Chapter 2
Positive CBT in Practice

Fredrike Bannink

Abstract Recent decades have witnessed the development of competency-based, collaborative approaches to working with clients. This article reveals how cognitive behavioural therapy (CBT) becomes positive CBT, with a shift in 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. The concept of positive CBT, which can be seen as Fourth Wave CBT, aimed at improving the well-being of clients and their therapists, draws on research and applications from positive psychology and solution-focused brief therapy. A functional behaviour analysis of exceptions to the problem and the 'upward arrow' instead of the 'downward arrow' technique are two of the many practical applications of positive CBT, described in this chapter.

Abbreviations

CBT	Cognitive behaviour therapy
FBA	Functional behaviour analysis
SFBT	Solution-focused brief therapy

Introduction

Cognitive behavioural therapy (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 to develop longer-term resilience and well-being? How can therapists use the least demanding interventions on their clients? How can therapists increase clients' self-efficacy and

F. Bannink (✉)
Bannink Therapy, Training, Coaching and Mediation Practice, Amsterdam, The Netherlands
e-mail: solutions@fredrikebannink.com

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self-esteem? What will it take to make CBT better and faster and therefore more cost-effective? And last but not least: How can CBT be more kind to its therapists? *Positive CBT* (Bannink 2012) emerged from the desire to find a new way forward in the application of traditional CBT. It aims to provide answers to the above questions.

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. Assessments focus on problems, limitations, and deficiencies and mention few or no client strengths and abilities. It is, however, the clients' strengths, abilities, and resources that are most important in helping to bring about change. Seligman (2011), cofounder of the positive psychology movement, states that if we want to flourish and have well-being, we must minimise 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 and solution-focused brief therapy. *Positive psychology* is the academic study of what makes life worth living and what enables individuals and communities to thrive. It is also the study of the conditions and processes that lead to optimal functioning in individuals, relations, and work. *Solution-focused brief therapy* (SFBT) is the pragmatic application of a set of principles and tools, best described as finding the direct route to 'what works' for this client, 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 and Jackson 2011).

This chapter provides a condensed description of positive CBT, with information regarding the same cognitive behavioural process as used in traditional CBT. This process includes enhancing the therapeutic alliance, followed by doing an assessment (although in positive CBT assessment is first and foremost about strengths, resources, what works, and goals), including making functional behaviour analyses. The next part of the treatment is inviting clients to change: changing their viewing, doing, and feeling. Homework tasks and the evaluation of the treatment are described, as well as the changing role of the positive CBT therapist.

From a theoretical point of view positive CBT is different from traditional CBT. Traditional CBT uses a logical positivist view (the foundations of science remain in objectively quantifiable observations), whereas positive CBT—as does SFBT—uses a social constructivist view (the individual's notion of what is real—including his sense of the nature of problems, abilities, and solutions—is constructed in daily life in communication with others). This also means a shift in the language used in therapy: instead of terms like 'learning' and 'unlearning' following learning principles (CBT), positive CBT uses the term 'becoming better at', because there are always exceptions to the problem (Wittgenstein 1968).

Positive CBT

If there is a *positive* CBT, 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—including *traditional* problem-focused CBT—have as their main goal to help clients bring about desired changes in their lives. In the past 30 years however, there has been a paradigm shift with the development of competency-based, more collaborative approaches to working with clients. Positive psychology and SFBT are amongst these approaches directed toward clients' strengths and their preferred futures, instead of their past or present deficits and problems.

Mental health is more than the absence of mental illness. The focus of positive CBT is not on mental illness and 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 be easily combined with traditional CBT. This positive focus has helped SFBT to become shorter in time than other psychotherapies (Franklin et al. 2012; Gingerich and Peterson 2013). The same may be true for positive CBT, because it uses the same positive focus. Many professionals working in the fields of positive psychology and SFBT claim that conversations with their clients are more light-hearted, which results in less burnout (Medina and Beyebach 2014).

A *strengths-based approach* with its roots in positive psychology 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, strengths offer people pathways to reduce pain and suffering, resolve concerns and conflicts, and more effectively cope with life stressors. The outcome is an improved sense of well-being and quality of life and higher degrees of interpersonal and social functioning.

