17

POSITIVE CBT TOOLS

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TABLE OF CONTENTS

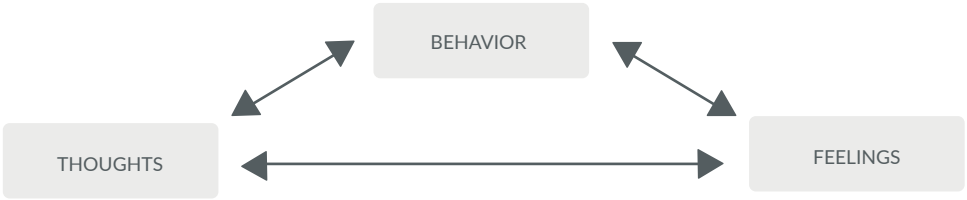
1

TRADITIONAL CBT

CBT EXPLAINED

Developed in the early 1960s by Aaron T. Beck, cognitive-behavior therapy (CBT) is one of the most well-researched psychological treatments to date. The basic premise of CBT is that what we think, how we feel and how we behave are all closely connected (see Fig. 1.1)—and all of these factors have a decisive influence on our wellbeing.

Fig 1.1 The cognitive model depicting the interrelationships between thoughts, feelings, and behavior.



CBT is a structured, present-oriented psychotherapy directed toward solving current problems and modifying dysfunctional (that is, inaccurate and/or unhelpful) thinking and behavior (Beck, 2011). According to CBT, dysfunctional thinking (which influences how a client feels and behaves) is common among psychological disturbances. Treatment, then, is guided by cognitive formulation, the beliefs and behavioral strategies that characterize specific disorders, and case conceptualization, the understanding of individual clients' specific beliefs and patterns of behavior. CBT teaches clients to evaluate their thinking in a more realistic and adaptive way, which has a positive subsequent impact on their emotional state and in their behavior. For example, if a client was socially anxious and found himself alone at a party, he might have the thought: "No one here wants to be seen with me." This thought might then lead to a particular reaction: he might feel embarrassed (emotion) and leave the party early (behavior). If this client were to then examine the validity of this thought, he might conclude that he was catastrophizing and that, in fact, everyone else was deep in conversation at that moment and someone may well have approached him soon after. He might see that he jumped to a potentially invalid conclusion. Looking at the situation from this new perspective would likely lead this client to feel more at ease and may lead to more functional behavior in the future.

As illuminated by the above example, CBT targets cognitive change—modifcation in the client's thinking and belief system—to bring about enduring

emotional and behavioral change (Beck, 2011). The thought "no one here wants to talk to me" is an example of an automatic thought, an idea that spontaneously comes to mind in a given moment. Helping clients become aware of the automatic thoughts that influence their feelings and behaviors is a key component of CBT, and often the first level of cognition addressed in treatment. CBT therapists also work at a deeper level of cognition by addressed clients' basic beliefs about themselves, their world, and other people. Such beliefs are known as core beliefs, and according to CBT, addressing a clients' core beliefs leads to lasting emotional and behavioral change (Beck, 2011). For example, the socially anxious person may hold the core belief, "I am boring." CBT therapists work to modify underlying dysfunctional beliefs (e.g., by helping this client see himself in a more realistic light as having both strengths and weaknesses) in order to produce enduring change.

TREATMENT

While treatment for each client will be individual and unique, there are certain principles that underlie CBT for all clients (Beck, 2011). First, treatment is based on an ever-evolving formulation of clients' problems and an individual conceptualization of each client in cognitive terms. Second, a sound therapeutic alliance must be established and maintained throughout treatment. Also, treatment is viewed as teamwork by both therapist and client, who collaborate and decide together on things like what to work on each session, how often sessions should occur, and what the client can do in between sessions as homework. Further, treatment is goal oriented and problem focused. As well, treatment emphasizes the present moment initially; examination of current problems and on specific situations that are distressing to the client is paramount. Furthermore, treatment should be informative, aiming to teach the client to be his or her own therapist; psychoeducation and relapse prevention are key. Moreover, treatment is time-limited, and sessions follow a certain structure in each session to maximize efficiency and effectiveness. And, treatment involves teaching clients to identify, evaluate, and respond to their dysfunctional thoughts and beliefs, and a variety of engaging techniques to change mood and behavior. These basic principles apply to all CBT clients.

