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BRIEF RATIONAL EMOTIVE BEHAVIOUR THERAPY: CONTEXT AND RATIONALE

Currently, there is a great deal of interest in brief therapy and most of the predominant therapeutic orientations have spawned brief forms of treatment. The number of books that have been published on this subject is growing and there is now a *Handbook on the Brief Psychotherapies* (Wells & Gianetti, 1990). In this opening chapter, I will do the following. First, I will consider the reasons for the growth of brief therapy; second, I will consider the issue of who is suitable for brief rational emotive behaviour therapy; and finally, I will provide a brief outline for the rest of the book.

THREE REASONS FOR THE GROWTH OF BRIEF THERAPY

It seems to me that the stimulus for the growth of brief therapy is threefold. First, there is the question of finance. In North America, insurance companies which are responsible for funding, at least in part, the psychotherapeutic services received by many people are increasingly unprepared to pay for long-term therapy. The tremendous growth of 'managed' mental health care schemes that has occurred recently in the States is designed to keep treatment brief and therefore cost-effective for the insurance companies. Whether they like it or not, many American therapists are turning to the brief therapy literature to discover how they can practise therapy briefly in order to maintain their livelihood.

Second, there is the related question of resources. In Britain, the field of counselling and psychotherapy has recently come under close critical scrutiny (e.g. Dryden & Feltham, 1992; Persaud, 1993). This is a

sure sign that these activities are being increasingly accepted by the general public. Agony aunts and uncles are constantly recommending their correspondents to seek counselling or therapy for their problems and it is not unusual for soap opera characters to be seen going off for a counselling session or even talking in the session itself. What this has meant is that currently in Britain it is far less 'shameful' to seek therapeutic help than in the past. This has led to an increase in the demand for counselling and psychotherapy in both the public and private spheres.

In the private sphere, this is not a problem when counselling and therapy are inexpensive, since clients are usually prepared to pay for it out of their own pockets. However, when such private help is more expensive, and this usually means that private psychiatric services are involved, there is greater reliance on insurance companies which, in Britain, are even more reluctant to pay for long-term 'outpatient' therapy than their American counterparts. This again has led private hospitals and clinics to think in terms of short-term psychotherapeutic intervention.

In the public sphere, the increased demand for services has not been met by increased resources. In short, a growing number of people in distress are seeking counselling and psychotherapy services from a static or even shrinking population of public-sector professionals. This again has led these professionals to offer brief (and sometimes very brief) intervention. Again these workers are looking for information on how to practise briefly and are turning to the literature and brief (naturally!) training workshops.

The impetus for offering brief intervention can also be seen in the voluntary helping sector in Britain. Counselling agencies run by MIND, for example, offer a set, small number of sessions to clients (e.g. six sessions) which in some cases can be renewed for a further set number of sessions. However, long-term therapy is not generally on offer. An exception to this norm of brief interventions is found in centres run under the auspices of Relate: National Marriage Guidance who according to its Head of Counselling discourage the blanket application of the practice of brief therapy (Hill, personal communication).

The third impetus for the development of brief therapy is the realization that a number of clients do not require long-term therapy and actually benefit from a brief intervention. The idea that more therapy is better for everyone is now considered a very outmoded one. In the past, therapy was brief by default which meant that clients dropped out early from therapy, while increasingly now therapy is brief by design in that this intervention is regarded as a treatment of choice for some clients. The

development of brief therapy by design rather than by default has itself led to an interest in (i) assessment for brief therapy (i.e. who will benefit from a brief intervention and how we can identify them), and (ii) the ingredients of an effective brief intervention. In this book, I will address these questions from the perspective of Rational Emotive Behaviour Therapy (REBT), a system of therapy which I will introduce in Chapter 2. However, readers interested in how practitioners from other perspectives address these questions should consult Budman (1981).

