Practicing Positive CBT
Praise for Practicing Positive CBT

“In reading Practicing Positive CBT there is a sense of being in the presence of a gifted, engaging, enthusiastic and inspiring therapist. The book practices what it preaches in supporting therapists to become more effective and successful, and I suspect enjoying their work along the way.”

Professor Willem Kuyken
University of Exeter, UK

“Practicing Positive CBT offers the best constructive vision to date of what CBT can look like when joined with positive psychology and solution focused brief therapy approaches. Bannink highlights positive therapy methods already embedded in CBT and offers a wealth of practical suggestions for how CBT therapists can become more positive in every aspect of therapy. Whether dipping into particular chapters for creative inspiration or studying this book cover to cover, therapists of all experience levels will find value on every page.”

Christine A. Padesky, PhD
Center for Cognitive Therapy, California, USA
Co-Author, Collaborative Case Conceptualization

“In this masterful and very accessible book Dr. Bannink captures the essential importance of building on positive feelings, motives, imagery, memories and behaviors. The psychology of ‘cultivation,’ so much a focus in Buddhist approaches to human suffering, is brought to life in new ways with extensive knowledge of the research literature. Full of fascinating insights and practical applications, this is a book to change what we focus on and how we work in helping people change. A book to read many times.”

Professor Paul Gilbert, PhD, FBPsS, OBE
Derbyshire Healthcare NHS Foundation Trust

“This book describes Fredrike Bannink’s synthesis of Cognitive Behavioral Therapy, Positive Psychology and Solution-Focused Brief Therapy. She names this Positive CBT. The emphasis is both on losing negative thoughts, emotions and behavior, and on enhancing positive experiences. As usual with her work, Fredrike has read very widely, including neuroscience, Appreciative Inquiry, Motivational Interviewing and many variations on the theme of CBT. In the text she demonstrates how to adapt Positive CBT to a number of the existing models and problems. The writing is clear and engaging. There are many illustrations with intriguing and apt stories about humans and other species. Case studies and exercises demonstrate how Positive CBT may be applied. Fredrike Bannink is also skilled in mediation and conflict management. Given the present ideological split between ‘traditional’ CBT, Positive Psychology and Solution-Focused Brief Therapy, this book may begin an interesting rapprochement between these therapies and their practitioners.”

Dr. Alasdair J. MacDonald, MB, ChB, FRCPsych, DPM, DCH
Consultant Psychiatrist, UK

“Positive Psychology is a research-based approach. Cognitive Behavioral Therapy (CBT) is often focused on cognitions and behavior that don’t serve people well. Fredrike Bannink takes these two approaches, combines them with the best of solution-focused, strength-oriented clinical methods and blends them into a seamless combination that can help any therapist or coach be more effective. Like discovering the restaurant of a master chef who has invented a new fusion of different culinary traditions, Bannink’s approach will leave you excited and satisfied.”

Bill O’Hanlon
Psychotherapist and author of Do One Thing Different and The Change Your Life Book, USA
Practicing Positive CBT

From Reducing Distress to Building Success

Fredrike Bannink

A John Wiley & Sons, Ltd., Publication
# Contents

*About the Author* ix
*Foreword* x
*Preface* xii
  *Story: The Hundredth Monkey* xiv
*Acknowledgments* xv

## PART I THEORY

### 1 What is CBT?
- Introduction 3
- CBT Techniques 4
- Empirical Evidence 5

### 2 What is Positive CBT?
- Introduction 7
- Shortcomings of the Problem-Solving Paradigm 8
  - Story 2.1: How to Not Be Unhappy 10
- Towards a Strengths and Solutions Paradigm 10
- Notes on Learning Theory 16
  - Story 2.2: I Can Choose 16
- Changing Role of the Therapist 16
- Differences Between Traditional CBT and Positive CBT –
  - An Overview 17
  - Story 2.3: Looking for Problems? 17

### 3 Possibilities of Positive CBT
- Introduction 19
- What is Positive in Traditional CBT? 20
- Possibilities of Positive CBT 31

### 4 Two Positive Sources
- Introduction 34
- Source 1: Positive Psychology 35
  - Story 4.1: The Power of Positive Emotions 41
Contents

- Source 2: Solution-Focused Brief Therapy ........................................ 41
  - Story 4.2: Do Something Different for a Change .......................... 42
  - Story 4.3: Working from the Future Back .................................. 49
- Short Comparison Between Positive Psychology and Solution-Focused Brief Therapy ................................................. 50
  - Empirical Evidence ....................................................................... 50
  - Neuroscience ................................................................................ 51
    - Story 4.4: The Drip System ......................................................... 55
    - The Body ................................................................................... 59

