the space. People who use the same term may use it with slightly different meaning, particularly across cultures.

When choosing words for this book, we sought advice from members of the gender-diverse community, experts in gender production, and professional organizations. Yet, terms in this book may fall short of our intent to be both sensitive and clear. They will inevitably become outdated. Even our own recent research articles and presentations use terms that we would not choose today. You will notice some terms in this book, particularly those describing participants in research studies, are within quotation marks. This is intended to acknowledge that the term would perhaps not be the current choice, but nonetheless was used at that time to describe a particular group. Quotations marks maintain reporting accuracy in perpetuity. We did not feel comfortable, for instance, assuming that 14 people described in an article as "male-to-female transsexuals" would all be described as "trans feminine" today, or whenever our words will be read.

Words matter because people matter. Words can lift people up or tear people down. We trust that open dialogue—truly listening and responding with compassion—can alleviate division and fear seeded in words.

2010; Spillers, 2007). Understanding another's mind, specifically their intentions, expressions, emotions, and somatic sensations, can be challenging and complicated. Current models of interpersonal relationships indicate this is not simply taking another's perspective. Rather, it is a "mandatory, nonconscious, and prereflexive mechanism that is not the result of a deliberate and conscious cognitive effort aimed at interpreting the intentions hidden in the overt behavior of others" (Gallese, Eagel, & Migone, 2007). For example, a parent's empathy for their crying baby's distress elicits a response to comfort the baby, not to start crying like the baby (see Gallese, Eagel, & Migone, 2007 for discussion of the neuronal underpinning of interpersonal relations). *Therapeutic empathy* does not mean you feel exactly how the client feels or know exactly what they are thinking; it means your behavioral response to the client is appropriate because of your accurate perception of them in that moment (Angus & Kagan, 2007).

At the heart of therapeutic alliance and empathy is *attunement*: the provider's awareness of and responsiveness to the client's thought processes, emotions, behaviors, and experiences (Erskine, Moursund, & Trautmann, 1999). The unconscious perception and response to subtle cues is brought to the conscious level (Gallese et al., 2007). Providers can lean into the session to facilitate the next step in the clinical plan or lean back and allow the moment to direct the process. There are times to lean in and act, and there are times to lean back and allow. In this sense, there is an ebb and flow in each session (Marks-Tarlow, 2012). Attunement requires the practioner be:

- Fully present, focusing on what is happening in the moment,
- aware of their own internal process,
- aware of and sensitive to the client's process,
- involved in the relationship, and
- open to being moved and affected by the relationship.

All the knowledge and science in the world will not be applied effectively if we are not attuned to what is unfolding in each session. Attunement provides the art complement to our science, the music to the clinical dance (Marks-Tarlow, 2014; Risser, 2015). When we are attuned, we are receptive to what is happening in the moment. It is in this state that intuition is allowed to play a role and insights show themselves. When this happens, there is an impulse toward what needs to be said or done.

Clinical Intuition

A gut feeling. A heart wrench for someone else's emotional pain. An intangible knowing. A sensation of direction from a greater source. Have you experienced any of these? Intuition can manifest in a variety of ways, but it is fundamentally a source of knowledge (Vaughan, 1979; Marks-Tarlow, 2014). Many consider it a recognition (Simon, 1992; Kahneman & Klein, 2009). In a review of neurobiological underpinnings of intuition, Marks-Tarlow (2014) concludes that "the mind is embodied in the brain, though the brain is embedded in the body; and the embodied nature of clinical intuition is precisely how clinicians tune into nuance, variability, and the full complexity of relationship, as expressed moment to moment."

For the practioner, clinical intuition about the client or the process provides an additional source of information and clinical guidance (Bove & Rizzi, 2009). It is not common sense, but it may be considered one's clinical sense. Providers attuned to their clinical intuition realize that the effectiveness of evidence-based practice (EBP) models lies not just in the components of empirical evidence, clinical expertise, and patient needs, but also in the synergy among them. The ingredient of clinical intuition is what transforms good EBP into great EBP. The sections below will guide you to include intuition in client-centered care in a way that is effective and ethical.

