

ORIGINAL ARTICLE

Positive cognitive behavioral therapy

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Abstract

Cognitive behavioral therapy (CBT) has been significantly influenced by the medical model of diagnosis and treatment. The structure of the therapy mostly focuses on the suffering and other negative symptoms and less on the strengths and abilities of the clients. Positive Cognitive Behavioral Therapy offers CBT joined with Positive Psychology and Solution Focused Brief Therapy. Positive CBT aims at improving the well-being and quality of life of the individuals. It is the clients' strengths, capabilities, and resources that are the most important in helping to bring about the change. One of the important goals of the therapy is a long-term resilience, which focuses on the personal strengths and adaptive abilities.

INTRODUCTION

Recent decades have been marked by the development of competency-based, collaborative approaches to working with the clients in psychotherapy. Specific psychotherapeutic approaches for fostering well-being and resilience have been established and validated in randomized controlled trials (Fava & Tomba 2009). The findings show that specific interventions can stimulate resilience. These interventions build a positive self-concept, the sense of continuous inner growth and meaning of life, the ability to form fulfilling interpersonal relationships, resiliency and internal locus of control (Fava & Tomba 2009).

Cognitive behavioral therapy (CBT) has developed to address a broad range of clients' issues and wishes. CBT show a high efficacy in the therapy of many problems ranging from anxiety and depressive disorders to

personality disorders, chronic pain and sleep disorders (Chambless & Ollendick 2001; Butler *et al* 2006). CBT also might be engaged to improve client's positive qualities and attributes (Mooney & Padesky 2002; Fava & Ruini 2003; Padesky 2006). Fava and Tomba (2009) showed how CBT-based approach to increasing psychological well-being could be used to increase resilience.

CBT has been powerfully influenced by the medical model of diagnosis and therapy. The structure of problem solving focuses the therapy more on the negative aspect and less on the strengths and abilities of the clients. Assessment focuses on problems, limitations, and deficiencies rather than on client strengths and abilities. Positive CBT with a shift in the focus of therapy from what is wrong with clients to what is right with them aims at improving the well-being by using an "upward arrow" instead of "downward arrow"

approach. It is the clients' strengths, capabilities, and resources that are most important in helping to bring about change. Therapists try to support their clients develop longer-term resilience by increasing clients' self-efficacy and self-esteem (Bannink 2012). Positive CBT draws on research and applications of Positive Psychology and Solution-Focused Brief Therapy.

Positive Psychology is an approach that looks for what makes life worth living and what empowers individuals and communities to prosper. The strengths-based approach with its roots in Positive Psychology is a philosophical viewpoint in which individuals are seen as skillful and as having capabilities and resources within themselves and their social networks. When triggered and incorporated with new experiences, understandings, and skills, strengths offer pathways to reduce pain and suffering, resolve concerns and conflicts, and more efficiently 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. The strengths framework is based on the following expectations (Saleebey 2007): (1) Despite life's difficulties, all people and situations retain strengths that can be organized to increase the quality of clients' lives. Therapists should respect this strong point and the ways in which clients wish to apply them. (2) Client's motivation is nurtured by a constant accent on strengths as the client expresses these. (3) The identification of strengths involves a cooperative examination between clients and therapists; "the experts" do not have the last word on what clients need. (4) Concentrating on strengths turns the therapist's concentration away from the inducement to "blame the victim" and on the way to learn how clients have succeeded to survive even in the most unwelcoming conditions. (5) All circumstances – even the bleakest – encompass resources.

These ideas developed in early years of this century in the framework of increased attention in positive psychology, the study of positive human potentials and capabilities (Fredrickson 2001; Seligman & Csikszentmihalyi 2000; Snyder & López 2002). Positive psychology, as the name proposes, is psychology with a positive direction. Positive psychology can be viewed as the "fourth wave" in the evolution of psychology after the disease model, behaviorism, and humanistic psychology. Solution Focused Brief Therapy is the practical use of a set of principles and tools, best defined as finding the direct route to "what works" for this client at this moment and in this background. The accent is given on constructing solutions as a counterweight to the traditional focus on the analysis of difficulties. It is a method 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 quite different from traditional CBT. Traditional CBT practices a logical positivist opinion (the basics of discipline come out of the objectively measurable observa-

tions), whereas Positive CBT – as does Solution-Focus Brief Therapy – uses a social constructivist understanding (the individual's concept of what is real – comprising his sense of the nature of difficulties, abilities, and solutions) It is built in daily life communication with others. This view also means a shift in the language used in therapy: instead of CBT terms like "learning" and "unlearning." Positive CBT uses the term "becoming better" (Wittgenstein 1968).