PART II APPLICATIONS ................................................................. 61

5 Enhancing the Therapeutic Alliance ........................................... 63
  - Introduction .................................................................................. 63
  - Building a Positive Alliance .......................................................... 64
  - Offering Acknowledgment .............................................................. 65
    - Story 5.1: Acknowledging the Problem ......................................... 66
  - Enhancing Hope ............................................................................. 66
    - Story 5.2: The Archer .................................................................. 69
    - Story 5.3: The Power of Hope ......................................................... 70
  - Reinforcing Strengths and “What Works” .......................................... 70
  - Enhancing Cooperation .................................................................. 72
    - Story 5.4: Misery I Love You! ......................................................... 74
    - Story 5.5: Everybody, Somebody, Anybody, and Nobody .............. 76

6 Assessment .................................................................................. 77
  - Introduction .................................................................................. 77
  - Case Conceptualization .................................................................. 77
  - Assessing Goals ............................................................................. 79
    - Story 6.1: Top Performers ............................................................... 86
  - Assessing Problems, Complaints, and Constraints ......................... 87
  - Assessing Strengths and Resources ................................................. 88
  - Assessing Progress, Motivation, Hope, and Confidence .................. 90
    - Story 6.2: At the Car Wash .............................................................. 92
  - Assessing Motivation to Change ....................................................... 93
  - Positive Self-monitoring ................................................................. 93
  - Positive Functional Behavior Analysis .......................................... 95

7 Changing the Viewing ................................................................. 99
  - Introduction .................................................................................. 99
  - Acknowledging Feelings and the Past .............................................. 99
  - Changing What the Client is Paying Attention to ......................... 101
    - Story 7.1: Finding the “Bright Spots” ........................................... 102
    - Story 7.2: The Dog I Feed Most .................................................... 110
    - Story 7.3: Shake it Off and Step Up .............................................. 111
  - Focusing on What the Client Wants in the Future ......................... 114
  - Challenging Unhelpful Beliefs ....................................................... 115
  - Using a Spiritual Perspective ......................................................... 124
Contents

8 Changing the Doing 128
   Introduction 128
   Story 8.1: For a Change Do Something Different 128
   Changing Repetitive Patterns 129
   Story 8.2: Sail Away From the Safe Harbor 130
   Noticing What the Client is Doing When Things are Going Better 131
   Story 8.3: Chocolate-chip Cookies 133

9 Changing the Feeling 138
   Introduction 138
   Reducing Negative Emotions 138
   Building Positive Emotions 140
   Balancing Positive and Negative Emotions 145
       Story 9.1: Consider a Sail-boat 147
       Story 9.2: The Nun Study 148
   Positive Emotions in the Medical Setting 148

10 Homework Assignments 152
   Introduction 152
   General Suggestions 153
   Basic Homework Assignments 156
   Self-monitoring 157
   Behavioral Experiments 160
   Routine Outcome Measurement 165
       Story 10.1: Brilliant Insights 166
   Reflecting on the Session 170

11 Subsequent Sessions 173
   Introduction 173
   Progress 174
   Behavior Maintenance 180
   Failures 185
       Story 11.1: Ten Million Dollars Lost 190
   Concluding Therapy 190

12 Role of the Positive CBT Therapist 193
   Introduction 193
   Watering the Flowers 193
   Role of the Positive CBT Therapist 194
   Supertherapists 196
   Easy and Fun 198
   The Alliance Revisited 200
   Microanalysis 200
   Benefits for Therapists 203

PART III MORE APPLICATIONS 207

13 Positive CBT with Couples and Groups 209
   Introduction 209
Contents

Positive CBT with Couples 210
  Story 13.1: The Norway Feedback Project 213
Positive CBT with Groups 215

14 Positive CBT with Children and Families 219
  Introduction 219
  Positive CBT with Children 220
    Story 14.1: Little Squid 222
  Positive CBT with Families 232
  Transcultural Positive CBT 236

15 Positive CBT in the Workplace 237
  Introduction 237
  Positive CBT in a Team 238
    Story 15.1: We Can Learn From Geese 239
  Positive CBT in an Organization 243
    Story 15.2: Swarm Intelligence 245
    Story 15.3: What You Give is What You Get 248

16 Positive CBT and the Future 250
  Introduction 250
  Research 250
  Training 251

17 FAQ 255
  Introduction 255
  20 Questions and Answers 255

Epilog 264
  Story: On the Other Side 264

Web Sites 265

Appendix A Protocols for the First Session 268
Appendix B Protocol for Finding Exceptions 270
Appendix C Protocol for Subsequent Sessions 272
Appendix D Positive FBA Interview 274
Appendix E Externalization of the Problem 275
Appendix F Interactional Matrix (Changing Perspectives) 276
Appendix G Questionnaire for the Referrer 278
Appendix H Exceptions Journal 279
Appendix I Session Rating Scale (SRS) 281

References 282

Author Index 294

Subject Index 298
Fredrike Bannink is a clinical psychologist and a child and youth psychologist. She currently has a therapy, training, coaching, and mediation practice in Amsterdam, the Netherlands. She is a trainer/supervisor with the Dutch Association for Behaviour and Cognitive therapy (VGCt) and cofounder and chair of the Association’s Solution-Focused Cognitive Behavioural Therapy Section. She is a lecturer at various postgraduate institutes.