If you have hesitations, you are not alone. We invite you to explore those hesitations as you keep reading. Decision-making literature in the helping professions acknowledges clinical intuition but debates its role and value in a professional capacity (Kahneman & Klein, 2009; Rogerson, Gottlieb, Handelsman, Knapp, & Younggren, 2011). Some scholars posit intuitive judgments arise from experience and subconscious attention to cues; people have been able to raise those cues to consciousness and develop some very effective interventions (e.g., Newborn Intensive Care Unit [NICU] nurses able to identify sepsis in babies before the medical tests can). In contrast, skeptical scholars have demonstrated that intuitive judgments are prone to systematic biases and are therefore made at the cognitive level. It is worthwhile to wonder when intuition can be trusted and explore the conditions that hone intuition as a skill.

In a paper comparing views of expert intuition, Kahneman and Klein (2009) describe points of agreement in the field of decision-making science. First, knowledge and experience are necessary for valid intuition, but not always enough. While a NICU nurse's intuition about a baby's health is better than

COLLABORATIVE GOAL SETTING

In preparation for a race, a runner considers factors that will influence their strategy. An important component of this preparation is their skilled collaborators. Serious runners partner with a coach to benefit from the support and guidance of someone with specialized knowledge. Together, runner and coach evaluate the distance and path of the course as well as the runner's capacity to train and perform. Collaboration during preparation is crucial to the first of the three intervention stages of "Ready, Set, Go!"

This chapter is about taking time with your client to chart the path, typically after you have assessment results but before you start voice work. A large part the provider's role is to empower the client to engage and make decisions about intervention. Your role as informer is a major reason to have current knowledge of intervention options, including hormonal, surgical, and behavioral avenues, and the rationales for potential targets of voice training. Do you know why we recommend elevating fundamental frequency in speaking, or how far to elevate it? What about the safest and most permanent way to elevate it? The rest of this book is intended to help you learn and explain what you know so you can teach your clients.

Knowing the intervention options is not as important, however, as acknowledging that interventions are only a part of what contributes to the production of gender. When developing a plan for the path forward, both the client and provider must recognize there will always be factors beyond their control. The cultural setting, the client's intentions and capacity to change, and the provider's clinical and cultural competence will significantly influence the strategy plan for intervention. Synergy of these elements has enabled the process to come this far, but there are important limitations to acknowledge to set reasonable goals. Agency is a term used to describe "capacity to act" or, in this case, capacity to contribute to communication (Ahearn 2010, p. 28). Most humans don't like to admit it, but there are limits to our agency. This is largely because several "agents" are constantly involved. These include not only the speaker, listener, and practitioners' actions, but also aspects individuals have even less capacity to influence: biophysiological process, sociocultural settings, and material forces (e.g., room acoustics, amplification devices). Furthermore, the ongoing interaction among these factors must be taken into account. Hancock and Azul's (2018) criti-

cal analysis of the literature resulted in the transdisciplinary ASSEMBLE approach, which is used to guide work in the crux of voice and gender:

Acknowledgment of ongoing and dynamic agency of:

Speaker's practices (e.g., self-presentation, lifestyle choices, self-attribution, responses to attributions from others)

Sociocultural mediation of meaning-making practices (e.g., linguistic rules and standards, normative forces, socialization practices)

External **M**aterial forces (e.g., physical, chemical, biological, technical)

Biophysiological processes (e.g., genetic, hormonal)

Listening practices (e.g., perceptions, interpretations, attributions)

Elected professional interventions (e.g., behavioral, surgical, medicinal)

The view of gender as continuously and flexibly constructed is critical in the ASSEMBLE model. We cannot expect nor aim for a single particular outcome of voice training, even at the individual level. While the speaker can modulate several contributions—these are the basis of much of the current research literature guiding our practice standards today—it is just as important to be aware of and develop a response to the contributions we are unable to control.

Explain and consider the elements of the ASSEMBLE model with your client in context of their wants and needs. Gender attribution from others, a common goal for many of our clients, is largely mediated by the listener's perception and processing, which are influenced by sociocultural factors and even external material factors such as the physical environment they are listening in. For example, large rooms require the speaker to raise their loudness, which may cause difficulty for maintaining the high pitch that cues listeners to attribute female gender to the speaker. Advances in science and medicine have enabled some influence on biophysiological processes in collaboration with our professional colleagues in endocrinology and surgical medicine, and the client should be well informed about those options as elected professional interventions.

Figure 6–11. External feedback via hand-over-hand posture.

2. During a comfortable inhalation, encourage the client to allow the lower hand to rise in response to abdominal expansion. The upper hand should remain stable during this time.
3. During exhalation, guide the client to release the abdomen with ease. The motion should be smooth and fluid without effort or gripping.
4. Repeat as needed. Ask the client to tell you when the motion can continue without feedback from the hands. Then ask the client to remove the hands and continue the same motion from passive breaths to vocalization during automatic sequences and then up the continuum as appropriate.

