

Helping clients help themselves



Photograph: Mike Park, University Photographer, the University of Hull

Active in the evolution of CBT over the past four decades and acknowledged as the most influential therapist in the field internationally, **Christine Padesky** aims to put herself out of business by teaching people skills they can use to help themselves

Interview: James Rye

In your psychology training you initially learned a person-centred therapy approach. Can you tell us what drew you to CBT?

In the late 1970s I was a graduate student member of a research team at UCLA. We were trying to help people with depression, and at that point purely humanistic methods of empathy, being interested and doing problem solving with depressed clients, really weren't being very effective. My faculty advisor and I had published a research article on gender differences in response to the Beck Depression Inventory, and Dr Beck sent us a copy of a manual which eventually would be published a year or two later as *Cognitive Therapy of Depression*.¹ When I read that I got very excited because it seemed like it was a therapy approach that was ideally suited to depression. It was very collaborative and skills based. I have always been very interested in being the type of psychologist who hopes I can put myself out of business by teaching people skills that they can use to help themselves, so they don't need to come to therapy. So cognitive therapy was very appealing to me because it gave me a very clear format in which I could teach depressed people skills that could help them learn how to manage their depression themselves. That was initially what attracted me to CBT.

In my early days as a therapist I was trained primarily in client-centred therapy, Gestalt therapy and behaviour therapy. And then I learned cognitive therapy and eventually became a CBT therapist. But as a therapist I think we bring our entire person to each encounter with a client, and so I bring my client-centred therapy training and my Gestalt training and every human experience that I've ever had to my therapy sessions. What makes me a CBT therapist is not any particular CBT method (this is something I learned from Dr Beck), but it's a framework. I really do look at the links between thoughts, behaviours, emotional reactions and physical responses, and also the environment (that's been something very important to me because I have strong roots in social psychology as well) – so looking at the cultural and behavioural context. When you put all these things together, it's that conceptual framework and way of looking at things that makes me a CBT therapist. But I might in any given session be using primarily client-centred methods, or primarily techniques that people might recognise as CBT, or I might be using a strengths-based approach. But I always have that overall CBT framework.

What I like about a CBT framework is that it tends not to be pathological. CBT philosophically sees people as doing the best they can to cope and get along well in life, and we tend not to look at people as collections of pathologies, which some systems of psychotherapy historically have done. So that's part of what appeals to me. I'm not someone who tends to see pathology. I'm much more interested in strengths and

in how people manage to get on as well as they do in the world, given all the stresses, strains and complications they face during the course of their lives.

Some people are suspicious about CBT, claiming that it is too mechanistic and doesn't deal with emotion. How would you respond to that?

Well, unfortunately some people do practise CBT in a very mechanistic way and some of those people have taught CBT in that way, so I think that prejudice comes about sometimes from good data, for good reason. But sometimes people don't recognise that CBT in its early days, and for the most part over the years, has been geared to people who have a lot of emotion on board – people who are highly depressed, highly anxious. When people are already having a lot of emotion, then sometimes it helps for them to look at things in a different way – a less emotional way – and so the cognition aspect is often emphasised to help them shift their perspective, so their emotion gets into a range that is easier for them to manage.

What people less familiar with CBT may not realise is that for people who keep emotion at arm's length – I work a lot with people who are highly avoidant of emotion – then we use lots of emotion-inducing methods. In fact, in our anxiety treatments, if people are not anxious, we do things to make them more anxious during therapy. Dr Beck always told me, 'You can't do cognitive therapy unless there is emotion present.' So, we certainly want emotion present in the room. I think it is a question of keeping the emotion in a good working range for psychotherapy – which may mean sometimes increasing the emotion, and at other times using methods that will actually serve to decrease the emotion in the room.

One of the other things I have heard said is that CBT is OK for certain presentations. Do you think that there are certain presentations that it would be inappropriate to use CBT with?

I do. However, I think it's a very narrow band. To put a historical context on it, when the first book, *Cognitive Therapy of Depression*, was published, the last chapter had a long list of things you should not use cognitive therapy with

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– things like personality disorders, psychosis etc – and now there are major CBT textbooks written about those things. I think it shouldn't be used for things that therapists themselves have not been trained in and don't know how to use it for. And certainly, for myself, I wouldn't use it for things that I don't have clinical knowledge about. But I think, in general, a therapist who is educated in CBT, might use it for almost anything except for people who have had some kind of brain injury or dementia that might interfere with memory, cognitive processing etc. That said we've always had a principle that the lower the functioning of the patient, the more behavioural our methods are and the less cognitive. In my own practice, I'm a CBT therapist and any person I feel competent to treat because I know about the sorts of things bringing them to therapy, I've found a way to work with them using the CBT model.

It does sadden me that some people in our field present a very narrow representation of CBT. I'm a bit unusual in that I'm a CBT generalist because as a private practitioner and now as a teacher of many topics, I've had to educate myself over the years about many different CBT applications. Some other people have done research and clinical practice in a very narrow field, and so they may come across as representing CBT in quite a narrow way. I think over the years I've developed more of an appreciation of the depth and breadth of CBT because I do see CBT as a very full system of psychotherapy with theoretical models and conceptual frameworks for many issues and a diverse range of methods that can be used. So for me, CBT is multi-layered, which I especially appreciate because I've had a front seat view and participated in the evolution of the field. I have quite a breadth of understanding of CBT, which I try to capture in my workshops and writings.

