Are you ready for positive cognitive behavioral therapy?

Pozitif bilişsel davranışçı terapiye hazır mısınız?

Fredrike P. Bannink[1]

Abstract

Recent decades have witnessed the development of competency-based, collaborative approaches to psychotherapy. Positive CBT (Cognitive Behavioral Therapy) offers the best constructive vision to date of what CBT looks like when joined with Positive Psychology and Solution Focused Brief Therapy. Positive CBT shifts the focus of therapy from what is wrong with clients to what is right with them, and from what is not working to what is. Two of its applications are the Positive Functional Behavior Analysis and the upward arrow technique, both described in this article. Positive CBT aims at improving the well-being of clients and therapists, drawing on research and applications from Positive Psychology and Solution-Focused Brief Therapy. Research is necessary to find out how Positive CBT is distinct from, can be combined with or may be even superior to traditional CBT.

Keywords: CBT, positive CBT, positive psychology, solution focused brief therapy, strengths, resilience.

Özet

Son yıllarda psikoterapiye yönelik yeterlik temelli, işbirliğine dayalı yaklaşımlar geliştirilmiştir. Pozitif BDT (Bilişsel Davranışçı Terapi), pozitif psikoloji ve çözüm odaklı kısa terapi ile birleştiğinde BDT'nin nasıl olduğuna ilişkin şu ana kadarki en yapıcı görüşü sunmaktadır. Pozitif BDT, terapinin odağını danışanlarda neyin sorunlu olduğundan neyin doğru olduğuna ve danışandaki olumsuz yönlerden olumlu yönlere taşımıştır. Uygulamalarından ikisi, her ikisi de bu makalede tanımlanmış olan, pozitif işlevsel davranış analizi ve yukarı ok tekniğidir. Pozitif BDT, pozitif psikoloji ve çözüm odaklı kısa terapiden yararlanarak danışan ve terapistlerin iyi oluş düzeylerini yükseltmeyi amaçlamaktadır. Pozitif BDT'nin geleneksel BDT'den nasıl farklılaştığı, ve hatta ondan daha etkili olup olmadığı ile ilgili ve bu iki modelin nasıl birleştirilebileceği ile ilgili yeni araştırmalar gereklidir.

Anahtar Kelimeler: BDT, pozitif BDT, pozitif psikoloji, çözüm odaklı kısa terapi, güçlü özellikler, psikolojik sağlamlık.

Introduction

CBT has evolved to address a broad array of client presentations and an impressive body of evidence attests to its efficacy. Yet outcomes, and particularly longer-term outcomes leave a substantial margin for improvement. What will it take to help more clients benefit more substantively from therapy? What more can therapists do to support their clients develop longer-term resilience? How can therapists use the least demanding interventions? How can CBT become better and faster and more cost-effective? How can CBT become more kind to its therapists? Positive CBT (Bannink, 2012; 2013) recently emerged from the desire to find a new way forward in CBT and hopes to find answers to the questions stated above.

CBT has been strongly influenced by the medical model of diagnosis and treatment. The structure of problem-solving - determining the nature of the problem and then intervening - influences the content of interaction between therapists and clients: they focus on pathology and on what is wrong with clients.

[1] Dr. Clinical Psychologist, Amsterdam The Netherlands, solutions@fredrikebannink.com

Assessments focus on problems, limitations and deficiencies and mention few or no clients strengths and abilities. It is, however, the clients' strengths, abilities, and resources that are most important in helping to bring about change. Seligman (2011), co-founder of the Positive Psychology movement, states that if we want to flourish and have well-being, we must minimize our misery; but in addition, we must have positive emotion, meaning, accomplishment, and positive relationships.

Positive CBT draws on research and applications from Positive Psychology (PP) and Solution-Focused Brief Therapy (SFBT). *Positive Psychology* is the academic study of what makes life worth living and what enables individuals and communities to thrive. It is the study of the conditions and processes that lead to optimal functioning in individuals, relations and work. *Solution Focused Brief Therapy* is the pragmatic application of principles and tools, best described as finding the direct route to 'what works' for this cliënt at this moment in this context. The emphasis is on constructing solutions as a counterweight to the traditional emphasis on the analysis of problems. It is an approach to change, which invites conversations about what is wanted, what is working, and what might constitute progress (Bannink & Jackson, 2011).

