



<b>Title</b>	Christine Padesky pushes the boundaries of Cognitive therapy in Dublin
<b>Authors(s)</b>	Carr, Alan
<b>Publication date</b>	2001
<b>Publication information</b>	Carr, Alan. "Christine Padesky Pushes the Boundaries of Cognitive Therapy in Dublin." The Psychological Society of Ireland, 2001.
<b>Publisher</b>	The Psychological Society of Ireland
<b>Item record/more information</b>	<a href="http://hdl.handle.net/10197/6549">http://hdl.handle.net/10197/6549</a>

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**Christine Padesky Pushes the Boundaries of  
Cognitive Therapy in Dublin**

**A Workshop Report**

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**Carr, A. (2001). Christine Padesky pushes the boundaries of Cognitive therapy in Dublin. *Irish Psychologist*, February, 86-87. Paper Submitted to Chris Morris, Editor of the *Irish Psychologist* in December 2000**

Despite floods and strikes of all sorts, a few hundred of us gathered in the Swift Centre at St. Patrick's Hospital in James's Street on December 7<sup>th</sup> and 8<sup>th</sup> to attend a ground breaking workshop presented by Dr. Christine Padesky, Director of the Centre for Cognitive Therapy in California and leading international expert in the field.

The workshop was organised by Dr. Tony Bates (Director of the M.Sc. in Cognitive Therapy at TCD) and Dr. Kate Gillespie (Director of the Cognitive Therapy Programme in Belfast).

The first day of the workshop dealt with basic skills in cognitive therapy and on the second day the focus was on a new protocol for working with clients with recurrent problems.

### **Balancing Alliance Building and Structuring**

The first half of day one focused on balancing the use of alliance building and structure maintaining skills in the early stages of therapy. Through a series of carefully crafted role plays (with Mairead Doyle from the UCD Clinical Psychology Programme playing a very credible borderline patient) Christine showed how an overreliance on either alliance building or structuring skills can compromise therapeutic progress. In contrast a careful balance of alliance building skills (such as the use of reflection and empathy) with structuring skills (such as specifying therapeutic goals) can greatly facilitate forward motion in therapy.

### **Guided Discovery**

In the afternoon of the first day Christine outlined and demonstrated the four key processes involved in guided discovery:

Asking carefully crafted open informational questions to illicit a detailed account of problematic episodes,

Listening empathetically and reflecting important aspects of what the client does and does not say,

Periodically summarising and writing down key aspects of the client's experience,

Asking, synthesising and analytic questions.

With synthesising questions, a therapist asks clients to explain how one aspect of their experience fits together with another aspect of their experience. With analysing questions the therapist gives a summary of two or more aspects of the clients experiences simply asks the client "What do you make of that?". In response to these synthesising and analytic questions clients state their 'discovery'.

After demonstrating the guided discovery process we (the entire audience) were invited to interview Christine using the four stages of the guided discovery outlined above. Different members of the audience had opportunities to take the microphone and ask Christine guided discovery oriented questions, offer empathy, summarise or ask analytical or synthesising questions. During this exercise Christine role played a patient with multiple problems. The exercise highlighted how difficult it is to follow the guidelines and not slip into patronising or advise-giving.

### **Working with people with multiple problems**

On the second day of the workshop Christine explained and demonstrated a new protocol for working with clients who have multiple problems and have been through multiple episodes of therapy and have failed to respond to routine cognitive therapy protocols. This is an approach which she has developed for working with people who have personality disorders, particularly borderline personality disorder. Throughout the course of the day she explained the steps involved in the process, role played the process with one of the workshop participants and invited all of us to work in triads (therapist, client, observer) to try and practice the various steps of the protocol. The procedures involved in the protocol were as follows.

First, the therapist invites the client to make a problem list and from that select a central recurrent problem.

The second step involves inviting the client to create a possibilities list of how they would like to be in the future and identify quite specific goals.

In the third stage the client identifies pivotal underlying assumptions which maintain the recurrent problem and these normally take the format of 'if A then B' statements. For example, if a persons central problem is they are always too busy and exhausted and the underlying assumption maybe "If I'm asked to do something, then I should always do it"

In the fourth stage of the protocol the client is invited to explore all the benefits of engaging in the recurrent problematic behaviour. At this stage it is possible for the therapist to create a compassionate formulation of the clients problems showing how apparently how irrational and bizarre behaviour is understandable and meaningful in light of the clients underlying assumptions and the benefits which come from behaving in a problematic way.