RESEARCH

As mentioned above, CBT has been studied rigorously since its conception, with the first outcome study published in 1977 (Rush, Beck, Kovas, & Hollon, 1977). The efficacy of CBT has been demonstrated across a wide range of psychopathology, including major depressive disorder, generalized anxiety disorder, social anxiety disorder, obsessive-compulsive disorder, substance abuse, eating disorders,

and personality disorders (Beck, 2011; Hofmann et al., 2012). Further, CBT has been shown to be effective in the treatment of couple problems, pathological gambling, and complicated grief (Sylvain, Ladouceur & Boisvert, 1997; Beck, 2011). Furthermore, empirical support for CBT has been established for medical problems with psychological components, including obesity, insomnia, and chronic pain (Beck, 2011; Ehde, Dillworth & Turner, 2014).

2

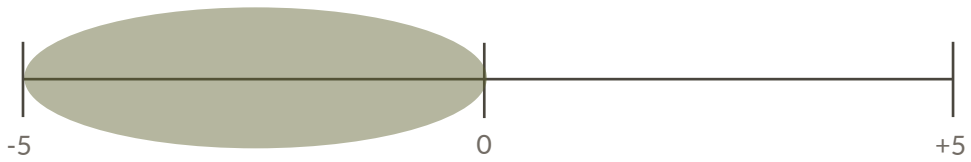
A WEAKNESS FOCUS

Traditional CBT treatment involves a strong focus on the client's current problems and on specific situations that are distressing to the client. The question "What is wrong with the client?" is at the heart of traditional CBT. It is hard to deny that it is an important question. Focusing on what is wrong with an individual is what we call a weakness focus. We place direct attention on the negative aspects of an individual. In the context of work and performance, a weakness focus means that we are primarily concerned with behavior that is causing suboptimal or low performance. For example, during a performance evaluation, the employer focuses only on why an employee is not reaching his sales targets, or why she is not able to communicate well with customers. In a clinical context, a weakness focus means that the emphasis is on behavioral or cognitive patterns that cause suffering and reduce well-being. For instance, a psychologist focuses only on the problems that the client is experiencing. From this perspective, the psychologist may discover that the client thinks negatively about the past and these thoughts cause negative consequences in dealing with the present. The idea behind the weakness focus may seem intuitive—by fixing what is wrong, we aim to make things right. As we will see, this view is far from complete and includes fundamental misconceptions about well-being.

THE DISEASE MODEL

After World War II, psychology became a science largely devoted to curing illness. As a consequence, a disproportionate amount of studies in psychology focused on psychopathology and factors that make life dysfunctional. Little research focused on the factors that promote psychological well-being. For instance, an analysis of the ratio of positive to negative subjects in the psychology publications from the end of the 19th century to 2000 revealed a ratio greater than 2:1 in favor of the negative topics (Linley, 2006). This disproportionate focus on psychopathology and markers of psychological disease has been referred to as the disease model of human functioning. The disease model can be easily explained by the picture in fig. 2.1.

Fig. 2.1 a focus on repairing weakness



In this picture, -5, represents suffering from problems, 0 represents not suffering from these problems anymore and +5 represents a flourishing, fulfilled life. The disease model is focused on the -5 to 0 part. Interventions that are grounded in this model have the goal of helping people move from -5 to 0. In a clinical context, this could mean that a therapist aims to reduce symptoms and to prevent relapse. The end goal (0-point) is achieved when the client is no longer experiencing diagnosable symptoms of psychopathology as described in the Diagnostic and Statistical Manual of Mental Disorders (DSM).

MISCONCEPTIONS RESULTING FROM THE DISEASE MODEL

Although the disease model has been the dominant view for many researchers and practitioners, there are some important misconceptions that have often been neglected or overlooked. The awareness of these misconceptions has contributed to the development of positive psychology as we know it today. In this section, we discuss some essential misconceptions that are based on the focus of the disease model.

