Workshop

SINGLE SESSION PSYCHOTHERAPY:
ENHANCING ONE-MEETING POTENTIALS

Presenter: Michael F. Hoyt, Ph.D.
The New Brief Therapy: Treating Anxiety, Depression & Trauma
Sponsored by the Milton H. Erickson Foundation
Hyatt-Regency Orange County, Garden Grove, CA
Friday, December 12, 2014, 10:45 a.m.-12:45 p.m.

Learning objectives:
(1) Understand basic features of brief therapy
(2) Recognize tasks and skills associated with different phases of treatment
(3) Understand guidelines (steps, indications & contraindications) for possible single session therapies
(4) Describe brief therapy techniques that may be useful in different clinical situations
(5) Consider application to participants’ own clinical cases

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BASIC FEATURES OF BRIEF THERAPY

1. RAPID AND POSITIVE ALLIANCE

2. GOAL FOCUS

3. CLEAR DEFINITION OF PATIENT/ THERAPIST RESPONSIBILITIES/ACTIVITIES

4. EMPHASIS ON STRENGTHS/COMPETENCIES, WITH AN EXPECTATION OF CHANGE HOPE

5. NOVELTY (CHANGE VIEWING AND DOING) PROMOTING "VIVENCIAS"

6. HERE-AND-NOW (AND NEXT) ORIENTATION

7. TIME SENSITIVITY/INTERMITTENCY

BRIEF THERAPY DEFINITION

"TIME-SENSITIVE TREATMENT TO RELIEVE PSYCHOLOGICAL DISTRESS AND/OR PROMOTE GROWTH VIA CHANGES IN THINKING, FEELING, AND ACTING."

"Well, I do have this recurring dream that one day I might see some results."
THE STRUCTURE OF BRIEF THERAPY:
TASKS AND SKILLS ASSOCIATED WITH DIFFERENT PHASES
OF SESSIONS AND TREATMENTS
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Pretreatment
Change begins even before we have contact with the client. He or she
or they have decided there is a problem and would like assistance to
resolve the difficulty. Some questions to ask while making an initial
appointment:
* What’s the problem—why now have you called?
* How do you see or understand the situation?
* What do you think will help?
* How have you tried to solve the problem so far—how did that work?
* When the problem isn’t present (or isn’t so bad), what is going on
differently?
* Please notice between now and when we meet, so that you can
describe it to me, when the problem isn’t so bad (when you and your
spouse are getting along, when you’re not feeling depressed, when
you don’t drink too much, etc.), what are you doing differently then?
This may give us some clues regarding what you need to do more of—
identifying exceptions to the problem that led you to call will focus
on solutions that may be useful to you. OK?

Early in Treatment and Early in Each Session
As we begin a session and a therapy, we attend carefully to forming a
good alliance, inquiring about possible changes since our last contact, and
establishing goals for the session and the therapy. Some useful questions
might include:
* Since we last spoke, what have you noticed that may be a bit better
  or different? How did that happen? What did you do?
* When is the problem not a problem?
* What do you call the problem? What name do you have for it?
* When (and how) does [the problem] influence you; and when [and how]
do you influence it?
* What’s your idea or theory about what will help?
* How can I be most useful to you?
* If we were only going to meet once or a few times, what problem
  would you want to focus on solving first?
* What needs to happen here today so that when you leave you can
  feel this visit was worthwhile?
* What are you willing to change today?
*Given all that you've been through, how have you managed to cope as well as you have?
*If we work hard together, what will be the first small indications that we're going in the right direction?
*On a scale of 1 to 10, where is the problem now? Where would it need to be for you to decide that you didn't need to continue coming here?
*Suppose tonight, while you're sleeping, a miracle happens, and the problem that led you here is resolved. When you awaken tomorrow, how will you first notice the miracle has happened? What will be the first sign that things are better? And the next? And the next?