Bakker *et al* (2010) state that therapists may specify the commencement of treatment immediately and if required, concentrate to the diagnostics at later. Severe psychiatric disorders validate the decision to conduct a thorough diagnosis since the finding of the causal etiology has direct therapeutic consequences (Bannink 2013). Clients with adjustment problem and mild anxiety disorder are frequently suitable for Positive CBT. In the course of the first and follow-up sessions, it will become clear whether an advanced diagnostic is needed. Application of positive CBT is also ideal in clients after acute treatment of the serious psychiatric disorder in remission who have relational or occupational problems. The strategies of positive CBT can be also used in addition to traditional CBT strategies in the whole spectrum of clients.

Positive CBT

In the past 30 years, there has been a paradigm shift, which led to the development of competency-based, more collaborative approaches to working with clients. Mental health is more than the absence of mental disease. The emphasis of Positive CBT is neither given on mental disorders and pathology, nor on what is erroneous with clients or on restoring what is worst, but on psychological health and strengths. It focuses on what is right with them and on creating what is best. Positive CBT focus on building client's strengths and on what works instead of just reducing problems. Positive CBT can be understood as being the other side of the CBT "coin" and can be easily combined with traditional CBT (Saleebey 2007; Kuyken *et al* 2009).

Padesky (2006) considered resilience as development, not a trait and explain it as the capability to cope with and adapt in the face of difficulty and/or to rebound back and reestablish positive functioning when stressors become overwhelming. The model of resilience stems from the observation that many children can achieve a positive developmental outcome despite adverse experiences (Yates & Masten 2004). Research of resilient children has underscored the importance of both internal factors (character strengths) and environmental elements (such as family cohesion and warmth) vis-à-vis the difficulties of poverty and troubled environment (Kupfer 1999; Yates & Masten 2004). Resilience assistances clients to cope with negative life events. Resilient persons continue in the face of difficulties and when needed, accept conditions that cannot be improved (Bonanno 2004). Resilience offers a buffer

to defend us from psychological and physical health consequences during difficult times (Rutter 1985; Yi *et al* 2008). Mooney and Padesky (2000) spoke about Strengths-Based Cognitive–Behavioral Therapy.

These expectations are based on the idea that therapists must respect clients' ways of looking at themselves and at their worlds and involve these perspectives in the therapeutic process.

HOW TO DISCOVER THE CLIENT'S STRENGTHS

Assessments are focusing on psychopathology, problems and deficits neglect clients' strengths and capabilities. However, the clients' strengths and resources are most important in bringing about improvement. Seligman (2011), one of the founders of the Positive Psychology movement, states that if we want to build and maintain well-being, we must on one hand lessen our misery; but on the contrary, we must have a positive meaning, emotion, accomplishment, and positive relationships.

Positive CBT beginning with building relationship. The therapist creates an encouraging start by exploring the everyday life of the clients: 'What kind of work do you do?' 'What do you like about your job?' 'What hobbies do you have?'. These questions can be understood as openings, but they also provide valuable information about client's strengths. Therapist set the tone for a more light-hearted dialogue than clients might expect. Many questions used in positive cognitive behavioral therapy was modified from the solution-focused approach to interviewing (de Shazer 1988).