MISCONCEPTION #1: FIXING WHAT IS WRONG LEADS TO WELL-BEING

Underlying the weakness focus of the disease model is the belief that fixing what is wrong will automatically establish well-being. However, as counterintuitive as it may sound, happiness and unhappiness are not on the same continuum. Positive affect is not the opposite of negative affect (Cacioppo & Berntson 1999). Getting rid of anger, fear, and depression will not automatically cause peace, love, and joy. In a similar way, strategies to reduce fear, anger, or depression are not identical to strategies to maximize peace, joy, or meaning. Indeed, many scholars have argued that health is not merely the absence of illness or something negative, but instead is the presence of something positive. This view is illustrated in the definition of mental health by the World Health Organization (2005): "a state of well being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community," (p. 18).

In support of this view, a growing body of research shows that the absence of

mental illness does not imply the presence of mental health. In a similar vein, the absence of mental health does not imply the presence of mental illness. Keyes (2005) found that although a higher score on subjective well-being correlates with less psychological complaints and vice versa, this relationship is far from perfect. In other words, there are people who suffer from a disorder, but still experience a relatively high level of subjective well-being, and there are people who report low levels of subjective well-being, but experience little psychopathological symptoms. This finding has been replicated in other studies using different measures and populations, for instance, in American adolescents between 12 and 18 years (Keyes, 2006), South African adults (Keyes et al., 2008), and Ducth adults (Lamers et al., 2011).

▶ MISCONCEPTION #2: EFFECTIVE COPING IS REFLECTED BY A REDUCTION IN NEGATIVE STATES

Typically, psychological interventions aim to reduce aversive states, like negative emotions or stress. This aim is in line with the disease model and is based on the assumption that a reduction in aversive states reflects both effective coping and greater well-being (or fewer problems). Interestingly, previous findings have repeatedly shown that effective coping does not necessarily mean a reduction in aversive states, like stress or negative emotions. An elegant illustration of this principle is found in the literature on dieting. For instance, research has revealed that is not the absence of stress that is related to successful weight maintenance, but rather the ability to effectively deal with stress (see, for instance, Gormally, Rardin & Black, 1980). Similar findings have been obtained in the life domain 'work'. Many studies have addressed the negative consequences of stress at work (see, for instance, Fletcher & Payne, 1980). Interestingly, research has also shown that it is not the experience of stress that is responsible for its acclaimed negative effect on health, but the way employees deal with perceived stress. For some individuals, stress can lead to positive consequences. In this case, stress is referred to as eustress, defined as a positive response to a stressor, as indicated by the presence of positive psychological states (Nelson & Simmons, 2004).

Research on eustress shows that when a stressor is being evaluated as positive in terms of its potential implications for well-being, a different psychological and physiological response follows than it does with a negative assessment. In this case, stress can improve, rather than reduce, well-being (Nelson & Simmons, 2006). Past studies have indicated support for a direct link between eustress and health (cf. Edwards & Cooper, 1988; Simmons & Nelson, 2007). These findings suggest that the way people deal with and perceive difficult experiences (i.e., eustress versus distress), rather than their occurrence, is a valuable indication of successful coping.

Further support for the idea that it is not merely a reduction in negative states that reflects effective coping comes from the literature on post-traumatic growth. Post-traumatic growth is the development of a positive outlook following trauma (Tedeschi & Calhoun, 1996, 2004). Positive changes may include a different way of relating to others, awareness of personal strengths, spiritual changes, and increased appreciation for life (Tedeschi & Calhoun, 2004). Post-traumatic growth can be perceived as an effective way of coping with adversity. It can emerge following a diversity of traumatic events, including war and terror (Helgeson, Reynolds, & Tomich, 2006). Growth following adversity, however, is not the absence of post-traumatic stress reactions, but the presence of positive states.

In sum, these findings suggest that it is important to focus on building people's strengths so that they can cope with difficult experiences. Rather than focusing solely trying on eliminating negative experiences (i.e., moving from -5 to 0), it seems important to also employ coping skills that promote well-being despite the negative experiences (moving towards +5). In support of this notion, past research has found that irrespective of the level of stress, personal resources are associated with psychological well-being (Cohen et al., 1982; Holahan & Moos, 1986; Kobasa, Maddi, & Kahn, 1982; Nelson & Cohen, 1983).