Readers may be wondering what exactly constitutes brief therapy. As might be expected there is no consensus on this point. Brief therapy can range from one session to 50 or 60 sessions depending on which authority one consults. Most people, however, would probably agree with Budman and Gurman (1988) who say that brief therapy is 25 sessions or less. To complicate matters, the approach to brief therapy that I discuss in this book is based on 11 sessions. It would be nice if such diversity did not exist, but the reality is different and as we shall see, REBT urges us to accept reality even if we dislike it!

WHO IS SUITABLE FOR BRIEF REBT?

There is much debate in the brief therapy literature concerning who is suitable for brief intervention. Some theorists (e.g. see Davanloo, 1978) argue in favour of stringent inclusion criteria while others (e.g. Budman & Gurman, 1988) are more liberal in their views on who is suitable for brief therapeutic intervention. In this section, I will outline my views on the question: who is suitable for brief REBT?

Suitability Criteria

In my view, there are seven indications that a person seeking help will benefit from brief REBT.

1. The person is able and willing to present her problems in a specific form and set goals that are concrete and achievable.

It often occurs that at the outset people seeking therapeutic help talk about their problems in vague, abstract terms. Your task as a brief REBT therapist is to help them as quickly as possible to translate these abstractions into specific problem statements. You will be able to do so with most people, but a minority are either unable or unwilling to discuss their problems or goals in a concrete form. If the person is able to specify

her problems and goals, but is not willing to do so, perhaps because she doesn't think it would be helpful to do so, then this person is not a good candidate for brief REBT or even for longer term REBT. In such instances it is useful to discover what she thinks will be therapeutic for her and then make a relevant referral. When a person appears unable to discuss her problems and goals in concrete terms, she is also not a good candidate for brief REBT, but may do better in longer term REBT, where you may be able to train her to be specific. You need to be cautious here, however, as some individuals have cognitive deficits which prevent them from being concrete. If you suspect that this is the case you may wish to refer the person for a neuropsychological assessment in the first instance.

2. The person's problems are of the type that can be dealt with in 11 sessions.

In my opinion, brief REBT is indicated when the person's problems are not severe. They may 'feel' severe to the person, but this is not what I am referring to. Rather, by the term 'severe' I am talking about problems that are chronic (i.e. not of recent onset) AND that significantly disrupt the person's life. It is the presence of both of these problem characteristics that, for me, contraindicates brief REBT. It could well be that a person may have a chronic problem that does not significantly disrupt his life or he may have a significantly disruptive problem that is acute (i.e. of recent origin). By themselves, these problems are not contraindications for brief REBT. However, like all forms of brief therapy, brief REBT works best when the person's problems are not in the severe range.

It is important to recognize that the person seeking help may come to therapy with a number of problems, some severe and some not. The person may be a good candidate for brief REBT if he is prepared to target his less severe problems for intervention AND the existence of his severe problems does not prevent him from doing so. However, unsurprisingly, it is more often the case that he will wish immediate help for his severe problems. In which case, longer term REBT should be offered instead of brief treatment.

3. The person is able and willing to target two problems that she particularly wants to work on during therapy.

It is as important to realize the limitations of brief REBT as it is to appreciate its strengths. One of its limitations is that, in all probability, you will not have the time to deal with all of your client's problems in depth. My view is that in 11 sessions you only have time to deal with two of your

client's problems in depth, while perhaps having the time to see the linking themes across her problems and doing SOME work on what I call the CORE irrational beliefs that underpin these problems (see Chapter 8). Given this, if the person seeking help cannot, for whatever reason, limit herself to working on two target problems, then brief REBT is not the modality of choice for this person and longer term REBT should be considered. I should add that if the person targets only one problem for change, then brief REBT is indicated. She doesn't have to target exactly two target problems. One will do!

4. The person has understood the ABCDEs of REBT and has indicated that this way of conceptualizing and dealing with his problems makes sense and is potentially helpful to him.