Saleebey (2007) describes the *strengths perspective* in psychotherapy. Despite life's struggles, all persons possess strengths that can be marshalled to improve the qualities of their lives. Therapists should respect these strengths and the directions in which clients wish to apply them. Client motivation is increased by a consistent emphasis on strengths, as the client defines them. Discovering these strengths requires a process of cooperative exploration between clients and therapists; therapists do not have the last word on what clients need to improve in their lives. Focusing on strengths turns therapists away from the temptation to judge or blame clients for their difficulties and toward discovering how clients have managed to survive, even in the most difficult circumstances. All environments—even the most bleak—contain resources.

Kuyken et al. (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 conceptualisation.

Furthermore, 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, b, 2014, 2015a, b) adds to the well-being of clients by inviting them to describe their preferred future (instead of their problems or their feared future) and finding strengths and solutions to reach their goal.

Research 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 perceived as well-functioning persons. Successful therapists also make sure they end sessions by returning to their clients' strengths (Gassman and Grawe 2006), enhancing a good therapeutic alliance along the way.

The Therapeutic Alliance

Therapeutic alliance has been defined in many ways and despite of this diversity of definitions, the consensus is that 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 make explicit efforts to facilitate the creation of a positive alliance and systematically monitor the alliance with the now available instruments, rather than relying on clinical impression. It is important to 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 client: *'What kind of work do you do?'*, *'What grade are you in?'* (when the client is a child), followed by questions as: *'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 favourite 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 client's life. They set the tone for a more light-hearted conversation than the client may have been expecting.

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 to their stories 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. It may be helpful to provide information about positive CBT with its focus on possibilities instead of impossibilities and strengths instead of weaknesses. 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 start looking at your preferred future and what is right with you?'*.

Assessment

Positive CBT is more interested in what clients want to change in their lives rather than exploring their problems and more interested 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 and solutions talk* at the point at which they have had enough time to describe their problems to feel heard (10–15 min is often enough). Assessing what clients want to be 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.

Kuyken et al. (2009) propose that psychotherapy has two overarching goals: to alleviate distress and to build resilience. Most current CBT approaches are concerned either exclusively or largely with clients' problems, vulnerabilities, and history of adversity. A strengths focus is often 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 the strategies a person employs to manage adversity is often a first step toward conceptualising resilience. These strategies may be behavioural (e.g., persisting in efforts), cognitive (e.g., problem solving, acceptance), emotional (e.g., humour, reassurance), social (e.g., seeking help), spiritual (e.g., finding meaning in suffering), or physical (e.g., sleeping and eating well).

Setting goals emphasises the possibility of change, and begins to focus clients on future possibilities rather than on problems. It reinforces the notion that clients' are an active member of the therapeutic relationship, and that full involvement is required: they will not be 'done' to. Hawton et al. (1995) state that defined goals help to impose structure on treatment. It 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. This is not to say that goals cannot be renegotiated during treatment, but that this should be done explicitly together with clients, thus reducing the risk that clients and therapist are pursuing different agendas. Finally, setting goals provides the opportunity for an evaluation of outcome related to the clients' problems.

Goals can be stated as increasing strengths or positive values (approach goal: e.g., be more considerate) as well as reducing distress (avoidance goal: e.g., feel less anxious). *'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?'*, followed by *'What difference will it make when your best 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 analysed. By asking about exceptions to the problem—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, granting due acknowledgement, 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 et al. (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 secondary health care are suitable for a positive CBT approach. During the first and follow-up conversations 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 traditional CBT, *self-monitoring* of problems is used to gain an accurate description of behaviours (rather than relying on recall) 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 or symptoms, 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 can choose to do more of what works to change their situation for the better.

Functional analysis methodology identifies variables that influence the occurrence of problem behaviour and has become a hallmark of behavioural assessment. Behavioural research demonstrates that behaviours can be learned and unlearned on the basis of patterns of association, reward, and punishment. Functional behaviour analysis (FBA) looks beyond the behaviour itself: the focus is on identifying significant factors associated with the (non) occurrence of specific behaviours. In FBA each problem is analysed in terms of A-B-Cs: antecedents, behaviours and beliefs, and consequences. Each of these factors increase or decrease the probability that the behaviour will occur. In traditional CBT a FBA is made of the ABCs of problem behaviour, whereas in positive CBT (see below) a FBA is made of desired behaviour and/or exceptions of the problem behaviour. CBT therapists may also choose to use both traditional and positive FBAs.