An increasing number of people in the UK are describing themselves as 'integrative' and the number of integrative training courses is growing. In your view, can parts of CBT be integrated into other models? One of the things that struck me when I came to your workshop in London in May 2014 was that someone whispered in my ear, 'This is similar to solution-focused therapy.'

Yes, many therapists who are CBT therapists started out integrating a bit of CBT into the therapy that they did, and then they got more enamoured with CBT. There are many therapists who integrate parts of CBT into the work that they do, and I actually encourage that. I don't think, if you've been practising one form of psychotherapy for a number of years, that it makes sense overnight to say, 'I'm going to switch to a different type of therapy.' I think you want to try out some therapy methods and see if they suit you and whether they seem to benefit your clients or not. The one concern I have about that is that if you are going to integrate CBT, you need to integrate a big enough chunk for it to actually be CBT. The vast majority of the therapists in the United States identify themselves as CBT therapists, but if you look and see what many of them do, I wouldn't recognise it as CBT. And so I've interviewed some therapists who say they are doing CBT, and I say, 'What makes you a CBT therapist?' and they'll say something like, 'Well, I ask people what they're thinking.' Well, I mean, that would be akin to me saying, 'I'm a psychodynamic therapist because I ask people, "What kind of family did you have, growing up?"'

So I would encourage people to maybe identify an area of their practice where they are not having success using whatever they are typically doing, or identify a part of CBT that they find appealing to them, and then learn a big enough chunk of it so they can practise it. So maybe if you're not

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making good progress with your depressed clients, you might say: 'OK, I'm going to learn enough about behavioural activation to use that with my depressed clients.' Or, 'I'm going to learn enough about how to use thought records so that I can teach my clients that skill.' And I may not do CBT with my anxiety clients or my couple clients, or whatever. So I think that's the main thing. Certainly CBT can be integrated. And Dr Beck, who I have had the benefit of knowing for 35 years now (and he and I taught together for many years), has always encouraged that as well. He never thought that therapists had to overnight become CBT therapists.

Great. That's a relief, as I feared the answer might be different to that.

Well, you know, I think Britain tends towards specialism. You have specialties. Looking at your university system it just astounds me that you're meant at the age of 18 to decide what you want to do and start studying that thing in depth. In the United States we are more generalists who specialise later in our careers. And so some in Britain think that you shouldn't even say you're doing CBT unless you're fully certified as a CBT therapist, and I really disagree with that. If you're interested in CBT, learn enough of it to give it a try, see if it benefits you and your clients. You know, CBT itself is very empirical, involved in testing things out. So I encourage therapists to do the same thing – learn enough to test it out and see if it's worthwhile or not.

I think to call yourself a CBT therapist you have to be fully trained, but there is no harm in getting some training and trying CBT out. Actually that's one of the reasons we wrote *Mind Over Mood*.² We wrote it for therapists who didn't really know that much about CBT but wanted to teach people who were depressed how to use thought records or other evidence-based methods – we hoped it could help therapists deliver CBT in a more competent way.

In the workshop I attended you mentioned CBT and imagery. Could you say more about that?

There is increasing research on imagery and the role that it plays. We are learning so much about thought processes and finding that the most important parts often aren't in words but they are in images. Our mind thinks about things in much more holistic ways. We don't think in very linear, analytic ways most of the time. As John Teasdale³ wrote about when he was at Cambridge, we have these two systems of thought, one of which is more analytic and rational, but the other which is more holistic and involves imagery, narration, storytelling and all of those kinds of things – the difference between prose and poetry, if you will. So, I'm very interested in all the research from cognitive psychology to neuroscience

that is articulating more clearly these systems. And I think, in terms of working with clients, imagery and metaphor are two of the main ways that we can tap into these other systems of knowing and thinking about things. And when people have very strong emotional reactions to things, or when they're really stuck deeply in ruts of behaviour patterns, very often it's through imagery and metaphor that we can bring about change more quickly. So I'm interested both in using classic CBT methods of identifying and testing out thoughts and images, as well as more purely paying attention to imagery and metaphor in that process. And also, of course, when we help people to construct new beliefs, to try to get people to come up with new creative ways of being in the world, imagery is one of our great allies because people can imagine new ways of being through imagery more quickly than they can usually articulate in words what they want to be doing.

Thank you so much for sharing your thoughts. My pleasure. I hope they are of some interest to therapists in the UK. ●

References

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About the interviewee

Christine A Padesky, PhD, co-founded in 1983 the Center for Cognitive Therapy in Huntington Beach, California. She is a Distinguished Founding Fellow of the Academy of Cognitive Therapy and former President of the International Association for Cognitive Psychotherapy. In 2002, the British Association of Behavioural and Cognitive Psychotherapies (BABCP) named her the Most Influential International Cognitive-Behavioural Therapist. In 2007 the Academy of Cognitive Therapy honoured her with its Aaron T Beck Award for enduring contributions to the field.

Find out more

Christine Padesky is teaching the following forthcoming workshops in the UK: 'Strengths-based CBT for vulnerable clients and chronic issues' in London, May 18-19; 'Anxiety traps! CBT solutions' in Manchester, May 29-30; and 'Best practices in CBT for depression and suicide' in Derby, June 1-2. For further details and to book, visit <http://padesky.com/calendar/>

Your thoughts please

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