She teaches CBT, Solution-Focused Brief Therapy, and Positive Psychology to psychologists and psychiatrists, and solution-focused interviewing to medical professionals. She is a trainer of the Mental Health Team of Doctors Without Borders.

In addition, she provides numerous in-company training courses in solution-focused therapy at mental health care institutions; for companies, she organizes solution-focused coaching and solution-focused leadership trajectories.

Fredrike Bannink is also a Master of Dispute Resolution and a mediator for the Amsterdam District Court. She is the author of many international publications in the fields of solution-focused therapy, solution-focused interviewing, solution-focused mediation/conflict management, solution-focused leadership, and positive psychology. Since 2005 she has been writing and presenting worldwide on the topic of bridging traditional CBT, Solution-Focused Brief Therapy, and Positive Psychology. Not surprisingly her top strength (according to the VIA strengths test) is “curiosity and interest in the world.”
Foreword

Cognitive-behavioral therapy 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, can leave a substantial margin for improvement. What would it take to help more clients benefit more substantively from therapy? What more can therapists do to support their clients in developing their longer-term resilience?

Many therapists are intrigued by the idea that identifying clients’ strengths and explicitly working with clients’ resilience might be an answer to these questions. But they feel ill equipped to work in this way. “It seems a good idea, but how do I do it in my practice?” Practicing Positive CBT is a wonderful addition to the CBT canon because it provides therapists with a well-structured, comprehensive, practical, and detailed manual for building their clients’ strengths and resilience. Its core is the important work of assessment, engagement, case conceptualization, and treatment, but applied to strengths and resilience. Positive CBT provides therapists with ideas for working across the life span, with couples, with families, and in organizational settings. Dr. Bannink writes with sensitivity to issues of diversity, modeling how diversity can be framed as a strength and incorporated into treatment.

Practicing Positive CBT provides both the key background theory and the detailed clinical techniques therapists can use with clients to identify and work with client strengths and a framework for building clients’ resilience. It is written in an engaging style that makes use of instructive stories, poems, and metaphors. A really potent tool in the book is the use of guided exercises that demonstrate experientially some of the key messages.

What Dr. Bannink is doing is radical, synthesizing CBT with the psychology of resilience in a grounded and pragmatic way. A key issue for the next decade will be to show that this integration enhances short and, most importantly, long-term client outcomes.

In reading Practicing Positive CBT there is a sense of being in the presence of a gifted, engaging, enthusiastic, and inspiring therapist. The book practices what
it preaches in supporting therapists to become more effective and successful, and I suspect enjoying their work along the way.

Willem Kuyken
Professor of Clinical Psychology
University of Exeter
United Kingdom
Preface

Traditional CBT has been strongly influenced by the medical model of diagnosis and treatment. The structure of problem-solving – first determining the nature of the problem and then intervening – influences the content of the interaction between therapists and clients: they focus on pathology and on what is wrong with the client. I will use the term “client” instead of “patient” throughout the book, because I prefer not to use the medical model.

Traditional therapists tend to be preoccupied with client problems, limitations, and deficiencies. Client assessments by interdisciplinary teams are often negative and mention few or no client strengths and abilities. It is, however, not this negative way of thinking but the clients’ strengths, abilities, and resources that are most important in helping to bring about change. The mission of the helping professions is to empower clients to live more productive and satisfying lives and to flourish. Empowering clients indicates the intention to, and the process of, assisting individuals, groups, families, and communities to discover and expend the resources and tools within and around them.

“If we want to flourish and if we want to have well-being, we must indeed minimise our misery; but in addition, we must have positive emotion, meaning, accomplishment, and positive relationships. The skills and exercises that build these are entirely different from the skills that minimise our suffering” (Seligman, 2011, p. 53). In other words: it’s about time to shift the focus from reducing distress and merely “surviving” to building success and positively “thriving.”