The next step is to invite the client to point out the costs of the difficult behaviour for example someone who is extremely busy and exhausted persistently may have limited amounts of time for friendship, pleasure and the finer things in life. At this point the protocol takes a twist in terms of routine practice of cognitive therapy. Rather than chip away at the underlying assumptions which maintain the recurrent problem behaviours by finding evidence to refute them what Christine does in the fifth stage of this protocol is to help clients identify, visualise, imagine and envisage a highly vivid possibility goal. To do this Christine may invite the client to close their eyes, create visual, auditory and aesthetic images of their possibility goals. Clients who are unable to visualise how they ideally would like to be maybe invited to select an icon who they can substitute for themselves and imagine this person acting out their possibility goals. So, for example a person whose central difficulty is being overly busy and exhausted may imagine themselves involved in highly enjoyable leisure activities, friendships and relationships. A key to this part of the protocol is to help the client connect experientially with his or her possibility dream or vision rather than just stating in a logical and analytical way how they would like to be. To help us understand the process of creating possibility goals Christine drew a distinction between experiential and the rational mind with reference to the work of Seymour Epstein's (1998) *Constructive Thinking: The Key To Emotional Intelligence*.

Once the client has created a possibility goal the therapist then invites the client to identify the new underlying assumptions and principals which support the possibility

goal. For example, if the central difficulty is overwork and exhaustion, and the client's possibility vision may involve engaging in more leisure and relationship oriented activities, at this stage in therapy they are invited to identify new principals and assumptions such as "If I'm asked to do some further work, then I can say No or delegate other aspects of my work if I say Yes" or " If a possibility of a new leisure activity comes up that I would like, then I can say Yes to it and simply change the pace at which I complete my job of work."

In the seventh stage of this new protocol the therapist and client work together collaboratively to develop behavioural experiments to evaluate the new underlying assumptions associated with the possibility dream. These experiments may involves self monitoring and observation, and using graded tasks to test out if their new beliefs, evaluating outcomes, solving problems posed by new behaviours and beliefs. With all of these homework experiments the client is invited to look for the evidence of the possibility vision in everyday events inside and outside therapy; to maintain a focus on the possibility goal rather than the problem; to use humour to keep the shift in perspective from the problem to the possibility; and to celebrate all movement toward the possibility vision.

The eighth stage of the protocol involves tolerating ambiguity and doubt. This applies as much to the therapist as to the client. With this type of work, unlike other cognitive therapy protocols there is little certainty about what the outcome of therapy will look like. So both the therapist and the client have to trust that identifying possibility visions and related assumptions; conducting behavioural experiments to check out these assumptions; and reaching the possibility goals are processes that will lead to a fruitful end result. However, there can be little certainty about what this end stage will be.

The final aspect of the protocol is the maintenance of change. In order to maintain change the possibility vision and the related assumptions must be made completely explicit. Clients must give themselves credit for how they are coping and

expect variations in their own coping including upswings and downswings. During downswings clients should be encouraged to view these as a part of progression rather than regression; to be a coach rather than a critic; to remind oneself that taking risks helps; to remind oneself that ambiguity and doubt are signposts to newness. To maintain change it is also important for clients to be invited to trust themselves to explain to important members of their network what they are doing to celebrate change; to allow themselves to be inspired by the experiences of others, movies, stories, icons, myths, music and the possibility dream itself, as they continue to reassess the possibility dream and their new belief system.

A fuller account of this protocol is given in an article by Kathleen Mooney and Christine Padesky: 'Applying client creativity to recurrent problems, constructing the possibilities and tolerating doubt' *Journal of Psychotherapy*, Vol 14, p.149-161.

### **Closing comments**

I was struck at the close of the workshop that this new protocol developed by Christine Padesky is an important integrative bridge between cognitive therapy and other systems of psychotherapy. It may also serve as a bridge between cognitive therapists and sceptics from other therapeutic traditions. For example, there are very obvious parallels between Padesky's new protocol and Solution Oriented Narrative Therapies currently in vogue among family therapists. The emphasis within Padesky's work on the importance of experiential learning and internal representations of self and other (in the form of if/then statements) holds much in common with object relations approaches to psychodynamic psychotherapy. The warmth and compassion which Padesky brings to her work would make it difficult for people within the client-centred and humanistic movement to be critical of cognitive therapy for its over-emphasis on the cerebral and for 'not having a heart'.

The structure and teaching style Christine used within the workshop created a

wonderful learning environment and a tremendous learning atmosphere. This workshop marked an important milestone in the development of cognitive therapy in Ireland and we are extremely grateful to the organisers particularly Tony Bates for making this event happen.