Therapies are more concentrating on what clients want to change rather than exploring symptoms, problems or difficulties. They are focused on what is right with clients than in what is wrong with them. The first challenge therapists encounter moving the clients from the problem-solving type of conversation to a strengths & solutions dialogue. Evaluating what client needs, what he/she wants to have different (goals), motivation to change, strengths and resources (exceptions to the problem) and competencies, hope and confidence. These all are parts of the assessment and case formulation (Bannink 2013). Setting goals focus clients on needs and future possibilities rather than on problems. The goal setting helps to guide the structure of treatment and also prepares clients for the end of therapy: saying explicitly that treatment will be completed when aims are reached, or that treatment will be withdrawn if there is merely a small improvement. Finally, setting goals offers an opportunity for an assessment of treatment result about the clients' problems. "What will be the best outcome of your coming to see me?" is a good approach to open this part of the session, or "Which of your needs do you want to satisfy?" "What are your best hopes?" "What are your best ideas about your future life?" and 'What difference In your life will it make if your hopes are met?'

Positive CBT does not avoid the problem and problem solving (Bannink 2014). Clients have the opportunity to speak about their problems and symptoms, and therapists are listening politely and respectfully. However, no specific details about nature and of the severity of symptoms or problems are requested, and causes or origins are not analyzed. Questioning about exceptions may make known that some syndromes or disorders could be excluded Another way to guide Positive CBT is to gather all the symptoms, problems and difficulties at first and later to "translate" all problem reports into aims: "What would you like to do instead?" "Which behavior you want to do at the end of the therapy?" and then describe the problems collection to what clients want different in their lives. Additional relevant question can be: "Suppose these issues would not be there, how will you or your life/relationship/work be different?"

Self-monitoring is frequently incorporated into treatment, both in the sessions and as a part of a homework exercise. Self-monitoring is not about clients' difficulties, but about clients' strengths and exceptions to the problems. This practice of positive self-monitoring helps the client to feel more competent and focus more on what works.

In the functional behavioral analysis, each problem is analyzed regarding A-B-Cs: Antecedents, Behaviors and Beliefs, and Consequences. In Positive CBT, a functional behavioral analysis is prepared for expected behavior and/or exceptions to the problem behavior. Seven possible questions of the positive functional behavioral analysis are (Bannink 2013):

1. Suppose tonight a miracle happens and all your problems are solved. However, because you are asleep, you do not 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 miracle has happened and 0 being the opposite), where are you today?
5. What will you do differently in the order it 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?

Assessment

At the end of every session, clients are asked to summarize, whether the aims and topics were discussed in the way they wanted to talk about and what was the most important for them from the session. Also, they are asked to provide feedback about the relation with the therapist, and whether the approach fit them (Duncan 2010). Clients are also asked whether they think another session is beneficial, and if so when they like to return. The aim of subsequent sessions is elaborated in Bannink (2010ab, 2012). In the next sessions clients and therapists sensibly search what is better. Therapists ask for a detailed account of positive exceptions, give positive feedback and highlight the clients' contribution to finding solutions.

HOW TO BUILD THE CLIENT STRENGTHS

Shifting the attention and meaning

The emphasis is placed on how clients think and what they pay attention to as an approach to modification their condition to be the better. This can include five strategies. The first strategy is to recognize feelings and the past without allowing them to regulate what clients can do. They are asked to generate more kind and supportive stories and discover a gentler, calmer, and more positive vision of themselves, others, and/or the condition (Gilbert 2010). The second strategy is to ask clients to modification what they are paying attention to in offending circumstances. Guiding attention to the clients' successes instead of their fiascos produces an encouraging expectancy: clients begin to see themselves or the situation in a more positive light. The third strategy is to focus on what clients want to be different in the future. This accentuates the opportunity of change and centers clients on the future opportunities rather than on the problems. The fourth strategy is to challenge maladaptive beliefs about themselves, others and the world. Therapist assists the clients to find supportive thoughts and schemas that contribute to a more positive understanding of the self, others, and the world. In reality, these positive cognitions do not have to be established, because they are previously present (exceptions to the problem) and only could be put into consciousness and confirm.

Upward arrow technique

The problem-focused downward arrow procedure in classical CBT is one of the methods to detect beliefs that underpin maladaptive reactions to a given situation. Questions using the upward arrow technique are (Bannik 2013): "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 it happens, what difference will that make (for yourself, for others)?" These queries are also repeated in response to each answer clients provide.