Positive FBA interview in three questions:

1. Suppose tonight while you are sleeping, 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? What do you expect to see and find in the world around you, particularly your work?
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 for you, what have you noticed that you or others do differently then? What other consequences have you noticed?

In Positive CBT clients do more of what works: there is not need to try something different, because solutions are already present. Clients' reports on the helpfulness of the intervention and collect further observations by self-monitoring, and the cycle of FBA repeats itself. By identifying strengths and exceptions, intervention plans focus on increasing the use of appropriate skills clients already possess rather than relying on manipulating antecedents and consequences to reduce negative behaviours. Questions are: *'What is better (since the last time we met)?'*, *'What is different (since the last time we met)?'*, *'What has been helpful (even just a little bit)?'*.

Changing the Viewing

O'Hanlon (2000) states that when people are not happy or are not getting the results they want, they should do something different. Clients have to change either the viewing or the doing of the problem, or both. This will almost certainly result in a change in the feeling of the problem.

In *changing the viewing* of the problem 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 view 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. The point of departure is that a problem does not always manifest itself to the same degree. Directing attention to the clients' past or present successes instead of their failures generates a positive expectation: clients begin to see themselves and/or the situation in a more positive light.

The third intervention is to focus on what clients want in the future rather than on what they do not like in the present or the past. Setting goals about what clients want to be different in the future emphasises the possibility of change and begins to focus clients on future possibilities rather than on their symptoms and problems.

The fourth intervention is to challenge unhelpful beliefs about themself and their situation. Traditional CBT assists clients to identify and reality-test unhelpful cognitions, which underlie repeated negative patterns of emotion and behaviour,

whereas 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 and last intervention is to use a spiritual perspective to help clients transcend their troubles and to draw on resources beyond their usual abilities. O'Hanlon (2000) describes the three Cs of spirituality as sources of resilience. *Connection* means moving beyond your little, isolated ego, or personality into connection with something bigger, within or outside yourself. *Compassion* means softening your attitude towards yourself or others by 'feeling with' rather than being against yourself, others, or the world. And *contribution* means being of unselfish service to others or the world.

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. People develop both positive and negative beliefs. 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?'*. These 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 analyse why the problem arose, but to change what clients are doing to solve it. The way to do that is to determine how they keep acting in the same way over and over again (the problem pattern), and begin to experiment with doing something different (breaking the pattern). In changing the *doing of the problem* 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. Clients may change the doing of the problem

by changing any part they can of their regularly repeated actions in the situation. By using paradox clients are invited to go with the problem or try to make it worse (more intense or more frequent) or try to deliberately make the problem happen. Invite clients to stop avoiding the problem or try to fix the problem, and instead embrace it and allow it to 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 that. Ask clients: *'When didn't you experience the problem after you expected you would?'*. Find a time that is an exception to the usual problem pattern and look for changes clients can make by deliberately repeating whatever action worked. 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. Ask clients: *'Why isn't the problem worse?'*. Use their own natural abilities to limit the severity of the problem they have been using without noticing. Most of the time clients know very well—often better than therapists do—what works and what doesn't work, but for a change they have to do something different from what they are currently doing.

In traditional CBT the *modification procedures* (like self-control procedures or behavioural experiments) are usually advised by the therapist, whose role is that of the expert. In positive CBT the modification procedures are already available: clients, coexperts on what works, are competent to make changes and have made changes before. Also there are always exceptions to the problem. The modification procedures may be the same as advised by traditional CBT therapists, with the difference that in positive CBT clients come up with modification procedures, which have helped before, are therefore 'evidence-based' and may be repeated.

Changing the Feeling

Traditional CBT aims to obtain a clear picture of situations which are distressing to clients, by helping them to clearly differentiate thoughts from emotions, it empathises with their emotions throughout the process and helps them to evaluate the dysfunctional thinking which has influenced their mood. 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 minimising 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.

In positive CBT the focus is on positive emotions: *'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?'*), all 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. The focus of positive CBT therapists is on noticing skills and resources of their clients and to compliment or play those resources back to them.