From a theoretical point of view Positive CBT is different from traditional CBT. CBT uses a logical positivist view (the foundations of science remain in objectively quantifiable observations), whereas Positive CBT – as does SFBT- uses a social contructivist view (the individual's notion of what is real – including his sense of the nature of problems, abilities and solutions - is constructed in communication with others).

Positive Cognitive Behavioral Therapy

Is there also a *negative* CBT, one may wonder. I don't believe that there is a negative form of CBT, since all forms of psychotherapy have as their main goal to help clients bring about desired changes in their lives.

Mental health, however, is more than the absence of mental illness. The focus of Positive CBT is not on pathology, on what is wrong with clients and on repairing what is worst, but on mental health and strengths, what is right with them and on creating what is best. In this quest Positive CBT does not have to be constructed from the ground up, but it does involve a change of focus from reducing problems to a focus on building on clients' strengths and on what works. Positive CBT can be seen as being the other side of the 'CBT coin' and can easily be combined with CBT. This positive focus has helped SFBT to become shorter in time than other psychotherapies (Franklin, Trepper, Gingerich & McCollum, 2012; Gingerich & Peterson, 2013). The same may be true for Positive CBT, because it uses the same focus. Many professionals working in the fields of PP and SFBT claim that conversations with their clients are more optimistic and light-hearted, which may result in less stress, depression and burnout.

A *strengths-based approach* with its roots in PP is a philosophical perspective in which people are seen as capable and as having abilities and resources within themselves and their social systems. When activated and integrated with new experiences, understandings and skills, the outcome is an improved sense of well-being and quality of life and higher degrees of interpersonal and social functioning. Kuyken, Padesky and Dudley (2009) state that in the CBT literature there has been a much greater emphasis on identifying precipitating, predisposing, and perpetuating factors for problems than on identifying strengths. They advocate the inclusion of strengths whenever possible during case conceptualization.

A *solutions-based approach*, focusing on what works for this client in this context and in this moment, with its roots in SFBT (Bannink, 2007; 2010a) adds to the well-being of clients by inviting them to describe their preferred future and finding solutions to reach their goal.

Research by Gassman and Grawe (2006) shows that successful therapists focus on clients' strengths, abilities and available support from the very start of a therapy session. They create an environment in which clients feel they are percieved as well-functioning persons. Succesful therapists also make sure they end sessions by returning to their clients' strengths, enhancing a good therapeutic alliance along the way.

The Therapeutic Alliance

The alliance represents a positive attachment between therapist and client, as well as an active and collaborative engagement in therapeutic tasks designed to help the client. Therapists should facilitate the creation of a positive alliance and systematically monitor the alliance with the now available instruments, rather than relying on clinical impression. Keep in mind that the client's view of the alliance (and not the therapist's) is the best-known predictor of outcome (Duncan, 2010).

Positive CBT starts with *building rapport*. The therapist makes a positive start by asking questions about the daily life of the clients: 'What kind of work do you do?' 'What grade are you in?' when the client is a child, followed by: 'What do you like about your work?' 'What are you good at?' 'What hobbies do you have?' 'What is your best subject in school?' 'Who is your favorite teacher?' These questions can be seen as icebreakers, but are also the start for uncovering useful information about strengths and solutions already present in the clients' life. They set the tone for a more light-hearted conversation than clients may have been expecting.

Assessment

Positive CBT is more interested in what clients want to change rather than exploring problems and in what is right with clients than in what is wrong with them. Therefore, the first challenge Positive CBT therapists encounter is inviting clients to shift from *problem talk* to *strengths & solutions talk* at the point at which they have had enough time to describe their problems to feel heard (10-15 minutes is often enough). Assessing what clients want different (their goals), strengths and resources (exceptions to the problem and their competences), motivation to change, progression, hope and confidence are all part of the assessment and *case conceptualisation* in Positive CBT.

Many clients like to have the opportunity to talk about problems, not least because they think that that is the intent of the therapy. Positive CBT therapists listen respectfully and offer acknowledgment, but do not ask for details of the problem. With the question: 'How is this a problem for you?' clients can often begin to talk about the problem in a different way. When clients insist on talking about their problems, therapists may ask: 'How many sessions do you think you need to talk about problems and what is wrong with you before we can look at your preferred future and what is right with you?'