**In the Middle of Treatment and the Middle of Each Session**

We keep track of client's goals and whether we have a good working alliance and are going in the right direction or if some course 'corrections' need to be made. Possible refocusing is directed by the client's response to questions such as these:
*How did that work?
*Is this being helpful to you? What would make it more so?
*Do you have any questions you'd like to ask me?
*Are we working on what you want to work on?
*I seem to have missed something you said—what can I do to be more helpful to you now?

**Late in Treatment and Late in Each Session**

Termination—extracting the therapist from the successful equation—becomes central. There are a number of issues to be addressed, as the following guideline questions suggest:

**Goal Attainment/Homework/Post-Session Tasks**
*Has this been helpful to you? How so?
*Which of the helpful things you've been doing do you think you should continue to do? How can you do this?
*Between now and the next time we meet (or, to keep things going in the right direction), would you be willing to do ______?
*Before we stop in a couple of minutes, when I'll walk you back to the waiting room, let's discuss what's next...
*Who can be helpful to you in doing ______? What might interfere, and how can you prepare to deal with those challenges?

**Goal Maintenance and Relapse Prevention**
*What would be a signal that the problems you were having might be returning? How can you respond if you see that developing?
*Suppose you wanted to go back to all of the problems you were having when you first came in—what would you need to do to to make this happen, if you wanted to sabotage yourself?
*How might [the problem] try to trick you into letting it take over again?
*What will you need to do to increase the odds that things will work out OK even if you weren't to come in for awhile?
*Who will be glad to hear about your progress? Who in your present or past [family, friends, colleagues] would support your efforts?

**Leavetaking**
*Would you like to make another appointment now, or wait and see how things go and call me as needed?
*Would you like to make our appointment for 3 weeks, or 6 weeks, or wait a bit longer?
*What is the longest you can imagine handling things on your own?
Attitudes conducive to the possibility of successful SST include:

1. View each session as a whole, potentially complete in itself. Expect change.
2. The power is in the patient. Never underestimate your patient’s strength.
3. This is it. All you have is now.
4. The therapeutic process starts before the first session, and will continue long after it.
5. The natural process of life is the main force of change.
6. You don’t have to know everything in order to be effective.
7. You don’t have to rush or reinvent the wheel.
8. More is not necessary better. Better is better. A small step can make a big difference.
9. Helping people as quickly as possible is practical and ethical. It will encourage patients to return for help if they have other problems, and will also allow therapists to spend more time with patients who require longer treatments.

Those most likely to benefit from SST include:

1. Patients who come to solve a specific problem for which a solution is in their control.
2. Patients who essentially need reassurance that their reaction to a troubling situation is normal.
3. Patients seen with significant others or family members who can serve as natural supports and “co-therapists.”
4. Patients who can identify (perhaps with the therapist’s assistance) helpful solutions, past successes, and exceptions to the problem.
5. Patients who have a particularly “stuck” feeling (e.g., anger, guilt, grief) toward a past event.
6. Patients who come for evaluation and need referral for medical examinations or other nonpsychotherapy services (e.g., legal, vocational, financial, or religious counseling).
7. Patients who are likely to be better off without any treatment, such as “spontaneous improvers,” nonresponders, and those likely to have a “negative therapeutic reaction” (Frances & Clarkin, 1981).
8. Patients faced with a truly insoluble situation. It will help to recast goals in terms that can be productively addressed.

Those for whom SST is less likely to be adequate and beneficial include:

1. Patients who might require inpatient psychiatric care, such as suicidal or psychotic persons.
2. Patients suffering from conditions that suggest strong biological or chemical components, such as schizophrenia, manic-depression, alcohol or drug addiction, or panic disorder.
3. Patients who request long-term therapy up front, including those who are anticipating and have prepared for prolonged self-exploration.
4. Patients who need ongoing support to work through (and escape) the effects of childhood and/or adult abuse.
5. Patients with longstanding eating disorders or severe obsessive-compulsive problems.
6. Patients with chronic pain syndromes and somatoform disorders.
Creative application of the following clinical guidelines facilitates SST:

1. “Seed” change through induction and preparation. Engage the patient via a pre-session phone call or letter encouraging a focus on goals and collection of useful information about competencies, past successes, and exceptions to the problem (as with techniques such as de Shazer’s Skeleton Key Question, 1985: “Between now and when we meet, I would like you to observe, so you can describe to me, what happens that you want to continue to happen.”)