▶ MISCONCEPTION #3: CORRECTING WEAKNESS CREATES OPTIMAL PERFORMANCE

According to Clifton and Nelson (1996), the behavior and mindset of many teachers, employers, parents, and leaders is guided by the implicit belief that optimal performance results from fixing weaknesses. Indeed, in order to promote professional development, employees are typically exposed to training programs that focus on correcting their weakness. In a similar vein, evaluation interviews often focus on areas that need improvement and aspects of work that employees are typically struggling with. A similar pattern can be found at many schools. Typically, the number of mistakes/errors are highlighted when student work is corrected and when report cards are taken home, the lower grades often attracting more attention. According to Clifton and Nelson (1996), fixing or correcting weakness will not result in an optimally functioning person or organization. In their view, fixing weakness will at best help the individual or organization to become normal or average.

Research findings show that the opportunity to do what one does best each day—that is, using strengths—is a core predictor of workplace engagement (Harter, Schmidt, & Keyes, 2002), and an important predictor of performance (see, for instance, Bakker & Matthijs, 2010; Salanova et al, 2005). These findings indirectly

support Clifton and Nelson's (1996) claim that boosting strength use, rather than improving weaknesses, will contribute to optimal performance.

MISCONCEPTION #4: WEAKNESSES DESERVE MORE ATTENTION BECAUSE STRENGTHS WILL TAKE CARE OF THEMSELVES

Another misconception that contributes to an excessive focus on weakness is the belief that strengths do not need much attention because they will take care of themselves and develop naturally. Just like skills, strengths can be trained and developed deliberately, and can be lost if neglected (Borghans, Duckworth, Heckman, & ter Weel, 2008; Peterson & Seligman, 2004). For instance, research has shown that people can learn to be more optimistic (Meevissen, Peters & Alberts, 2011). In general, these studies show that over time, practice and effort can help to build new habits that boost strength use. Boosting strengths means that not only is the frequency of use increased, but also the number of different situations in which the strength is applied. When strengths are not used or trained, their potential impact on well-being remains limited. When a child who is very creative is only minimally exposed to activities that call upon creativity, the child is unlikely to develop the skills, knowledge, and experience that will maximize his creative potential. Although many strengths are already present at a very young age, they still need to be nurtured to realize their full potential.

MISCONCEPTION #5: A DEFICIT FOCUS CAN HELP TO PREVENT PROBLEMS

If we keep focusing on repairing weakness, we will increase our understanding of weaknesses. First, this means that we will increase our understanding of all the negative characteristics that accompany and predict problems and disorders. For instance, from past research we know that depression is characterized by an attentional bias towards negative information (Mogg, Bradley & Williams, 1995) and that factors like low self-esteem and low self-efficacy are negatively related to job performance (Judge & Bono, 2001). Second, a focus on repairing weakness will bring forward different ways to decrease the gap between -5 and 0 (see fig. 2). Indeed, during the past 40 years, many interventions have been developed that aimed to cure mental illness or other problems. These interventions are primarily aimed at fixing things when they have already gone wrong.

Obviously, it is important to have different interventions and treatment programs to deal with problems and setbacks. However, what we have learned over 50 years is that the disease model does not move us closer to the prevention of problems. When it comes to prevention, the question is not "How can we treat people with problem X effectively?", but "How can problem X be prevented from occurring?"

Working exclusively on personal weaknesses and disorders has rendered science poorly equipped to design effective prevention programs. During the past 50 years, the disease model has not helped us to move closer to the prevention of serious issues, like burnout, depression, or substance abuse. Major advances in prevention are largely the result of a perspective that systematically builds competency rather than corrects weakness (see, for instance, Greenberg, Domitrovich, & Bumbarger, 1999, for a review of effective prevention programs for youths). In order to design effective prevention programs, we must also focus on the +5 part (see fig. 2): Why do some people flourish despite difficult circumstances? How do some employees avoid burnout symptoms? Why do some employees show a high level of work engagement? What are the characteristics of resilient and flourishing individuals, and what can we learn from them? How can we use this knowledge to design interventions that help people become resilient so that they are capable of bouncing back when the going gets tough?