Kuyken et al. (2009) propose that psychotherapy has two overarching goals: to alleviate distress and to build resilience. They think a strengths focus is more engaging for clients and offers the advantages of harnessing client strengths in the change process to pave a way to lasting recovery. Clients are often not aware of the coping strategies they use to be resilient and highlighting these increases the likelihood clients will consider their use during future challenges. Noticing strategies clients employ to manage adversity is often a first step toward conceptualizing resilience.

Setting goals focuses clients on future possibilities rather than on problems. It helps to impose structure on treatment and also prepares clients for discharge: making explicit that therapy will be terminated when goals are achieved, or that therapy will be discontinued if there is little progress. Finally, setting goals provides the opportunity for an evaluation of outcome related to the clients' problems. 'What will be the best outcome of you coming to see me?' is a good way to start this part of the session, or 'When can we

stop meeting like this?' or 'What are your best hopes?' and 'What difference will it make when your hopes are met?'

Positive CBT is not *problem-phobic*. Clients are given an opportunity to describe their problems, to which therapists listen respectfully. But no details about the nature and severity of the problem are asked and causes are not analyzed. Asking about exceptions - a form of differential diagnosis - may reveal that some disorders can be eliminated (e.g., when asked about exceptions, a child who would otherwise be diagnosed with ADHD, appears to be able to sit still in the classroom).

Another way of conducting Positive CBT is to first collect all symptoms, complaints and constraints and then to 'translate' all problem-descriptions into goals: 'What would you like to see instead?' and then discard the problems collection by tearing it up or just ignoring it when working with what clients want different in their lives. Another useful question is: 'Suppose these problems would not be there, how will you or your life/relationship/work be different?'

Bakker, Bannink and Macdonald (2010) state that therapists may choose to commence treatment immediately and if necessary pay attention to diagnostics at a later stage. Severe psychiatric disorders or a suspicion thereof justify the decision to conduct a thorough diagnosis, since the tracing of the underlying organic pathology has direct therapeutic consequences. Ambulant intakes in primary or second-line health care are suitable for Positive CBT. During the first and follow-up sessions it will become clear whether an advanced diagnosis is necessary, for example if there is a deterioration in the client's condition or if the treatment fails to give positive results. Analogous to *stepped care* one could think of *stepped diagnosis*.

In CBT *self-monitoring* of problems is used to gain a description of behaviors to help adept the intervention in relation to client progress and to provide clients with feedback about their progress. Self-monitoring is often integrated into therapy, both in the sessions and as part of homework assignments. In Positive CBT self-monitoring is not about clients' problems, but about clients' strengths and about exceptions to the problems. When clients use this form of *positive self-monitoring* they often feel more competent and choose to do more of what works.

Functional analysis methodology identifies variables that influence the occurrence of problem behavior and has become a hallmark of behavioral assessment. Functional Behavior Analysis (FBA) looks beyond the behavior itself: the focus is on identifying factors associated with the (non)occurrence of specific behaviors. In FBA each problem is analysed in terms of A-B-Cs: Antecedents, Behaviors and Beliefs, and Consequences. In CBT a FBA is made of problem behavior, whereas in Positive CBT (see below) a FBA is made of desired behavior and/or exceptions of the problem behavior.

Positive FBA Interview in 7 questions

1. Suppose tonight a miracle happens and your problems are all solved. But because you are asleep, you don't know that this miracle happens. What will be the first thing you notice tomorrow morning that will tell you that this miracle has happened? What will be the first thing you notice yourself doing differently that will let you know that this miracle occurred? What else? What else?

2.Tell me about some recent times when you were doing somewhat better or (part of) the miracle was happening, even just a little bit.

3.When things are going somewhat better, what have you noticed that you or others do differently? What other consequences have you noticed?

4.On a scale of 10-0 (10 being the mircale has happened and 0 being the opposite), where are you at today?

5. What will you be doing differently that will tell you/others that you are one point higher on the scale?

6.What will be better for you/others when you are one point higher on the scale? What other consequences will you notice?

7.What/who may help you to achieve one point higher on the scale?