2. Develop an alliance and co-create obtainable treatment goals. When getting started, inquire about change since pretreatment contact and amplify accordingly (see Weiner-Davis, de Shazer, & Gingerich, 1987). Introduce the possibility of one session being adequate, and recruit the patient’s cooperation.

3. Allow enough time. Most of us work in the 50-minute hour, which is usually adequate; but consider scheduling a longer session to allow for a complete process or intervention.

4. Focus on “pivot chords,” ambiguities that may facilitate transitions into different directions. Look for ways of meeting the patient in his or her worldview while, at the same time, offering a new perspective—“re-framing” introduces the possibility of seeing and/or acting differently.

5. Go slow and look for patient’s strengths.

6. Practice solutions experientially. Rehearsing desired outcomes provides a “glimpse of the future,” teaches and reinforces useful skills, and inspires enthusiasm and movement.

7. Consider taking a time-out. A break or pause during a session allows time to think, consult, focus, prepare, punctuate.

8. Allow time for last-minute issues. “Eleventh-hour” questions should be asked about six o’clock, to allow time for inclusion or prioritization. Unaddressed issues may impede a sense of the session being complete and satisfactory.

9. Give feedback. Information should be provided that enhances patient’s understanding and sense of self-mastery. Tasks or “homework” may be developed that will continue therapeutic work.

10. Leave the door open. The decision to stop is usually best left to the patient.
SINGLE SESSION THERAPY
Michael F. Hoyt, Ph.D.

Exercise 1: Pre-Session Contact (Phone Call)
Some questions to consider:
1. What’s the problem? What is the situation now? (suicidal/homicidal/psychotic/medical?)
2. Who is the customer—who’s most concerned?
3. What hidden agenda may there be?
4. How and how soon do you anticipate the problem will be solved?
5. How do you think therapy will be helpful in dealing with the problem?
6. What made you decide that now was the right time for therapy?
7. Am I (therapist) the right person for this case?
8. What benign assignment might be useful—to gather information, to recruit the patient’s cooperation, to help shift their perspective? The Skeleton Key Question (de Shazer, 1985): “Between now and when we meet, I would like you to notice the things that happen to you that you would like to keep happening in the future. This will help me find out more about your goals and what you’re up to.” Other benign questions: “Please give some thought to what you would like to accomplish in therapy, and how you will know if it’s helping.”

Exercise 2: Beginning the Session (the Patient Has Arrived)
Some tasks to accomplish:
1. Joining, connecting.
2. Orienting to purpose of meeting: Help you solve a problem, help you determine the next steps you need to take, figure out what to do, identify how you can handle the situation, etc.
3. Mention availability of future sessions if needed and possibility of SST.
4. Recruit cooperation—work hard and figure out a solution; does that sound like something you want to do?
5. Assess current status—what has changed or been noticed since making appointment? Attempted solutions?
6. Co-create achievable goals: General characteristics of well-formed goals (from de Shazer, 1991): small rather than large; (2)salient to clients; (3)described in specific, concrete, behavioral terms; (4)achievable within the practical contexts of clients’ lives; (5)perceived by clients as involving their hard work; (6)described as the “start of something” and not the “end of something”; and (7)treated as involving new behavior(s) rather than the absence or cessation of existing behavior(s).
SINGLE SESSION THERAPY

Exercise 3: Closing the Session (Finishing and Follow-Through)
Some items to address:
1. Giving feedback—emphasizing patient’s strengths and capacities.
2. Assign task or homework if indicated (see below)
3. Ask: How will you use this meeting? Get specifics.
4. Determine if patient is satisfied and wants to stop, or schedule more sessions. Leave door open. Invite follow-up, positive or negative.