Changing the behavior

The first strategy is to focus clients to concentrate on the repetitive patterns that they are trapped in or that others are trapped with them and try to modify something possible about these patterns (Bannik 2014). In connecting new activities to the problematic pattern, clients are asked to find something they can do every time they have the difficulty, something that is good for them, usually something difficult. Alternatively, ask them to do this avoided action first, every time they feel the urge to 'do' the problem.

The second strategy is to notice what clients are doing when things are going better, and invite them to do more of it (Bannik 2014): "When didn't you experience the problem after you expected you would?" Invite clients to concentrate on what happens as the problem finishes or jumps to the end. Then request clients to perform consciously some appropriate behaviors they did, but early in the problem situation. Alternatively, guide them to employ good solution patterns from other circumstances in which clients feel skilled. Scrutinize patterns on the job, at home, with friends, in hobbies, and in other circumstances to find something clients can use successfully in the offending condition. Alternatively, ask: "Why isn't the problem worse?" Use their skills to decrease the severity of the problem. Most of the time clients recognize better than therapists what works and what doesn't, but for an adjustment they must something change in the way they are doing at present.

Changing the emotions

Seligman (2011) described some undesirable consequences with the approach of making miserable persons less miserable. The reducing of the negative affect does not automatically increase positive affect. The research in a coaching context done by Grant and O'Connor (2010) presented that problem-focused questions decrease negative affect and increase self-efficacy, but do not increase understanding of the nature of the problem and don't enhance positive affect. On the other side, solution-focused decreased negative affect, increases positive affect, self-efficacy as well client's insight and understanding of the nature of the problem. Typical questions are: "How will you feel when your best hopes are met?" "What will you feel different when you notice that the steps you take are in the right direction?" Also taking back to the successful strategies from the past by asking questions about previous successes and skills activates positive emotions.

The broad theory of positive emotions (Fredrickson 2009) proposes that negative emotions limited our thought-action repertoires while positive emotions enlarge our attentiveness and encourage innovative, various and exploratory thoughts and actions. The power of using open questions, focused on what clients do need ("How will you recognize this session has been useful?" "How will you recognize the problem has

been solved?' 'What has been working well?' 'What is better?'), help to broaden the arrangement of thoughts and actions. Using imagination or metaphors also generates positive emotions and has a great influence on the capability to develop concepts and actions. The use of greetings and competency questions ('How did you handle to do that?' 'How did you decide to do that?'), also stimulate positive emotions.

Homework

Homework is considered to be essential. For example, self-monitoring is the most broadly used homework, used both at the initial diagnostic stage and as a tool to monitor subsequent change. The solution-focused idea in Positive CBT means that when clients transform their constructions, which is expected to happen in the course of the sessions and between them, behavior change follows naturally. In Positive CBT, homework tasks are essential if clients thinking is useful. Homework is projected to direct clients' attention to those characteristics of their experiences and circumstances that are the most helpful in the realization of their goals. When clients are doubtful about change, they are asked to observe rather than to do something.

Another extensively used homework is the application of behavioral experiments (Bennett-Levy *et al* 2004). Positive CBT uses the same behavioral experiments as traditional CBT, but with the positive focus. In the observational experiments, the clients are invited to observe and gather data, which are appropriate for their specific positive thoughts and beliefs. When they pay attention to their positive thoughts or beliefs, the chances that clients will find confirmations for these positive approaches increase. On the other hand, when they concentrate on the negative thoughts or beliefs, the chances that clients will find evidence for the negative approaches increase. In the discovery-oriented experiments, the clients are asked to act "as if" their preferred future has happened or as they are one or two points higher on the scale of progress.

DEVELOPING MORE ADAPTIVE SCHEMAS

Schemas are core beliefs that CBT therapists play a central role in the maintenance of long-term psychiatric problems. Schemas can be effectively changed (Beck *et al* 1990). The schemas that are of highest attention in therapy are those closely connected to the negative affective states or maladaptive behavioral patterns. Everybody has self-schemas as well as schemas about others and the world that move emotional and behavioral responses. Schemas play a powerful conservation role for problems because they regulate what we notice, attend to, and reminisce about our experiences (Miller & Turnbull 1986; Padesky 1994). Management of CBT usually consists of challenging the maladaptive beliefs, as well as identifying and strengthening more adaptive attitudes. An alternative schema must be established

before the client will see the evidence and say "Well, many things look that I might be OK!"