You don’t have to be ill to get better

In the past 30 years there has been a development of competency-based, more collaborative approaches to working with clients. Positive Psychology and Solution-Focused Brief Therapy are amongst these approaches, which are predominantly directed toward clients’ preferred futures and strengths instead of their past problems and deficits. In this book I will explore with you how traditional CBT becomes Positive CBT.
Mental health is more than the absence of mental illness. The focus of Positive CBT is no longer only on pathology, on what is wrong with the client and on repairing what is worst, but first and foremost on strengths, what is right with him and on creating what is best. The focus is no longer on merely reducing distress, but also on building success. 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.” It is a competency-based model, which brings together the best elements of change-based and meaning-based psychotherapeutic approaches to offer a new perspective on psychotherapy and on traditional CBT.

Positive CBT is a new approach to the practice of CBT and this is the first book ever written on the subject. Mindfulness, ACT, and EMDR are considered to be the third wave in CBT, whereas Positive CBT may well become its fourth wave and will increase the repertoire of available interpretation schemes and create a broader range of therapeutic options when intervening with clients and their families. By increasing the intrinsic motivation of clients, a positive focus allows the practice of CBT to become shorter in time. It also generates more autonomy for clients, as well as more light-hearted conversations, which may in turn result in less stress, depression, and burnout among therapists.

This book is aimed at all professionals who would like to adopt a (more) positive approach to psychotherapy and CBT, or who would simply like to increase the range of techniques available to them. Cognitive behavioral therapists will discover a new approach to (or may become better at) significantly increasing client motivation, co-creating preferred outcomes and pathways to achieve them with their clients. Therapists trained in Positive Psychology and/or Solution-Focused Brief Therapy will find useful information on how to combine elements of CBT with their own therapeutic approach. The book is not intended for therapists who are satisfied with the current concepts and models in psychotherapy and CBT, but is meant for those therapists who reflect seriously enough on their profession and its possibilities to be dissatisfied with the current state of affairs. And it is meant for therapists who are interested in examining where the concept of Positive CBT may lead.

Are you curious to know how an elephant, a squid, a mule, dogs, monkeys, geese, a dragon, and a swarm of birds all contribute to Positive CBT? The answer will be revealed to you whilst reading this book. The format of the book has something of a workshop-like quality: 68 exercises, 41 cases (including 20 FAQ and answers), and 31 stories are introduced throughout the book to give you the opportunity to integrate the Positive CBT approach through action learning. Robert Frost (1874–1963) wrote a beautiful poem entitled “The Road Not Taken” in his collection Mountain Interval (1920) in which two roads diverged in a wood and he took the one less traveled by, which to him has made all the difference. Hopefully you have the courage and curiosity to take “the road less traveled”; it may make “all the difference” for your clients and for yourself! I invite you to share your comments via email at solutions@fredrikebannink.com.
How many monkeys do you think it will take before Positive CBT will flourish?

Story: The Hundredth Monkey

The Japanese monkey Macaca fuscata had been observed in the wild for a period of 30 years. In 1952, on the island of Koshima, scientists were providing monkeys with sweet potatoes dropped in the sand. The monkeys liked the taste of the raw sweet potatoes, but they found the dirt unpleasant. A young female found she could solve the problem by washing the potatoes in a nearby stream. She taught this trick to her mother. Her playmates also learned this new way and they taught their mothers too.

In a couple of years all the young monkeys learned to wash the sandy potatoes to make them more palatable. Only the adults who imitated their children learned this social improvement... other adults kept eating the dirty sweet potatoes.

Then something startling took place. In the autumn of 1958 a certain number of monkeys were washing potatoes — the exact number is not known. When the sun rose one morning there were 99 monkeys on Koshima Island who had learned to wash their potatoes. Suppose that later that evening the hundredth monkey learned to wash potatoes... by that evening almost everyone in the tribe was washing sweet potatoes before eating them. The added energy of this hundredth monkey somehow created an ideological breakthrough!

A surprising thing observed by the scientists was that the habit of washing sweet potatoes then jumped over the sea — colonies of monkeys on other islands and the mainland began washing their sweet potatoes. Thus, when a certain number achieves awareness, this new awareness may be communicated from mind to mind. Although the exact number may vary, the “Hundredth Monkey phenomenon” means that when a limited number of people know of a new way, it may remain the conscious property of just those people. But there is a point at which if only one more person tunes in to a new awareness, a field is strengthened so that this awareness is picked up by almost everyone!

Source: Unknown
Acknowledgments

An author never writes a book alone. It is always a product of many people who work together and ultimately ensure that the name of the author appears on the cover.

I thank my husband, Hidde, and my daughters, Eva and Eline, for giving me the opportunity and encouragement to write my books. I thank my friends, colleagues, students, and above all my clients at home and abroad who have helped me discover, apply, and improve my work over the years.

I also thank my publisher Darren, who kindly invited me to write this book, my dear friends and translators Paula and Steve, and everyone else who has contributed to the realization of this book. Grazie also to my Italian cats for keeping me company during many pleasant hours of thinking and writing.
Part I
Theory
What is CBT?