Tasks in Brief Therapy (see Levy & Shelton, 1990; Mahrer et al., 1995; Meichenbaum & Turk, 1987)

Why Don’t Patients Comply?
1. The client does not remember or know how to complete the task.
2. The client does not believe complying will help.
3. Factors in the client’s life make compliance difficult.

Steps to Enhance Compliance:
1. Be sure assignments contain specific details about the desired behavior.
2. Give direct skill training when necessary (e.g., relaxation training)
3. Reward compliance—elicit positive responses of patient and others as well as therapist
4. Begin with homework that is likely to be successfully accomplished—the “foot in the door” technique
5. Use a system that will remind patients of the assignment (e.g., cues, others)
6. Have the patient make a public commitment to comply—will you do it?
7. The patient should believe in the value of the assignment for treating his or her problem—does that make sense? Have patient develop task.
8. Use cognitive rehearsal strategies—prepare for stressors, practice confronting stressors, have patient reward self for completing homework
9. Anticipate and reduce the negative effects of compliance
10. Closely monitor compliance—heighten accountability.

References
STAGES OF CHANGE

"A journey of a thousand miles must begin with a single step."
—Lao-tzu (c. 600 B.C.)

"The readiness is all."
—Shakespeare (Hamlet, Act V, Scene ii)

Prochaska's stages of readiness:
Precontemplation is the stage at which there is no intention to change behavior in the foreseeable future....
Contemplation is the stage in which people are aware that a problem exists and are seriously thinking about overcoming it but have not yet made a commitment to take action....
Preparation is a stage that combines intention and behavioral criteria. Individuals in this stage are intending to take action immediately and report some small behavioral changes....
Action is the stage in which individuals modify their behavior, experiences, and/or environment in order to overcome their problems....
Maintenance is the final stage in which people work to prevent relapse and consolidate the gains attained during action....[M]aintenance is a continuation, not an absence, of change....Stabilizing behavior change and avoiding relapse are the hallmarks.
Termination is the stage in which there is zero temptation to engage in the problem behavior, and there is a 100 percent confidence (self-efficacy) that one will not engage in the old behavior regardless of the situation.

Some solution-focused therapy strategies:
Precontemplation: Suggest that the client "think about it" and provide information and education;
Contemplation: Encourage thinking, recommend an observation task in which the client is asked to notice something (such as what happens to make things better or worse), and join with the client's lack of commitment to action with a "Go slow!" directive;
Preparation: Offer treatment options, invite the client to choose from viable alternatives;
Action: Amplify what works—get details of success and reinforce;
Maintenance: Support success, predict setbacks, make contingency plans;
Termination: Wish well, say goodbye, leave an open door for possible return if needed.

References
FIGURE 2: The Ending (Termination) Phases of Treatment (and Sessions): Subtracting the Therapist from the Successful Equation

- initiation of ending
- goal assessment
- tasks/homework
- relapse prevention
- aftercare planning
- leavetaking

late

*continued progress
*monitoring
*return
as needed

follow-through

"Fifty Ways Not to Leave Your Client"

You just insist they come back, Jack
Make a new treatment plan, Stan
Avoid the topic of ending--be coy, Roy
Tell them they're not ready, Freddie
If they try to cancel, make a big fuss, Gus
They still need to discuss much
Before they can leave, Steve
("How could you do this to me?")
And don't forget your fee, Lee
BRIEF(ER) THERAPY WITH LONGER-TERM PATIENTS (M. Hoyt, Ph.D.)