Therapist and client need to identify alternative, more flexible schemas. It is important to find the preferred schema as early as possible. The schema change will be more efficient if the alternative, more flexible schema is the focus of data gathering and evaluation rather than the maladaptive schema. To identify the alternative, more flexible scheme, the therapist asks the client, "How would you like it to be? For self-schemas ask, "If you were not _____, how would you like to be?" For other schemas ask, "If people were not _____, how would you like them to be?" For world-schemas ask, "If the world was not _____, how would you like it to be?! For clients who cannot name an alternative, it may be necessary to ask further questions with a shift in perspective (Padesky1994). Would you prefer to be more like that?

The better alternative schema is optimally described in the client 's words. The new schema that the client decides to use is somewhat different from what the therapist would expect. Therapist sometimes wonders whether the substitute schemas should be absolute in formula or symbolize a more safe assumption. Should the real substitute to "I am unlovable" be "I am lovable sometimes to some people?" (Padesky 1994). Since the schemas are absolute, the alternative used in the treatment ought to be defined as an absolute declaration. Harmful maladaptive absolute is paired with an encouraging positive absolute. Remarkably, a negative absolute is more absolute than a positive formula of the equivalent absolute (Padesky 1994), because negative schemas suggest deficiency (e.g. unlovable never means lovable under any surroundings) whereas positive schemas indicate presence that may not be perfect (e.g., lovable means someone can love you but not automatically that every person will like you). This semantic connotation of dissimilarity between positive and negative fundamentals that a more positive alternative schema will be more stable and more capable of summarizing a range of life experiences than a negatively stated schema.

The use of continuum approaches, positive data logs, historical tests of the schema, role playing, and core belief worksheets are used to strength adaptive schema.

Continuum methods

Pretzer (1983) advises using the concept of the continuum to weigh negative and positive schemas. In its simple form, a client could be asked to rate himself on a scale between 100% unlovable and 100% lovable. The therapist could try to move the client 's self-evaluation to a center on this range to decrease absolutistic philosophy (Padesky 1994). Harmful maladaptive absolute is paired with an encouraging positive absolute. Development of the substitute and more flexible schema could be heightened only if psychotherapeutic work is prepared on a continuum that registers the manifesta-

tion of the adaptive schema. Thus, rather than using a continuum that varies from 100% unlovable to 100% lovable, it is often more productive to use a continuum that ranges from 0–100% lovable.

Role playing

One role-playing option is an exercise where the client plays a role of himself to be a child in an early life scene that evoked the negative feelings connected to the schema of current therapy focus and replaying the event to more positive experience. Firstly therapist can empathically help the client to explore the childhood experience and later asks about the child needs in this situation and who could satisfy these needs. Then they together replay the scene, and the therapist can play somebody significant to the child in this scene who helps child according to the client's needs.

To support an alternative schema with its attendant emotional and behavioral reactions, the client is frequently probed to produce a novel role from which he re-experiences the original event. For example, the client may play a role of himself as a child with the voice of his/her adult experience and may assertively respond to an abusive parent. Therapist and client may write a script for what the client can say and do in this new role. Many clients must play this new role with the therapist several times before their experience reaches integrity for them. This role playing can offer a potent first experience of what it would be like for the client to hold an alternative schema and also to respond to events and others in new ways.

Role playing will not change schemas in isolation, but must be followed with other strategies, like the historical support of alternative schema and positive daily data logs, which support new schema on an everyday basis.

Historical support for alternative schema

As schemas are created over a lifetime, a lifetime of data needs to reflect (Young 1984). The therapist helps the client to make a list of confirming evidence for new belief related to each age period of the client's life. For each developmental period (typically from 0 for every three years period), therapist and client write a summary of the data since it is the confirmation of new more adaptive assumption.

It is recommended that therapist begins with the infancy and toddler period because only a few clients will judge themselves harshly during these ages (Table 1).

