Brief Cognitive Behaviour Therapy

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Preface

This book is aimed at practitioners such as counsellors, psychotherapists, and clinical and counselling psychologists who are in training or are already experienced but wish to learn more about brief counselling and psychotherapy or wish to continue their professional development. It is hoped this book will be a useful source to lecturers and trainers of such practitioners, as well as to other helping professionals such as psychiatrists, mental health nurses, community mental health nurses, nurse therapists, care managers and others. It may be of particular help to those working in time-limited settings.

Brief and time-limited therapy is becoming more popular due to the demands of the marketplace. This has led to an increasing number of therapists becoming interested in cognitive behaviour therapy and we hope this book will provide a useful and easily understood framework. We have found that many therapists and counsellors who work in time-limited settings and those offering brief therapy have not received any formal training or read any books devoted to the subject.

This book will introduce the reader to brief therapy in Chapter 1 and quickly provide a framework for brief cognitive behaviour therapy. This will be expanded in the whistlestop tour of Chapter 2 where we will first meet Tom, whom we shall follow throughout the book. We shall also meet other people during the course of the book who are taken from the authors' clinical practice using dialogue to illustrate aspects of the framework. Chapter 3 covers the assessment stage of therapy and gives some guidelines on suitability for brief cognitive therapy. Although therapy begins in the assessment, Chapter 4 considers in more detail the beginning stage of therapy by focusing on the therapist's goals for therapy and the client's difficulties as seen through the cognitive conceptualization. The therapist's goals and the cognitive conceptualization of the client's difficulties are continued throughout the process of therapy. Chapter 5 covers the middle stage of therapy and describes a range of techniques, tools and interventions used in the practice of brief cognitive behaviour therapy. Chapter 6 sees the end stage of therapy in which a new therapist emerges: the client. Chapter 7 includes a number of additional strategies and techniques that can be used within a brief

cognitive behaviour therapy framework. Chapter 8 is devoted to hypnosis as an adjunct to therapy and includes a script which focuses on reframing unhelpful beliefs. Chapter 9 summarizes treatment protocols for the major disorders such as panic and post-traumatic stress disorder (PTSD); also included is suicide.

Terms used

Where pronouns are used, no specific sex is intended: 'he' and 'she' have been used randomly. We have generally used the word 'client' to mean anyone receiving therapy; this is synonymous with 'patient', which may appear in some of the references. We appreciate that some people may object to the use of one or other of these or similar words, preferring other descriptions such as 'user', 'consumer', etc., but we have used client wherever possible for clarity. The term 'therapist' has been used to mean 'psychotherapist', 'counsellor', 'practitioner', etc. We recognize that a debate continues about these titles (see James and Palmer, 1996), but will not develop the arguments further here. We have generally used 'cognitive behaviour therapy' in preference to 'cognitive therapy' or 'cognitive behavioural therapy'. The terms 'cognitive conceptualization', 'case conceptualization' and 'cognitive formulation' have been used interchangeably.

Within the main text, we discuss some aspects of the language we use with clients and emphasize the importance of establishing a (relatively!) common meaning. In the Introduction we note that brief therapy endeavours not to focus on 'deficits', 'weaknesses' and 'pathology'. For these reasons, we have preferred the terms 'helpful' and 'unhelpful' thinking (or beliefs), rather than 'functional' and 'dysfunctional', 'healthy' and 'unhealthy', or 'rational' and 'irrational' thinking (or beliefs). This helps to normalize the client's condition rather than stigmatize their plight. Helpful thinking is therefore seen as what helps a person to achieve their short- and long-term goals and a balance between them. Similarly, we prefer the term 'thinking error', which is part of 'normal' experience (if we accept ourselves as fallible, not perfect, human beings – see Chapter 5), rather than 'cognitive distortion' or 'twisted thinking' (Burns, 1989).

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(BC and PR)