Introduction

Cognitive behavioral therapy (CBT) is a psychotherapeutic approach, a talking therapy. The roots of CBT can be traced to the development of behavior therapy in the early 1920s, the development of cognitive therapy in the 1960s, and the subsequent merging of the two. It was during the period 1950 to 1970 that behavioral therapy became widely utilized, with researchers in the United States, the United Kingdom, and South Africa who were inspired by the behaviorist learning theory of Pavlov, Watson, and Hull.

Pioneered by Ellis and Beck, cognitive therapy assumes that maladaptive behaviors and disturbed mood or emotions are the result of inappropriate or irrational thinking patterns, called automatic thoughts. Instead of reacting to the reality of a situation, an individual reacts to his or her own distorted viewpoint of the situation. For example, a person may conclude that he is worthless simply because he failed an exam or did not get a date. Cognitive therapists attempt to make their clients aware of these distorted thinking patterns, or cognitive distortions, and change them (a process termed cognitive restructuring).

Behavioral therapy, or behavior modification, trains clients to replace undesirable behaviors with healthier behavioral patterns. Unlike psychodynamic therapies, it does not focus on uncovering or understanding the unconscious motivations that may be behind the maladaptive behavior.

CBT integrates the cognitive restructuring approach of cognitive therapy with the behavioral modification techniques of behavioral therapy. The goal of CBT is to help clients bring about desired changes in their lives. The objectives of CBT are to identify irrational or maladaptive thoughts, assumptions, and beliefs.
that are related to debilitating negative emotions and to identify how they are dysfunctional, inaccurate, or not helpful. This is done in an effort to reject the distorted cognitions and to replace them with more realistic and self-helping alternatives. The client may also have certain fundamental core beliefs, called schemas, which are flawed and require modification. For example, a client suffering from depression may avoid social contact with others and suffer emotional distress because of his isolation. When questioned why, he reveals to his therapist that he is afraid of rejection, of what others may do or say to him. Upon further exploration with his therapist, they discover that his real fear is not rejection but the belief that he is uninteresting and unlovable. His therapist then tests the reality of that assertion by having the client name friends and family who love him and enjoy his company. By showing the client that others value him, the therapist both exposes the irrationality of the client’s belief and provides him with a new model of thought to change his old behavior pattern. In this case, the client learns to think “I am an interesting and lovable person; therefore I should not have difficulty making new friends in social situations.” If enough irrational cognitions are changed, he may experience considerable relief from his depression.

Initial treatment sessions are typically spent explaining the basic tenets of CBT to the client and establishing a positive working relationship. CBT is a collaborative, action-oriented therapy effort. As such, it empowers the client by giving him an active role in the therapy process and discourages any over-dependence on the therapist. Treatment is relatively short, usually lasting no longer than 16 weeks.

Both positive alliance – a positive bond between therapist and client – and empirically supported treatment methods enhance therapy outcome. There is evidence that positive therapy alliance potentiates the effectiveness of empirically supported methods (Raue and Goldfried, 1994) and there is also evidence that using effective methods leads to a more positive alliance (DeRubeis, Brotman, and Gibbons, 2005).

**CBT Techniques**

Different techniques may be employed in CBT to help clients uncover and examine their thoughts and change their behaviors. They include:

- Clients are asked to keep a diary recounting their thoughts, feelings, and actions when specific situations arise. The journal helps to make them aware of their maladaptive thoughts and to show their consequences on behavior. In later stages of therapy, it may serve to demonstrate and reinforce positive behaviors.
- Cognitive rehearsal. The clients imagine a difficult situation and the therapist guides them through the step-by-step process of facing and successfully dealing with it. The clients then work on rehearsing these steps mentally. When the situation arises in real life, the clients will draw on their rehearsed behavior to address it.
What is CBT?

- Clients are asked to test the validity of the automatic thoughts and schemas they encounter. The therapist may ask the clients to defend or produce evidence that a schema is true. If clients are unable to meet the challenge, the faulty nature of the schema is exposed.
- Modeling. The therapist and client engage in role-playing exercises in which the therapist acts out appropriate behaviors or responses to situations.
- Conditioning. The therapist uses reinforcement to encourage a particular behavior. For example, a child gets a gold star every time he stays focused on tasks and accomplishes certain daily chores. The star reinforces and increases the desired behavior by identifying it with something positive. Reinforcement can also be used to extinguish unwanted behaviors by imposing negative consequences.
- Systematic desensitization. Clients imagine a situation they fear, while the therapist employs techniques to help the client relax, helping the person cope with his fear reaction and eventually eliminate the anxiety altogether. The imagery of the anxiety-producing situations gets progressively more intense until the therapist and client approach the anxiety-causing situation in real-life (graded exposure). Exposure may be increased to the point of flooding, providing maximum exposure to the real situation. By repeatedly pairing a desired response (relaxation) with a fear-producing situation (open, public spaces) the client becomes desensitized to the old response of fear and learns to react with feelings of relaxation.
- Relaxation, mindfulness, and distraction techniques are also commonly included.
- Cognitive behavioral therapy is often also used in conjunction with mood stabilizing medications to treat conditions like depression and bipolar disorder.
- Homework assignments. Cognitive-behavioral therapists frequently request that their clients complete homework assignments between therapy sessions. These may consist of real-life behavioral experiments where patients are encouraged to try out new responses to situations discussed in therapy sessions.