Six Ways to Get Stuck

1. Belief systems
2. Emotional Reactivity
3. Relationship reluctance (or the opposite: Dependency)
4. Vagueness (lack of therapy goals)
5. External locus of control
6. Bad realities

Focus on strengths and here-and-now: Goals & Agency

Therapy cannot solve everything: We owe it to our clients to be clear about what we can and cannot help them achieve.

If Not Succeeding, Checklist of Possible Problems

1. Victim vs. Autonomy
2. “Psychiatry” and “Psychotherapy” (TIBs)
3. Courtroom
4. Do Me Something
5. Lack of Achievable Goals
6. Biological Factors
7. Missed Dxs (e.g., A & D, MDD, OCD, D.V.)

Stages in Briefer Therapy with Longer-Term Clients

1. Developing therapeutic rapport and relationship focused on change
2. Developing short-term goals for providing symptom relief
3. Developing and achieving long-term goals
4. Transitioning out of therapy

Signs of Progress:

1. Identifying achievable goals
2. Asking for help (allowing therapist to influence)
3. Increasing sense of “agency”
4. Developing and using supports other than therapy

Questions to Ask:

“How do you hope I might help you?”
“What need you accomplish today to get one step closer to needing to come in less often?”
“What do you want to be different in the next 1-2 months to feel a bit better?”
“What might be a small sign that you’re getting more control of your life?”
“If you got stuck, what could you do? Who could you talk to other than therapist?”

Strategies for More Efficient Care of Long-Term Patients
1. Use primary-care physicians more
2. Use collaterals—family members, church members
3. Deconstruct the diagnosis—Borderline, Depressive, Narcissistic—see as verbs, teach skills needed (e.g., DBT)
4. Intermittent treatment—episodes, steps, AMAC (remembering, breaking the silence, grieving, confrontation)
5. Continuous but not intensive—don’t gratify dependency, keep brief, require action for more sessions
6. Group therapy—classes, day tx, need structural arrangements
7. Use community resources—AA, CODA, Recovery Inc.
8. Discuss benefits/limits up front—create difficult terminations with unreal expectations
9. Use phone—ask for positive reports
10. Make tape
11. Case manager

Other Strategies
1. Stop early if in good place
2. Signal that session is ending soon (“Before we stop in a couple of minutes, when I’ll walk you back to the waiting room, let’s discuss what’s next....”)
3. Don’t assume another appointment:
   a. “Would you like to make another appointment now, or wait and see how things go and call me as needed?”
   b. Make only one at a time—implication being that only one may be needed
   c. Re-cultivate pt’s motivation: “Do you want to keep the appointment next week? We could cancel it if you don’t want to work.”
   d. Frame range of appointment: “Would you like to make our next appointment for 3 weeks, or 6 weeks, or wait a bit longer?”
   e. Taper frequency of sessions, emphasizing intermittent treatment and an “open door.”
   f. Remember as we walk to the door and down the hallway, that every word counts.
   g. Proper documentation.
1. Nonpathology-Based Model
2. Utilization
3. Indirection
4. Action
5. Strategic
6. Future Orientation
7. Enchantment

2. The Basic Ericksonian Footprint (S. Lankton)

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<th>Stage</th>
<th>Summary Statement About the General Goal for Each Stage</th>
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<td>Blending</td>
<td>Reducing resistance.</td>
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<td>Utilizing</td>
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<td>Elaborating</td>
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<td>Ambiguity</td>
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<td>Reframing</td>
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<td>Co-creating</td>
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REDECISION THERAPY: THE POWER IS IN THE PATIENT

Goulding & Goulding Thinking Structure
I. Contact
II. Contract
III. Con--First and Subsequent (vs. Autonomy)
IV. Chronic Bad
   A. Feeling
   B. Thinking
   C. Behavior
   D. Body
V. Games/Fantasies/Belief Systems
VI. Childhood Decisions
   A. Resolution
      1. Injunction and Redecision
      2. Ego State Decontamination and Reconstruction
      3. Self-Reparenting
      4. Etc.
   B. Anchor
   C. Adult Plan
   D. Change of Stroke Patterns