If sitting upright was not effective in eliciting the target, the next step is to apply the instructions above while the client leans way back on a chair, or lies on their back on a treatment table or a yoga mat on the floor. This may allow the process to occur with greater ease as the body responds differently with the benefit of gravity.

make a major adjustment in pitch from the initial target until oral resonance and intonation have been well established.

The time to stabilize the final F0 is determined by considering:

- normative data of cisgender males and females and research regarding levels of pitch and resonance influential to gender attribution (see Chapter 5),
- ease of intonation production with range for emotional expression (i.e., they aren't stuck in monotone F0),
- ease of healthy resonance at this level, and
- the client's comfort with this final level physically, mentally, and emotionally.

Option 2: Start with Oral Resonance

Some new clients have initial difficulty pitch matching or manipulating pitch skillfully, even with maximum cuing. To ease clients into these early sessions, it is helpful to establish the first target pitch level by focusing on oral resonance as the primary goal and pitch as the secondary goal. At this point, simply monitor pitch and focus on the resonance sensation. Most clients become more confident and skilled in directly monitoring their own pitch later in their program.

Shifting the shape of the vocal tract manipulates formant frequencies and changes the feel and sound of the voice. Perceptually, there is a distinction between the lower, heavier, darker sound of the male voice with the higher, smoother, lighter one more consistent with the perception of a female voice. In our experience, trans women will indirectly and spontaneously elevate their pitch to achieve forward focus.

As you guide them to explore sound in a variety of ways, aim for effortless, forward, clear, and pleasant productions. Direct the client to notice how and where they feel the sound, and how it sounds to them. Repeat each activity a few times until they are stable.

Resonance Cueing Options

The development of oral resonance can be challenging for clients. It can feel like they are grasping for an invisible target at first. In general, you will guide the client to feel a buzzing or vibration sensation in the mask of the face that may be perceived on the lips, palate, cheekbones, or eyes, or behind

the nose, rather than in the throat. Several cueing options for this are described below. Using light contact on nasal consonants may help introduce oral resonance because of the strong sensation between the lips and front of the mouth during those sounds. Front vowels also facilitate forward placement. For clients who are not attuned to their body or physical sensations, using audio clips and demonstrating contrasting models can develop their skill and confidence with auditory discrimination.

Imagery

- "Place the sound in front of you/your mouth/your face."
- "Make the sound penetrate that wall in front of you."
- "Imagine your voice is on the outside of the body in front of you."
- "Put your voice up on the shelf in front of you."

Overshoot the Target

- "Feel the sound up here" (point between the eye brows, or the top of the head).
- "Feel it in your nose. Sound nasal. Now drop it to the roof of your mouth. Now your lips."

Client Flexibility. "Speak the tone":

- "Behind you and then in front of you."
- "Low in the body, and then high in the body"
- "With low energy and then high energy"
- "With a light voice and a heavy voice"
- "With tense lips and relaxed lips"
- "Louder and softer"
- "Stronger and weaker"

Descriptive Vocabulary. Ask clients how it feels to them. Use their vocabulary for effective productions. For example, one client felt like there was "a buzzing bee stuck in her head." Another client referred to the "pitch roll sensation" when trying to achieve oral resonance. A particularly creative client referred to the target resonance during volume glides as sounding like the close-up of the spaceship rushing by the screen in the *Star Wars* movie. She was able to use that as a cue for generalization to connected speech later in the session.

Then it is gone. She feels freer. The space she is in appears brighter to her. Then she moves on in the day.

If you or your client is new to this process, it may be helpful to know that it is easier to keep ourselves calm and focused if we talk ourselves through this process step by step. Think of it as if you are helping your best friend through a difficult time. Self-talk such as, “It’s ok. Let’s go and find a quiet spot,” can be very helpful versus the voice of panic that can sometimes arise when we feel out of control.

Within the clinical process itself, sometimes clients are not comfortable dealing with arising emotion in the session and sometimes they are. It depends on the client, the situation, and their relationship with the provider. For clients who are more aware of their emotions, this has become a natural part of sessions; it is more automatic for clients to release emotions freely and then move into whatever is next.

The role of the provider in this situation is to:

- provide a safe space,
- be a nonjudgmental witness,
- permit the process to occur in an organic way,
- allow clients to be responsible for their own experience, and
- provide a mirror for clients who need to see themselves as honored for their journey.