Changing The Viewing

In changing the viewing the focus is on changing how clients think and what they pay attention to as a way to change their situation for the better. This can involve five interventions. The first intervention is to acknowledge feelings and the past without letting them determine what clients can do. They are invited to create more compassionate and helpful stories and find a kinder, gentler vew of themselves, others, and/or the situation (Gilbert, 2010). The second intervention is to invite clients to change what they are paying attention to in a problem situation. Directing attention to the clients' past or present successes instead of their failures generate a positive expectation: clients begin to see themselves or the situation in a more positive light;

The third intervention is to focus on what clients want different in the future. This emphasizes the possibility of change and focuses clients on future possibilities rather than on their symptoms and problems. The fourth intervention is to challenge unhelpful beliefs about themselves and their situation. Positive CBT assists clients to find adaptive helpful cognitions that give rise to a more positive experience of the self, others, and the world. These (more) adaptive cognitions do not have to be developed, because they are already present (exceptions to the problem) and may be used again. The fifth intervention is to use a spiritual perspective to help clients transcend their troubles and to draw on resources beyond their usual abilities.

Upward Arrow Technique

As an example of how Positive CBT differs from traditional CBT which uses the *downward arrow technique*, I introduced the *upward arrow technique,* with a focus on positive reactions to a given situation, or to exceptions to the problem. So-called *core beliefs* are central, absolute beliefs about self, others and the world. The automatic thoughts and underlying assumptions lead therapist and clients toward relevant core beliefs. The problem-focused *downward arrow technique* is one of the ways to identify beliefs that underpin negative reactions to a given situation. Questions are: 'What does that matter?' 'What is so bad about.....?' 'What is the 'worst case scenario'?'The questions are repeated in response to each answer clients provide.

Questions using the *upward arrow technique* are: 'How will you like the situation/yourself/others to be different?'; 'What will be the best outcome?'; 'What will be the 'best case scenario'?'; 'Suppose that happens, what difference will that make (for yourself, for others)?' These questions are also repeated in response to each answer clients provide.

Changing The Doing

One way to solve a problem is not to analyze why the problem arose, but to change what clients are doing to solve it, by determining how they keep acting in the same way (problem pattern), and to experiment with doing something different (breaking the pattern). The focus is on concrete actions clients can take to make these changes. The first intervention is to invite clients to *pay attention to repetitive patterns* that they are caught up in or that others are caught up in with them and change anything possible about these patterns. By using paradox clients are invited to go with the problem or try to make it worse or try to deliberately make the problem happen. In linking new actions to the problem pattern clients are invited to find something they can do every time they have the problem, something that is good for them, usually something burdensome. Or ask them to do this avoided action first, every time they feel the urge to 'do' the problem.

The second intervention is to notice what clients are doing when things are going better, and invite them to do more of it: 'When didn't you experience the problem after you expected you would?' Invite clients to notice what happens as the problem ends or starts to end. Then invite clients to deliberately do some of the helpful actions they did then, but earlier in the problem situation. Or import solution patterns from other situations in which clients feel competent. Examine patterns at work, in hobbies, with friends, and in other contexts to find something clients can use effectively in the problem situation. Or ask: 'Why isn't the problem worse?' Use their own abilities to limit the severity of the problem they have been using without noticing. Most of the time clients know better than therapists what works and what doesn't, but for a change they have to do something different from what they are currently doing.

In CBT *modification procedures* are usually advised by the therapist. In Positive CBT modification procedures are already available: clients are competent to make changes and have made changes before. Also there are always exceptions to the problem (Wittgenstein, 1968). The modification procedures may be the same as advised by traditional CBT therapists, with the difference that now clients themselves come up with modification procedures (their previous successes), which have helped them before, and may be repeated.

Changing The Feeling

In CBT the therapist's job is to minimise negative effect: by dispensing drugs or in instigating psychological interventions, thereby rendering people less anxious, angry or depressed. Seligman (2011), however, described some disappointing results with this approach of making miserable people less miserable. He found that as a therapist, he would help a client get rid of his anger, anxiety or sadness. He thought he would then get a happy patient, but he never did. He got an empty patient, because the skills of flourishing are something over and above the skills of minimizing suffering.

As an example of how reducing negative affect does not automatically increase positive affect, research in a coaching context done by Grant and O'Connor (2010) showed that problem-focused questions reduce negative affect and increase self-efficacy, but do not increase understanding of the nature of the problem or enhance positive affect. Solution-focused questions increase positive affect, decrease negative affect, increase self-efficacy as well as increase participants' insight and understanding of the nature of the problem.

Positive CBT focuses on enhancing positive affect: 'How will you feel when your best hopes are met?' 'What will you be feeling differently when you notice that the steps you take are in the right direction?'

Also bringing back the best from the past by asking questions about previous successes and competences triggers positive emotions.