Historical supporting of new circumstances can help clients to develop a more pleasant and nurturing view of themselves. The main outcome often helps the client to develop greater awareness of the ability to see more positive relationships and events. Recall of positive relationships that may have been forgotten can assist the client to learn that some people could be carrying about him from childhood in a reliable way.

Positive data log

Another method relevant to the change of the schema is using the positive data logs. This method can be presented to a client as soon as the client agrees to evaluate an alternative schema. The client has a task to look actively for the every little arguments and observation that support new schema in everyday life and keep them in a daily log. Using of positive data logs is a challenge for the therapist to help and encourage client's persistence in efforts to recognize and record data that clients even do not believe that they exist. Therapist supports this effort within the therapy session. Once the positive data log has been implemented into the therapy, the therapist should be attentive to any data declared in

Tab. 1. Historical support for the alternative schema.

What facts in the life supporting positive view for myself according to the assumption: "I have worth to love of other people – I am lovable."	
0-3 years:	parents were happy when I was born, I was a pretty normal baby, I stand up and speak very early, my grandmother loved me, and teacher at kindergarten said me, that I am lovely girl.....
3-6:	I had friend who loves me very much, we played many nice games together, when I was in examination before school, the psychologist tells the parents I am clever girl, I like other children and have empathy, if they had a problem, I had more friends in kindergarten, parents and grandparents continue with loving me
6-9:	I was good at school, make many friends, been at the „center“ of schoolmate, carrying about my little brother, most of the people love me, I have excellent friend in school, we say everything about our life
9-12:	I had two very good girlfriends, I loved them, and they loved me, I was dancing, and other girls in dance-club had good relation with me
12-15:	I helped mother and father in their conflict, I defended my mom when father criticized her
15-18:	I was admitted to secondary school, teachers and student had good relation with me, I met the first boyfriend, and I loved him and he loved me so much
18-21:	I pass the examination on secondary school, mother and father were proud of me, I was admitted to University
Summary, who I am insight: I am good girl, I love people, I wish everybody the best, I think about others, what they want, try to help others, try to be fair, support, loyal, gentle to others,	

Tab. 2. Positive data log confirming the new schema: "I am practical and handy."

Hour	Day: Thursday
6:00	I waked up early and ironed all of John's shirts – he enjoyed and thanked me. I said that it is "normal" but felt happy
9:00	I gave the director a finished project – she praised me and said she cannot imagine how they could do all things without me when I go to a maternal holiday - I felt very well after this valuation
12:45	Claire told me that even in the pregnancy, I can pretty dress and that suits me - I was pleased.
18:00	I cooked cakes with cream that everyone loves - the children were happy, and it made me happy, too
19:30	I forced myself and learned English half a hour - I am very pleased with myself

subsequent therapy sessions that could be recorded in this log. When the client discounts the prominence of the evidence, the therapist assures the client that even subtle bits of data are necessary to record (Table 2).

STRENGTHS-BASED CBT

Padesky and Moony (2012) called their approach Strengths-Based CBT and developed it as a four-step approach to building positive qualities. Strengths-Based CBT offers a supportive addition to clients who descript or display an indication of not being resilient. Furthermore, it can be used with many clients to increase relapse control towards the end of the therapy by building a personal model of resilience that can be used post-therapeutically. This approach comprises four steps to resilience (Padesky & Moony 2012):

1. Search for strengths;
2. Construct personal model of resilience;
3. Apply the personal model of resilience to areas of life problems; and
4. Practice resilience.

Step 1: Search for Strengths

The strengths according to Padesky and Moony (2012) were demarcated as strategies, beliefs, and personal resources that can encourage the resilience. Davis in his review identified several areas of competency that are linked with the resilience (Davis 1999):

1. good health and an easy temperament;
2. secure attachment and basic trust in other people;
3. interpersonal competence including the ability to recruit help;
4. cognitive competence that encompasses the capacity to read, the capacity to plan, self-efficacy, and intelligence;
5. emotional competence including diverse emotional skills such as the ability to regulate one's emotions, delay gratification, maintain realistically high self-esteem and employ creativity and humor to one's benefit;
6. the ability and opportunity to contribute to others; and
7. holding faith that one's life matters and life has meaning, including a moral sense of connection to others.