Homework Tasks

In traditional CBT homework is considered important, because learning and unlearning are required following learning principles and it is assumed that change takes place especially between therapy sessions. For example, *self-monitoring* is the most widely used adjunct to CBT, and is almost invariably used both at the initial assessment stage and to monitor subsequent change. Another widely used adjunct are *behavioural experiments*. There are three types of experiments in CBT (Bennett-Levy et al. 2004). 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. For example, the client may try to answer the question: *'If I go the supermarket alone and do not take my usual precautions, will I actually faint (as my existing belief would predict) or will I just feel anxious (the prediction of an alternative theory)'*.

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. For example, a client may try to answer the question: *'Will people think I am stupid or abnormal if I sweat in social situations?'*.

The third type constitutes of *discovery-oriented experiments*, when clients have little or no idea what will happen when they undertake a behavioural experiment and need to collect data systematically in order to 'build a theory'. For example, a client may try to answer the question: *'What would happen if I acted "as if" I was valued by others?'*. Or the client may be encouraged to try out different ways of behaving in order to collect those data (*'How might a valued person act in these circumstances?'*).

Positive CBT employs the same types of behavioural 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. For example, the client may answer the question: *'Will people think I am likeable if I go to this party?'*. 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 too. Discovery-oriented experiments: clients are invited to act as if their preferred future has already arrived or are one or two points higher on the scale of progress. During the session clients may be invited to pretend things are going better and show the therapist (for some minutes) how their life/relationships will be different and how this will appear.

In positive CBT homework tasks are only 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 therapy sessions, behaviour 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. Presenting homework or tasks as an 'experiment' or even a 'small experiment' may make it easier for clients, because it alleviates the pressure to be successful at accomplishing the task. Before coming up with suggestions, it is useful to ask whether clients want to do homework anyway. If they say that they don't have any need for them, they will probably have a good reason: perhaps they don't consider it useful, or maybe they don't have time. In those instances, therapists needn't come up with suggestions or may ask clients what they would consider to be useful. When clients are feeling somewhat hesitant about change, invite them to observe rather than to do something.

Solution-focused therapists Walter and Peller (1992) mention four basic homework tasks. The first task is to observe for positives: *'Between now and the next time, notice what is going on in your life (marriage, family, work, etc.) that you*

would like to see continue'. The second task is to do more of the positives or exceptions when these are perceived as deliberate and within clients' control: *'Keep up what you are doing that is helpful and take notice of what you are doing that is helpful so that you can tell me about it next time'*.

The third task is to find out how spontaneous exceptions happen: *'On the odd-numbered days of the week you pretend to feel different and see what happens. I know that you might not always feel that way, in fact, you might feel the same old way. However, I think there is some potential in how you act and think differently when you do. So, every other day, pretend to feel different and on the even-numbered days just do as you normally do. Observe what differences you notice'*. The fourth task is to do some small piece of a hypothetical solution (*'Suppose a miracle happened and your problems are gone'*): *'You might want to experiment with this new idea. You might want to do just a small piece of it to try it on for size'*.

Evaluation

In *subsequent sessions* clients and therapist carefully explore what is better. Therapists ask for a detailed explanation of positive exceptions, give compliments, and emphasise clients' input in finding solutions. At the end of every session clients are asked whether they think another meeting is useful, and if so, when they like to return. In fact, in many cases clients think it is not necessary to return or schedule an appointment further into the future than is typical in other forms of psychotherapy. The goal of subsequent sessions is further described in Bannink (2010a, b, 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 or approach was a good fit for them (e.g., Session Rating Scale; Duncan 2010).

Role of the Positive CBT Therapist

In Positive CBT the role of the therapist is different from the role in traditional CBT. From being the only expert in the room, who explores and analyses the problem and then gives advise to clients on how to solve their problems, the role changes to one where the therapist does not need to push or pull. Positive CBT therapists are 'not-knowing' (they ask questions) and are '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, in order to achieve their goal, to envisage a wide horizon of personal possibilities.

Clients are seen as coexperts and therapists invite them—by asking solution-focused questions—to share their expertise to reach the preferred future. Therapists

also change their focus of attention by using learning principles during the therapy sessions: positive reinforcement of *strengths and 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 cognitive behaviour therapy 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 analysis to goal analysis, from a focus on deficits and weaknesses to one that builds on resources and strengths, and from reducing distress to building success. Positive CBT recently emerged from the desire to find a new way forward in the application of traditional CBT. Research is currently being done at the Maastricht University in the Netherlands to find out how positive CBT is distinct from, or may be even superior to traditional CBT.

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