As will be shown in Chapters 2 and 3, REBT is based on a specific model of psychological disturbance and its remediation. In my view, it is important that the person seeking help understands the nature of this model so that he can make an informed decision whether or not to commit himself to brief REBT. This is why I believe that in this approach to brief treatment it is important for you to explain the REBT model of psychological problems and their treatment in the first session. This is done by teaching your client the ABCDEs of REBT (see Chapter 3). If your client has understood this model and thinks that this way of conceptualizing and dealing with his problems makes sense and is potentially helpful to him, then this is a good sign that he could benefit from REBT. If he thinks that it is not relevant to his problems and/or not useful then this is a contraindication for brief REBT. If the person is undecided about the potential relevance and utility to his problems, then you need to address this issue more fully before asking him to commit himself to brief REBT.

5. The person has understood the therapist's tasks and her own tasks in brief REBT, has indicated that these seem potentially useful to her and is willing to carry out her tasks.

Various codes of professional ethics stipulate that a person seeking help has to give informed consent before the therapist uses a therapeutic intervention. In brief REBT, we take this seriously by explaining in the first session what our tasks are as brief REBT therapists and what we consider our clients' tasks to be. This, of course, has to be explained in terms that clients can understand and I deal with this issue in Chapter 3. Your client is a good candidate for brief REBT in this respect if she has understood your respective therapeutic tasks, has given some indication that she believes that these tasks may be useful to her and she has said that she is willing to carry out her tasks.

You need to take care in forming your opinion of your client's suitability for brief REBT on this criterion. For example, your client may say that she understands what you both need to do to make brief REBT effective, but she may think that these tasks will not be helpful to her. Or she may understand the tasks, see their potential utility, but not be prepared to carry them out, hoping that you will do the work for her. You need to explore and respond constructively to any doubts and reservations that she may have about the task domain of REBT. This may involve correcting any misconceptions that she might have about this approach to therapy. Finally, you need to form an opinion concerning whether or not the person seeking help has the ability to put her therapeutic tasks into practice. If you judge that she does not, you need to effect a suitable referral.

6. The person's level of functioning in his everyday life is sufficiently high to enable him to carry out his tasks both inside and outside therapy sessions.

Most proponents of brief therapy recognize that this approach works better with clients who are functioning relatively well in life (e.g. see Davanloo, 1978). Consequently, my view is that it is best to offer brief work to this clinical population. I do not go along with the view that is sometimes expressed that brief therapy can be offered to everybody because all will gain SOMETHING from this approach. I believe in tailoring the therapy modality to the person rather than offering everyone a single modality (Dryden, 1993). Consequently, you need to make a judgment concerning whether or not your client is functioning sufficiently well in life to respond productively to brief REBT. This can be done in a number of ways.

First, as various authorities advocate (e.g. Malan, 1980) you can carry out a thorough formal assessment of the person's level of psychological functioning or arrange for someone to do this for you. Some therapy agencies have an intake interview policy where everyone seeking help receives an assessment-oriented intake interview with someone who will not become that person's therapist, but will refer the person to a therapist if he or she judges that this is someone suitable for brief therapy.

Second, you can rely on the judgment of an external referral agent. Thus, many of my referrals come from psychiatrists who carry out a full mental status examination and take a full history from the people whom they refer to me. A full report invariably accompanies the referral. In the vast majority of cases where they have referred to my brief therapy practice, I have found that their judgment has been accurate. This is also true of a

smaller number of General Practitioners who refer to my brief therapy practice (including the GP who referred Carol to me).

Third, in the absence of a full report on the person's level of psychological functioning from someone whose judgment you trust, and when you do not yourself carry out such a full assessment, you may decide to assume that the person is healthy enough to be suitable for brief REBT unless and until you have evidence to the contrary. If and when you gain such evidence, you will decide to refer the person to a more suitable treatment modality. For reasons discussed earlier, I do not agree with this approach. I prefer to make a judgment myself whether the person is suitable for brief REBT or to rely on the judgment of someone whose opinion I trust that this is the case rather than make the assumption, on limited information, that the person is suitable for brief REBT until proven otherwise.