Conventionally, CBT models describe common triggers and maintenance factors for specific problems that dispose of for certain models of understanding and building an adequate therapy. Padesky and Moody (2012) recommend that CBT models for the construction of positive qualities need a different approach. They believe the best models for building positive qualities will follow a 'many pathways' method. It is not required to teach clients new skills. Instead, therapists can help clients to recognize the strengths they already possess and form resilience from obtainable strengths. People are resilient in the periods of life-related to the enjoyable or romantic interests, dedicated values or minor daily 'never miss' actions. However, people are commonly unmindful of their strengths and do not recognize themselves as resilient. For this purpose, therapists help clients to search for 'invisible strengths' within normal mutual practices and highlight these to client attentiveness. Rather than focus on domains in which the client is not resilient, depth examination of areas in which clients exhibit constant activity and that are not associated with the problems is much better. The research shows that individuals are more likely to hold mistaken beliefs and maladaptive behavior patterns in the zones of troubles than they do in zones where things function well (Clark *et al* 1989).

Once an appropriate area (i.e., not associated with the problem) is selected, the therapist articulates curiosity in the activity by smiling and articulating the interest. Positive feedback to the client is essential because individuals often feel a bit tense about revealing positive abilities to others in the absence of feedback from somebody who is pleased to listen about these. When a therapist answers back positively, clients are more probable to disclose significant information about their resilience. As a final point, the model also depends on the observation that all activities meet some difficulties. These obstacles upset people when they are engaged in activities in which they lack confidence or passion. Humans work through difficulties when they have a high degree of commitment to or pleasure of what is going on.

Step 2: Paradigma – the personal model of resilience

Therapist and client build together a personal model of resilience on the base of the strengths accepted and elab-

orated throughout the search phase. It is essential that the personal model of resilience be defined the client himself and contains client-generated imagery and metaphors as often as possible. Imagery and metaphors support the personal model of resilience to be unforgettable. Clients can often use an image or metaphor to create new ideas when different tasks present themselves.

Step 3: Apply the personal model of resilience

Once the personal model of resilience is created, the client is requested to reflect how it could help to retain resilience in case of difficulty. Common challenges in problematic conditions are reflected and written. The therapist asks clients to scan their personal model of resilience and create the concepts of what might help them continue in the case of difficulties and/or to accept characteristics of the circumstances that cannot be transformed. The focus of these dialogs is on continuing resilience in the face of problems rather than the triumph of solving or overcoming them. This change in focus is frequently somewhat exciting for clients. They often report feeling like to be less discouraged if they do not have to solve a problem but rather remain stand-up in the face of it.

4: Practice resilience

Through the final stage of Strengths-Based CBT for resilience, therapists and clients plan behavioral experiments to train resilience. Dissimilar to classic behavioral experiments, which are typically established to test specific assumptions (Bennett-Levy *et al* 2004), resilience experiments are set up to verify the quality and utility of the personal model of resilience. Both, clients and therapists can be disposed to think about experiments regarding whether they lead to a preferred outcome. When a therapist examines behavioral experiments through a 'resilience lens', problems and obstructions become chances to acquire and reinforce resilience. Therapists can work with clients in a playful way if experiments do lead to a decrease in adversity.

Once clients have practice in using their personal model of resilience in intentional experiments, therapy shifts to look for reasonable chances to practice resilience in daily situations. The clients are fortified to welcome negative life events as opportunities to train resilience. Some clients comment that this view changes life into a 'win-win' experience. If things go well, they win. If the things do not go well, they have extra chance to 'win' by being resilient. This viewpoint often allows clients to embrace challenges and can help them to stop avoidance. Thus, the practice of resilience not only helps people to cope with life difficulties, but it also reduces the amount of life events that are experienced as aversive.

Therapeutic frame for strengths-based CBT

In Positive CBT, the role of the therapist is dissimilar from the role in CBT. From being the only professional

in the room, which explores and analyzes the problem and then gives advice to clients on how to solve problems, the role changes to collaborator where clients are seen as co-experts inviting to share their expertise with the therapist. Positive CBT therapists are 'not-knowing' (they ask questions) and 'leading from one step behind.'