3

POSITIVE CBT

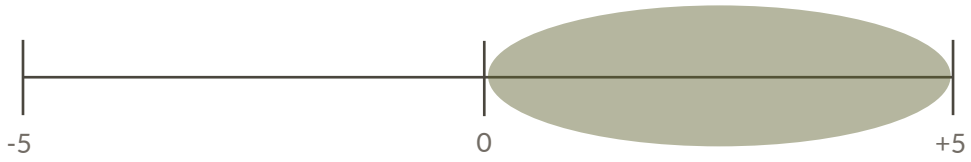
THE ROOTS OF POSITIVE CBT

In 1998, Martin Seligman strongly encouraged the field of psychology to widen its scope and move beyond human problems and pathology to human flourishing. Seligman introduced the field of positive psychology. According to Seligman (2002), positive psychology aims to move people not from -5 to 0 but from 0 to +5 (see fig. 2), and to do this, a different focus is needed. Rather than merely focusing on what is wrong with people and fixing their problems, the focus should also be on what is right with people and boosting their strengths.

The questions that positive psychology aims to answer are: What characteristics do people with high levels of happiness possess? And, what qualities do people who manage their troubles effectively have? In other words, what strengths do these people possess? These questions do not fit the disease model. These questions force us to consider the bigger question of "What is right with people?" If we learn what differentiates happy and resilient people from unhappy and unresilient people, then we can use this knowledge to increase happiness and boost the resilience of others.

An important mission of positive psychology research is, therefore, to investigate human behavior using a strengths approach. This focus on human flourishing and markers of psychological well-being has been referred to as the health model of human functioning (see fig. 2.2).

Fig. 2.2 a focus on building strengths



CRITICAL NOTES

At first sight, the previously discussed misconceptions about a deficit focus may give rise to the idea that one should predominantly focus on human strengths, rather than weaknesses. While it may be true that correcting weakness will not create optimal performance or well-being, it is also true that only focusing on human strengths while ignoring weaknesses will not automatically lead to optimal performance or well-being. Especially when weaknesses cause problems or hinder optimal strength use, they need to be addressed and managed. While

many traditional psychologists may falsely believe that taking away negatives will automatically create positives, positive psychologists and practitioners must avoid the trap of believing that creating positives will automatically take away the negatives. As discussed above, the positive and negative are on two separate continua. Attention must be paid to processes for building the positive and to processes for coping with the negative. For this reason, positive psychology can best be considered as an addition to existing psychology, not a replacement. It can best be considered as an enrichment of the field, rather than a rejection of it. Or, to use Seligman's words: "Positive psychology is not just happyology" and "is not meant to replace psychology as usual," (Seligman, 2001).

Although a vast amount of research has addressed aspects of human functioning that are linked with lower levels of well-being, it is incorrect to categorize psychological research in terms of positive and negative. These are evaluative terms and raise the false impression that research can be categorized as "good" and "bad" or "right" and "wrong." First, psychological research aims to shed more light on human functioning in general; it is not devoted to positive or negative human conditions. Moreover, increasing insight into aspects that hinder well-being is equally as valuable asinto those that promote well-being. Categorizing studies on human dysfunction as "negative psychology" should, therefore, be avoided.
When examining the psychopathology and clinical psychology literatures over the past 40 years, one could conclude that this research has mainly adopted a "negative" view of human functioning. However, the field of psychology reaches far beyond the subdomains of psychopathology and clinical psychology. Examples of other subdomains include health psychology, social psychology, developmental psychology, and organizational psychology. Many studies in these other domains have focused on well-being for years, even before the introduction of Positive Psychology in 2000. These studies have primarily focused on the positive side of human functioning, addressing topics like job satisfaction, safe sex practices, and high self-esteem.