Empirical Evidence

There is empirical evidence that CBT is effective for the treatment of a variety of problems, including mood, anxiety, personality, eating, substance abuse, and psychotic disorders. Treatment is often manualized, with specific technique-driven brief, direct, and time-limited treatments for specific psychological disorders.

CBT is used in individual therapy as well as group settings, and the techniques are often adapted for self-help applications. Some clinicians and researchers are more cognitive oriented (e.g., cognitive restructuring), while others are more behaviorally oriented (e.g., in vivo exposure therapy). Other interventions combine both (e.g., imaginal exposure therapy). Many CBT treatment programs for specific disorders have been evaluated for efficacy; the health-care trend of evidence-based treatment, where specific treatments for
Practicing Positive CBT

symptom-based diagnoses are recommended, has favored CBT over other approaches such as psychodynamic treatments.

CBT may be seen as a class of treatments, which have the same features in common and also differ in important respects. It is problem-focused and structured towards the client; it requires honesty and openness between the client and therapist, as the therapist – being the expert – develops strategies for managing problems and guiding the client to a better life.
What is Positive CBT?

Introduction

Suppose you are hungry and decide to eat in a restaurant. After having waited for some time, you are invited to take a seat and the manager introduces himself. He asks you questions regarding your hunger: “How hungry are you? For how long have you been preoccupied with this feeling? Were you hungry in the past? What role did hunger play at home with your family or with other relatives? What disadvantages and possibly advantages does hunger have for you?” After this, having become even hungrier, you ask if you can now eat. But in addition the manager wants you to complete some questionnaires about hunger (and perhaps about other issues that the manager finds important). Once everything is finished, a meal is served to you that you did not order, but that the manager claims is good for you and has helped other hungry people. What are the chances of you leaving the restaurant feeling satisfied?

According to the traditional cause-effect model (also called the “medical model” or the “problem-focused model”), one must first find out exactly what the matter is in order to assert a correct diagnosis before a remedy can be provided. In our western thinking, the cause-effect model is the pre-eminent model to make the world understandable. The model is useful if one is dealing with relatively straightforward problems that can, in actual fact, be reduced to simple and unambiguous causes, as is the case with medical or mechanical problems. When you have a toothache, the first question you ask is: what is wrong with my teeth? When your vacuum cleaner breaks down, the first question you ask is: what is wrong with my vacuum cleaner? The medical model consists of: diagnosis + prescribed treatment = symptom reduction. As far as psychotherapy is concerned, however, this model has a major disadvantage, that is, that it is heavily problem-focused. If the problem and its possible causes are studied in depth, a vicious circle may develop with ever-growing problems. The atmosphere becomes
Practicing Positive CBT

laden with problems, which poses the risk that solutions recede ever further from view and also that the hope of improvement dwindles. In this vein psychology became a victimology and psychologists and psychiatrists became pathologizers. Exploring or analyzing the factors that cause or perpetuate a problem does not automatically result in an improvement of the problem. Einstein (1954) stated that we cannot solve problems by using the same kind of thinking we used when we created them. Duncan (2010) also states that psychotherapy is not a medical endeavor, it is first and foremost a relational one. Yet, the medical model is the predominant description of what we do. “My account of psychotherapy lies outside of the language of diagnosis, prescriptive treatment, and cure and seeks to reflect the interpersonal nature of the work, as well as the consumer’s perspective of therapeutic process, the benefit and fit of the services.” (p. 184)

The British Psychological Society in their DSM-5 response (2011) state that they are concerned that clients and the general public are negatively affected by the continued and continuous medicalization of their natural and normal responses to their experiences – responses which undoubtedly have distressing consequences which demand helping responses but which do not reflect illnesses so much as normal individual variation.

Furthermore, research shows that among professionals using the problem-solving model there is a high percentage of stress, depression, suicide, burnout, and secondary traumatization. I shall explore these shortcomings further in the next paragraph.