The *broaden-and-build theory of positive emotions* (Fredrickson, 2009) suggests that negative emotions narrow our thought-action repertoires, whereas positive emotions broaden our awareness and encourage novel, varied and exploratory thoughts and actions. The power of asking open questions, focused on what clients do want ('How will you know this session has been useful?' 'How will you know the problem has been solved?' 'What has been working well?' 'What is better?'), serve to widen the array of thoughts and actions. Using imagination (for example using the *miracle question*) also creates positive emotions and has a powerful impact on the capacity to expand ideas and activities. The use of compliments and competence questions ('How did you manage to do that?' 'How did you decide to do that?') also elicit positive emotions.

Homework

In CBT homework is considered important. For example, *self-monitoring* is the most widely used adjunct, and is almost invariably used both at the initial assessment stage and to monitor subsequent change. Another widely used adjunct are *behavioral experiments*. Bennett-Levy, Butler, Fennell, Hackman, Mueller and Westbrook (2004) describe three types of (problem-focused) experiments. One type is *experimental manipulation of the environment*. This necessitates doing something, which is different to what the client usually does in a particular situation. Another type constitutes of *observational experiments*, in that it is either not possible or not necessary to manipulate key variables. Instead clients set out to observe and gather evidence, which is relevant to their specific negative thoughts or beliefs. The third type constitutes of *discovery-oriented experiments*, when clients have little or no idea what will happen when they undertake a behavioral experiment and need to collect data in order to 'build a theory'. Or the client may be encouraged to try out different ways of behaving in order to collect those data.

Positive CBT employs the same behavioral experiments, but again with a positive focus. *Experimental manipulation of the environment*: clients are invited to explore exceptions to the problem: What has the client done – even slightly - differently before? How has that been helpful? Does the client think it might be a good idea to use this solution again? *Observational experiments*: clients are invited to observe and gather evidence, which is relevant to their specific positive thoughts and beliefs. When they pay attention to their positive thoughts or beliefs, chances are that clients will find evidence for these positive ones, whereas when they pay attention to negative thoughts or beliefs, chances are that clients will find evidence for the negative ones. *Discovery-oriented experiments*: clients are invited to act 'as if' their preferred future has arrived or are one or two point higher on the scale of progress.

In Positive CBT homework tasks are important if clients think it is useful. The solution-focused idea in Positive CBT is that when clients change their construction, which is assumed to take place during and between sessions, behavior change follows naturally. Homework is intended to direct clients' attention to those aspects of their experiences and situations that are most useful in reaching their goals. When clients are hesitant about change, they are invited to observe rather than to do something.

Evaluation

In *subsequent sessions* clients and therapists carefully explore what is better. Therapists ask for a detailed description of positive exceptions, give compliments and emphasize clients' input in finding solutions. At the end of every session clients are asked whether they think another session is useful, and if so, when they like to return. The goal of subsequent sessions is described in Bannink (2010ab; 2012). At the end of

every session clients are invited to give feedback about the relationship with the therapist, whether the goals and topics were discussed that they wanted to talk about and whether the method/approach was a good fit for them (Session Rating Scale, Duncan, 2010).

Role of Positive CBT Therapist

In Positive CBT the role of the therapist is different from the role in CBT. From being the only expert in the room, who explores and analyzes the problem and then gives advise to clients on how to solve their problems, the role changes to one where clients are seen as co-experts and therapists invite them to share their expertise. Positive CBT therapists are 'not-knowing' (they ask questions) and 'leading from one step behind'. In this therapists, metaphorically speaking, stand behind their clients and tap them on the shoulder with solution-focused questions, inviting them to look at their preferred future and to envisage a wide horizon of personal possibilities.

Therapists change their focus of attention by using operant conditioning principles during the session: positive reinforcement of *strengths & solutions-talk* (paying attention to conversations about goals, exceptions, possibilities, strengths and resources) and negative punishment of *problem-talk* (not paying attention to conversations about problems, causes, impossibilities and weaknesses).

Conclusion

Positive CBT offers the best constructive vision to date of what CBT looks like when joined with Positive Psychology and Solution Focused Brief Therapy. Positive CBT shifts the focus of therapy from what is wrong with clients to what is right with them, and from what is not working to what is. This transition represents a paradigm shift from problem-solving to solutions and strengths-building. Positive CBT emerged from the desire to find a new way forward in the application of CBT. Research is necessary to find out how Positive CBT is distinct from, can be combined with or may be even superior to traditional CBT.

Are you ready for Positive CBT?

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