What are you willing to change today?
What (specificity, goal, target, focus)
are (active verb, present tense)
you (self as agent, personal functioning)
will (choice, responsibility, initiative)
to change (alter or modify, not just "work on," "try," "explore," or "understand")
today (now, in the moment)
? (inquiry, open field, therapist inviting and respectfully receptive but not insistent)

References
SOLUTION-FOCUSED THERAPY BASIC QUESTIONS

Miracle Question:
"Suppose that one night, while you were asleep, there was a miracle and this problem was solved. How would you know? What would be different?"

Skeleton Key Question:
"Between now and next time we meet, I would like you to observe, so that you can describe to me next time, what happens in your [pick one: family, life, marriage, relationship] that you want to continue to have happen."

Goal-Building Questions:
"What brings you here today? How can I be helpful to you? What changes have you noticed since you first made the call to set up this appointment? What needs to happen here so that when you leave you will think, ‘It was good that we went to see the therapist?’ What will tell you that you are on track?"

Exceptions Questions:
"When in the past might the problem have happened, but didn’t? What is different about those times when the problem does not happen?"

Efficacy (Agency) Questions:
"How did you do that? How did you get that to happen? What was each of you doing differently when you were doing better?"

Endurance (Coping) Questions:
"Given the terrible situation, how come things aren’t worse? How have you managed to cope as well as you have?"

Scaling Questions:
Hope: “On a scale from 1 to 10, 1 being absolutely no hope and 10 being complete confidence, what number would you give your current level of hope? What will tell you that your level has gone up one level? What number will be high enough to warrant your working hard to try and change things?”
Motivation: “ .... ”
Progress: “On a scale from 1 to 10, where 1 is the problem at its worst and 10 is the day after the miracle, what number would you give your current level of progress? What number will tell you that you have made enough progress so that you can consider it solved?"

References
SST Therapy Bibliography


CAPTURING THE MOMENT: SINGLE SESSION THERAPY AND WALK-IN SERVICES
Michael F. Hoyt & Moshe Talmon, Editors
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Bernard L. Bloom, “Foreword”

About the Editors and Contributors
1. Michael F. Hoyt and Moshe Talmon, “Editors’ Introduction--Single Session Therapy and Walk-In Services”
2. Moshe Talmon, “When Less is More: Lessons from 25 Years of Attempting to Maximize the Effects of Each (and Often Only) Therapeutic Encounter”
5. Arnold Slive and Monte Bobele, “Walk-In Single Session Therapy: Accessible Mental-Health Services”
6. Monte Bobele and Arnold Slive, “One Session at a Time: When You Have a Whole Hour”
8. Pam Rycroft and Jeff Young, “Single Session Therapy in Australia: Learning from Teaching”
10. Nancy McElheran, Janet Stewart, Dean Soenen, Jennifer Newman, and Bruce Maclaurin, “Walk-In Single Session Therapy at The Eastside Family Centre”
15. Steve Andreas, “SST with NLP: Rapid Transformations Using Content-Free Instructions”
17. Chris Iveson, Evan George, and Harvey Ratner, “Love is All Around: A Solution-Focused Single Session Therapy”
18. Tziporah Rosenberg and Susan McDaniel, “Single Session Medical Family Therapy and the Patient-Centered Medical Home”
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25. Moshe Talmon and Michael F. Hoyt, “Moments are Forever: Single Session Therapy and Walk-In Services Now and in the Future”

Appendix A: Michael F. Hoyt and Moshe Talmon, “What the Literature Says: An Annotated Bibliography”
Appendix B: Michael F. Hoyt and Moshe Talmon, “The Temporal Structure of Brief Therapy: Some Questions Often Associated with Different Phases of Sessions and Treatments”