**Shortcomings of the Problem-Solving Paradigm**

The problem-solving paradigm has become very popular in business, government, and in coaching, psychotherapy, and conflict management. In traditional forms of psychotherapy – and also in CBT – the focus is on pathology. The diagnosis of the problem is the first step. The next step is finding the causes of the problem, using the cause-effect model (the so-called “medical model” or “mechanical model”) as previously mentioned.

This is a very common way: something has gone wrong and we have to put it right. In medicine and psychotherapy problems are called a “deviation” from the normal: health is normal, sickness is a deviation and has to be removed.

The problem-solving model is very straightforward: identify the cause and remove it. And indeed analyze the problem, find the cause, put it right is a simple and attractive idiom. It makes sense and it is action-oriented. But unfortunately is it inadequate for a number of reasons:

- In a complex interactive situation we may never be able to isolate one cause;
- There is a danger in fastening on to a particular cause, because it is easy to identify, ignoring the rest of the situation;
- We may identify the cause but cannot remove it;
- The sometimes false notion that once the cause is removed the problem will be solved and things will be back to normal, or should it be: which is usually not the case;
- If we define the goal and decide how to get there, how precise does our definition of the destination have to be.
What is Positive CBT?

Problem-solving certainly has a place in psychotherapy and other areas. The main limitation is that we may put much too definite a view on what we believe the solution should be before we have really done our thinking about the matter. As soon as we say “this is the problem” we have defined the sort of solution we expect.

In designing a positive outcome – instead of problem solving – in Positive CBT we set out to design something, there is an output, there is something to achieve. It is not just a matter of removing a problem; there is a designed something that was not there before. In this design the focus shifts from problem analysis to outcome analysis or goal analysis.

“With design there is a sense of purpose and a sense of fit. Problem analysis is always looking back at what is already there; design is always looking forward at what might be created. We need to design outcomes. I do not even like saying design ‘solutions’ because this implies that there is a problem. Even when we cannot find a cause, or, after finding it, cannot remove it, we can always attempt to design an outcome. The main point about the design idiom is that it is open ended. We set out to achieve an outcome. At the beginning we do not know exactly what the outcome is going to be, though there is yet a strong sense of purpose” (De Bono, 1985, p. 42).

There is growing dissatisfaction among clients and professionals with the use of problem-focused models of therapy. Studying problems in depth often leads to the premature discontinuation of sessions, because nothing changes and the client loses hope of improvement. The good news about psychotherapy is that the average treated client is better off than 80% of the untreated sample. It facilitates the remission of symptoms and improves functioning. It also often provides additional coping strategies and methods for dealing with future problems (Lambert and Ogles, 2004).

The bad news, however, is that there has been no improvement in psychotherapy outcomes in more than 30 years, that the drop-out rates are very high (47–50%), and that there is a lack of consumer confidence in therapy outcome. There is a continued emphasis on the medical model and there are continued claims of superiority amongst models despite the absence of evidence. Wampold (2001, p. 204) states: “Research designs that are able to isolate and establish the relationship between specific ingredients and outcomes . . . have failed to find a scintilla of evidence that any specific ingredient is necessary for therapeutic change.” So let’s see if we can find an answer to the bad news mentioned previously.

Exercise 2.1

Consider a typical problematic situation. Write down the typical questions you ask yourself or others about it. Examine these questions closely. Does asking them help you feel better or worse? Does asking them help move you forward to where you want to be or merely give you an explanation for why you are stuck or can’t change? If your questions are not helping you, find some more helpful questions.
Towards a Strengths and Solutions Paradigm

As stated before, traditional therapists tend to be preoccupied with client problems, limitations, and deficiencies. Client assessments by interdisciplinary teams are often negative and mention few or no client abilities. It is, however, the clients’ abilities, strengths, and resources that are most important in helping to bring about change.

A “strengths-based approach” with its roots in Positive Psychology may be the answer to the bad news, mentioned earlier. It is a meta-view, an overarching 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 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. Strengths-based Positive Psychologists and other practitioners promote change through respectful educational, therapeutic, and operational processes that encourage and empower others.

Saleebey (2007) calls this the “strengths perspective” with the following basic assumptions:

- Despite life’s struggles, all persons possess strengths that can be marshaled 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;

---

**Story 2.1: How to Not Be Unhappy**

The ancient Greeks already faced the choice between “how not to be unhappy” or “how to be happy.” The Stoics (third century BC: Zeno, and later Seneca and Epictetus) practiced discomfort and difficulty; their aim was not to be unhappy. Today the word “stoic” commonly refers to someone indifferent to pain, pleasure, grief, or joy.

Epicurus was another ancient Greek philosopher (second century BC) and the founder of the school of philosophy called Epicureanism. For the Epicurists the objective was to attain a happy, tranquil life, surrounded by friends and living self-sufficiently. Their aim was to be happy.