Therapists change their emphasis of attention by using operant conditioning principles throughout the session: 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).

The therapeutic alliance embodies an encouraging attachment between therapist and client, as well as an active and cooperative engagement in tasks designed to help the client together. The conversations with the clients are more light-hearted, which may result in less stress, depression, and burnout. Therapists should facilitate the formation of a positive cooperation and methodically monitor the relationship with the available instruments, rather than depend only on clinical impress. The client's view of the relationship (and not the therapists) is the best-known predictor of results (Duncan 2010).

Therapists need to implement new beliefs and manners when they shift to using of CBT approaches to strengthen positive abilities such as resilience. For example, Strengths-Based CBT approach contains a belief that clients now have the creative potentials they need to build new qualities. Further, the resilience model suggests that the strengths required for resilience can be found within repetitive activities. Therapists are stimulated to search actively for strengths and the mechanisms needed to build resilience inside the client's mutual daily experiences. Therapist's confidence in these beliefs can be enhanced by cognizance of the resilience research that validates resilience can develop from many diverse combinations of strengths (Davis 1999; Luthar *et al* 2000). Regarding behavior, Strengths-Based CBT supports the strategy that therapists actively encourage clients rather than accept a position of therapeutic neutrality. CBT therapists who are working to build positive qualities will discuss discovery it useful to smile more than is usual in therapy to (a) reassure client creativity and (b) communicate to clients that debates of strengths and positive ambitions are greeted and appreciated by the therapist. Therapeutic silence is also essential. Creative progressions profit from time to contemplate. When a client is requested to imagine in what way they might practice their personal model of resilience in a challenging condition, the therapist is recommended to keep silence with a slight smile on his/her expression to transfer assurance that the client can prosper in the discerning of somewhat.

Elicitation of positive imagery and metaphors is accentuated by this method. Imagery has a more mean-

ingful impact on emotion than words (Hackmann *et al* 2011; Holmes & Mathews 2010). When it arises from imagining positive events, imagery is linked to greater positive mood than thinking about positive events in words (Holmes *et al* 2009). Positive attitudes are empirically related to growth in emotional resources as well as to health improvement, well-being, and resilience (Fredrickson 2001). Thus, it appears that the use of imagery can strengthen the likelihood of enacting positive qualities in one's life. Imagery and metaphors also support clients to build novel applications of their personal model of resilience. Behavioral experiments are set up to exam the utility of a personal model of resilience rather than to assess certain beliefs. Guided discovery is applied to create new ideas rather than to cut up existing beliefs; this entails the use of constructive language and constructive questioning approaches. For example, when client says, 'I did not handle that so good this week,' a classic CBT approach is to deconstruct that statement by asking, 'What makes you think that way?'; alternatively, 'What didn't you like?' When developing positive qualities, therapists are encouraged to be constructive and ask a question towards something new, 'What do you wish you had done instead?' (Mooney & Padesky 2001). The emphasis is on the construction of new beliefs and behaviors that promote how the client would like to be, rather than testing dysfunctional beliefs (Mooney & Padesky 2000; Padesky 1994).

CONCLUSIONS

Positive CBT moves the emphasis of treatment from what is bad with clients to what is right with them, and from what is not working to what works. This change represents a paradigm modification from problem-solving to solutions and strengths-building. There are many ways to discover positive qualities, and everybody can build a personal model to develop the desired quality, drawing on strengths. Recognized strengths are then used to generate an individual model for developing that quality more useful during the client's life. Behavioral experiments are planned to test the usefulness of the individual model, and the client continues to run through the new quality until it is reinforced to the expected degree. Therapists providing Positive CBT are stimulated to familiarize some modifications in comparison to standard CBT practice such as a greater use of rewarding, facilitating, metaphors laughing, quietness, imagery, and constructive therapy interview and strategies. Next research is needed to discover how Positive CBT is distinct from, can be combined with or may be comparable or adjunctive to traditional CBT.

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