For others, emotions simply do not arise, and this is of course perfect for them. As providers, we work with what is in front of us.

It is helpful for both clients and providers to understand that it will not always be convenient in day-to-day life to just stop what we are doing to integrate unpleasant emotions. We do not always have the time or the privacy to deal with them in the moment. A very effective alternative is to take a couple of notes to remind us of the trigger (e.g., “I was criticized”) and our reaction (e.g., anger: ‘How could she say that!” and fear: “How can I face those people again?”) and wait until we get to our car or get home to some privacy in order to make the most of each experience.

Letting Go of the Layers

Once we experience a particular emotion such as fear, and release it, we feel greater freedom and peace. However, like

layers of an onion, there may be more that will rise again, perhaps with a different kind of intensity to it or a different angle to a similar triggering experience. Often when we go through this process, we are made aware of the connection this experience has with an old childhood trauma, and that the recent negative emotion has arisen in order for us to clear it out of our field of experience. The more we let go of the layers, the more we realize that life gets easier, and we feel lighter and freer.

Eventually, even a lifetime of chronic anxiety can level out to occasional stress and tension. It is important that we recognize these ups and downs as a part of life, look back to see the growth we have made because of them, and share our experience to help others.

Permission to be Human

Emotions will be a part of voice work. When we discuss this with our clients early in their care, we teach them that it is okay—even desirable—to give themselves permission to experience their fear, anxiety, and sadness so that they may experience joy, happiness, and well-being (Fredrickson, 2011). They may be working with their therapist to deal with the reasons certain emotions exist in their experience, but meanwhile we should be aware of whether the emotions are interfering with voice and communication goals.

One of our seasoned clients was especially mindful of emotions arising during her vocal transformation. She understood through the work with her psychotherapist that she may experience emotions as she goes through various phases of her process, and that it is natural and fine. So, when she found herself going through it, she was more able to just experience the emotions rather than judging herself or trying not to feel them and stuffing them out of her perception again. She was giving herself permission to be human. The paradox is when one tries to suppress, repress, or avoid painful emotions they only intensify. But when we let ourselves experience emotions, they are manageable rather than debilitating.

It may help some clients to understand that there is nothing wrong or immoral about emotions or about feeling anger or fear toward people in our lives. Emotions are not immoral, they are amoral (Ben-Shahar, 2007). They are above the moral domain. Negative emotion is not good or bad, it is like the law of gravity: It just is, and we can learn to accept it as such. When we view emotions as part of human nature, it becomes easier to accept them as we do the laws of physical nature.

Giving ourselves permission to be human should not lead to resignation and immobility (e.g., “Okay, I’ll sit in front of the television and zone out because there is nothing that I can do”). Accepting the emotion and acknowledging its presence is followed by choosing the most appropriate action. We must be very clear about the distinction between emotions and behaviors.

There are certain things we cannot change, such as having anger or frustration occasionally. What we can change is our behavior, whether we choose to cry for another day, a week or 30 days or go out and look for positivity boosters in our lives. Our response to emotions is where we have the choice.

Positivity Boosters

If we lived in perfect circumstances, perhaps we could be involved in meaningful and satisfying activities all the time, but for most of us this is not possible. We may have jobs, home lives, or personal circumstances that may be draining or undesirable to us. Even in the best of circumstances, most of us go through periods of high stress, leading to a happiness deficiency. Fortunately, engaging in activities that are personally meaningful positively affects our lived experience, even in areas not directly related to these activities (Sheldon, Houser-Marko, & Diener, 2001). Even brief activities that are personally satisfying and meaningful can give us confidence and fulfillment that can trickle into other areas of our lives. These activities can function like a candle in a dark room—and just as it takes a small flame to light up an entire physical space, one or two happy experiences during an otherwise uninspiring period can transform our general state (Ben-Shahar, 2007).

An example of a positivity booster that may easily be discussed with clients is to ask them to notice one thing that makes them happy each day, and write it down or tell someone. Another is to list things they have enjoyed doing in the past or have thought about trying, and to try one of them within the upcoming week or month. For example: drawing, reading, crossword puzzles, baking cookies, being alone, being with others, grilling, gardening, cooking, listening to music, exercising, meditating, or watching or participating in sports.

Expressing gratitude can be a powerful positivity booster. Emmons and McCullough (2003) conducted a series of studies and found an overall effect of gratitude on psychological and