As we face the same dilemma today, we can also let our clients decide what they would prefer: how to not be unhappy or how to be happy. In Chapter 6, I will elaborate further on these so-called approach goals (to be happy) or avoidance goals (to not be unhappy).
What is Positive CBT?

- Discovering strengths requires a process of cooperative exploration between clients and therapists; expert 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.

Furthermore, a solutions-based approach, focusing on “what works” for this client, in this context, and in this moment, with its roots in Solution-Focused Brief Therapy may add to the well-being and flourishing of clients by inviting them to define their preferred future (instead of their problems) and finding solutions to reach their goal. Biologists Histed, Pasupathy, and Miller (2009) found that monkeys learn more from their successes (e.g., what has successfully worked before) than from their failures and states that the same is probably true for human beings. This book brings together the best of these two approaches, which are at the basis of Positive CBT. Chapter 4 will provide a detailed description and a short comparison of both.

Exercise 2.2

Sit comfortably, close your eyes and repeat the following sentence ten times: “I have a big problem!” Observe closely what you are experiencing physically and emotionally. Notice carefully the effect that this sentence has on your body and on your emotions.

Stretch a little, get up and do the exercise again. Set yourself comfortably again, close your eyes, and then repeat the following sentence ten times: “I have a great opportunity!” Once again, observe the effects that this sentence has on your physical and emotional state.

CBT therapists Kuyken, Padesky, and Dudley (2009, p. 114) state: “Therapists often consider amelioration of client distress the most important therapy outcome. It is an outcome that CBT therapists generally view as primary; they assume that their clients share this view. However, a recent large survey of people receiving mental health services revealed the most important outcomes for clients are: attaining positive mental health qualities such as optimism and self-confidence; a return to one’s usual, normal self; a return to usual level of functioning; and relief from symptoms (Zimmerman et al., 2006).”

Kuyken, Padesky, and Dudley state that although identified strengths can be incorporated at each stage of case conceptualization, this has not typically been demonstrated in the CBT literature. There has been a much greater emphasis on identifying precipitating, predisposing and perpetuating factors for problems. They advocate the inclusion of strengths whenever possible during case conceptualization. These strengths can be personal or cultural values or both. Resilience is a broad concept that refers to how people negotiate adversity
to maintain their well-being. The term describes the psychological processes through which people draw on their strengths to adapt to challenges. Research done by Masten (2001) shows an important distinction between strengths and resilience. Strengths refer to attributes about a person such as good coping abilities or protective circumstances such as a supportive partner. Resilience refers to the processes whereby these strengths enable adaptation during times of challenge. Thus, once therapists help clients identify strengths, these strengths can be incorporated into conceptualizations to help understand client resilience.

When therapists focus on problems, on what their clients do not want, on disadvantages, failures, deficits, and the dreaded future, there will be less resilience, whereas when therapists focus on what their clients want instead of their problems, on exceptions to the problems, advantages, successes, strengths, and their preferred future, there will be more resilience.

What a client (and his therapist) focuses his attention on tends to increase and expand in both his awareness and his life. When someone is having problems, it is usually because he is attending to the same thing over and over again. The statement: “Insanity is doing the same thing over and over again and expecting different results” is generally attributed to Einstein. In Positive CBT clients and therapists are invited to shift their attention from analysis, explanations, and problems, to thoughts, actions, and feelings that can help clients flourish. Positive CBT therapists always listen for openings in problem-focused conversations. These openings can be about what clients want different in their lives, openings about exceptions, openings about competences and resources, openings about who and what might be helpful in taking the next step.

Improvement is often realized by redirecting attention from dissatisfaction about a status quo to a positive goal and to start taking steps in the direction of that goal. This process of shifting attention often uses three steps:

1. Acknowledge the problem of the client ("This must be hard for you")
2. Suggest a desire for change ("So I guess you would like things to be different?")
3. Ask about the desired outcome ("How would you like things to be different?")

According to Positive Psychology, getting rid of unhappiness is not the same thing as achieving happiness. Getting rid of fear, anger, and depression will not automatically fill you with peace, love, and joy. Getting rid of weaknesses will not automatically maximize your strengths (see Table 2.1). In traditional CBT book titles you find the same problem-focused way of thinking: “Overcoming depression,” “Coping with obsessive-compulsive disorder,” or “Your route out of perfectionism.”

Happiness and unhappiness are not on the same continuum. Strategies to minimize fear, anger, or depression are not identical to strategies to maximize peace, joy, strength, or meaning. Subjective well-being is a function of three different factors: high positive affect, low negative affect, and high life satisfaction, whereby positive and negative affect are on different continua. Fredrickson (2009) argues that a key to emotional flourishing is having a high positive-to-negative emotion ratio. We can improve our state, either by increasing positive