POSITIVE CBT

Positive CBT is a term coined by Fredrike Bannink (2012) and rooted in positive psychology. According to Bannink, "In Positive CBT there is a different focus from that of traditional CBT. The focus is on clients' adaptive, operant behavior, rather than on passive, respondent behavior" (Bannink, 2012, p. 16). In other words, just like positive psychology, the main focus of Positive CBT is no longer solely on pathology, on what is wrong with the client and on repairing what is not working, but on strengths, what is right with him and on promoting flourishing. The focus is no longer on merely reducing problems, but also on building competencies. Basically, positive CBT is traditional CBT applied through the lens of positive

psychology. The most important difference between traditional CBT and positive CBT are summarized in table 3.1.

Table 3.1 Differences between traditional CBT and Positive CBT

Traditional CBT	Positive CBT
Interventions designed to increase well-being by diminishing that which causes pain and suffering	Interventions designed to increase well-being by enhancing that which causes or constitutes human flourishing
Avoidance goals: away from what clients do not want (problems or complaints)	Approach goals: towards what clients do want (preferred future, what clients want to have instead of their problems or complaints)
Past or present oriented; cause and effect medical model	Present and future oriented; letting go of cause- effect medical model
Analyzing problems is important	Designing positive outcomes and analyzing exceptions is important
Focus on problems and weaknesses	Focus on solutions and strengths
helps to clarify the current position of the boat	helps the client increase awareness of his current values, goals, strengths, weaknesses, etc.
Conversations about what clients do not want; positive reinforcement of "problem-talk"	Conversations about what clients do want instead of their problems; positive reinforcement of "solutions-talk"
The problem is always present"	The problem is never always present; there are always exceptions
Success is defined as the solving the problem	Success is defined as reaching the preferred outcome, which may be different from (or better than) solving the problem

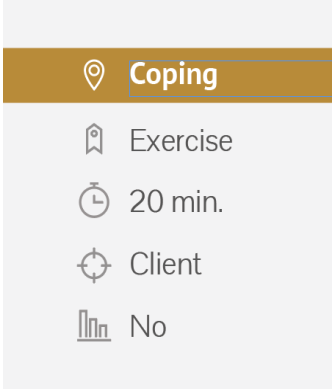
4

THIS PRODUCT

This product contains 17 different positive CBT tools. Each tool is structured in the same way, consisting of a background section, a goal description, advice for using the exercise and suggested readings.

UNDERSTANDING THE ICONS

On the first page of every tool, a legend is shown, consisting of several icons:



- The first icon displays the main category the tool belongs to.
- The second icon shows the type of tool. The following options are available:

» Exercise (a tool that describes an activity that is done once, during a session)
» Assessment (a tool that aims to assess a trait or characteristic of a person)
» Overview (a tool that provides an overview or list of something; research findings, facts, etc.)
» Advice (a tool that is directed at the helping professional providing advice on how to carry out a certain activity)
» Meditation (a tool that describes a form of meditation)
» Intervention (a tool that describes an activity that needs to be done more than once during a certain period)

- The third icon provides an estimation of the duration of the tool. In other words, how long it takes to complete the exercise. This is always an estimation of the total time it takes. Note that for some tool types, like overview, advice, protocol and intervention it is difficult if not impossible to provide an

estimation of the duration. In these cases n/a (not available) is written.
- The fourth icon describes the intended audience for this tool; available options include client, coach or group.
- The last icon indicates whether this specific tool has been tested at least once in a scientific study and has been published in a peer reviewed journal (yes or no). Note that if there is a strong theoretical and scientifically tested basis underlying the tool, but the tool itself in its current form has not been directly addressed in research, the icon will still indicate "no".

USING THE TOOLS

Please note that the tool in this product are not a substitute for a clinical or coaching certification program, which we recommend you take before you call yourself an official "therapist" or "coach" and before you see clients or patients.

Note that you are advised to use these tools within the boundaries of your professional expertise. For instance, if you are a certified clinician, you are advised to use the exercises within your field of expertise (e.g. clinical psychology). Likewise, a school teacher may use the exercises in the classroom, but is not advised to use the exercises for clinical populations. Positive Psychology Program B.V. is not responsible for unauthorized usage of these tools.

5

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