7. There is early evidence that a good working bond can be developed between you and the person seeking help.

The approach to brief REBT described in this book lasts 11 sessions. Given this, it is important that you are able to develop a good working bond very early in therapy. On this criterion, a person is a good candidate for brief REBT when she is able to discuss her problems openly with you and a good rapport develops between the two of you. However, if in the first session the person is very reticent with you and there seems to be an antipathy between the two of you that cannot be easily remedied, then the person is not a good candidate for brief REBT, at least with you as her therapist. If this occurs, it is sensible for you to make a suitable referral.

Having described the seven indications that suggest that a person is suitable for brief REBT, let me consider the contraindications for brief therapy. While there is no definitive answer to this question in the brief REBT field, my view is that if any of the following conditions exist, I will not offer the person a contract for brief therapy:

1. the person is antagonistic to the REBT view of psychological disturbance and its remediation;
2. the person disagrees with the therapeutic tasks that REBT outlines for both therapist and client;
3. the person is unable to carry out the tasks of a client in brief REBT;
4. the person is presently seriously disturbed and has a long history of such disturbance;
5. the person seeking help and the therapist are clearly a poor therapeutic match;

6. the person's problems are vague and amorphous and cannot be specified even with the therapist's help.

Between the definite indications and contraindications for brief REBT lies the grey area where a person may meet some of the indications for brief REBT, but not others. As long as the person does not meet any of the contraindications listed above, the only guidance I can give is that the greater the number of indications present, the more likely it is that the person is suitable for brief REBT. It is useful to discuss cases that fall into the grey area with your supervisor.

The other factor to take into account is the client's actual response to brief REBT. This cannot be known until you have begun therapy, but it is worthwhile to point out that a person may meet all the suitability criteria that I have outlined, but still respond poorly to REBT. The reverse is also true. I have occasionally taken the risk and offered a person who has met few of the indications for brief REBT (but none of the contraindications) a brief therapy contract and have been pleasantly surprised at his positive response. My view concerning the client's response to brief REBT has been put succinctly by Budman and Gurman (1988: 25):

> 'Our recommendations in patient selection are to monitor the patient's response to treatment on a trial basis; to be prepared to make creative modifications as necessary (two such modifications may involve the patient's seeing another therapist or including the patient's family) and to be prepared to use various alternatives, including longer and more open-ended treatment.'

I would only add one thing to this statement. Be aware of and do not exceed your own limitations. Thus, if you consider that involving a client's family would be a helpful, creative modification, but you do not have the skills to do this, either refer the case to an REBT therapist with expertise in family work or involve such a therapist in the family sessions as a co-therapist.

THE BOOK'S STRUCTURE

Having considered the context of and rationale for brief REBT, let me bring this chapter to a close by outlining the structure of the rest of the book. First, in Chapter 2, I will provide a brief introduction to the basic principles and practice of REBT. Then, in Chapter 3, I will discuss how to form a working alliance quickly with brief therapy clients and show how to prepare them to get the most out of REBT. In Chapter 4, I will deal with

the important issue of assessing clients' problems from an REBT perspective which is a core task before change-directed interventions are employed. In Chapter 5, I will show you how to help your client to understand the rational solution to her problems whereby she gains intellectual insight into the determinants of her problems and what she needs to do to effect change. Chapter 6 is devoted to teaching your client what she needs to do to move from intellectual to emotional insight or, to put it differently, to understand what is involved in integrating the rational solution into her belief system so that she can overcome her problems. Chapters 7 and 8 are devoted to helping your client to initiate and maintain the integration process both inside (Chapter 7) and outside therapy (Chapter 8). In Chapter 9, I will discuss the process of brief REBT and finally in Chapter 10, I will illustrate this process by describing my work with a single case (Carol) from beginning to end.

Throughout this book, I will use my work with Carol to illustrate the ideas that I discuss. This case is a real one and I have obtained written permission from the client concerned to use it for educational purposes. However, I have changed all identifying material to preserve client confidentiality. I have chosen this case because it demonstrates what can be achieved from brief REBT with a well-motivated client in a therapy that went relatively smoothly. While I fully recognize that not all cases are as smooth as the one selected, this case does allow me to present brief REBT as clearly as possible. However, I shall discuss the many obstacles that can occur in brief REBT and how to address these in Chapter 9.