Workshop 33

SINGLE SESSION THERAPY

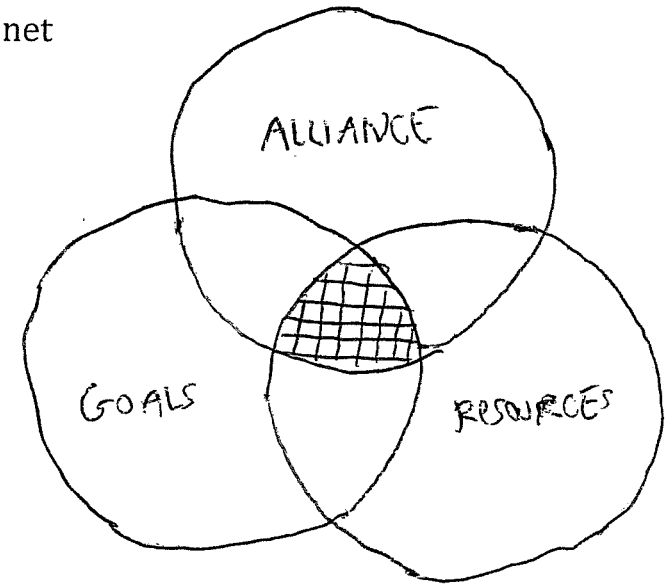
Presenter: Michael F. Hoyt, Ph.D.

12th International Congress on Ericksonian Approaches to Psychotherapy
Phoenix, Arizona
Sunday, December 13, 2015, 8:30a.m.-10:30 a.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 situations
(5)Consider application to participants' own clinical cases.

Contact: DrMHoyt@comcast.net



"Context of Competence"

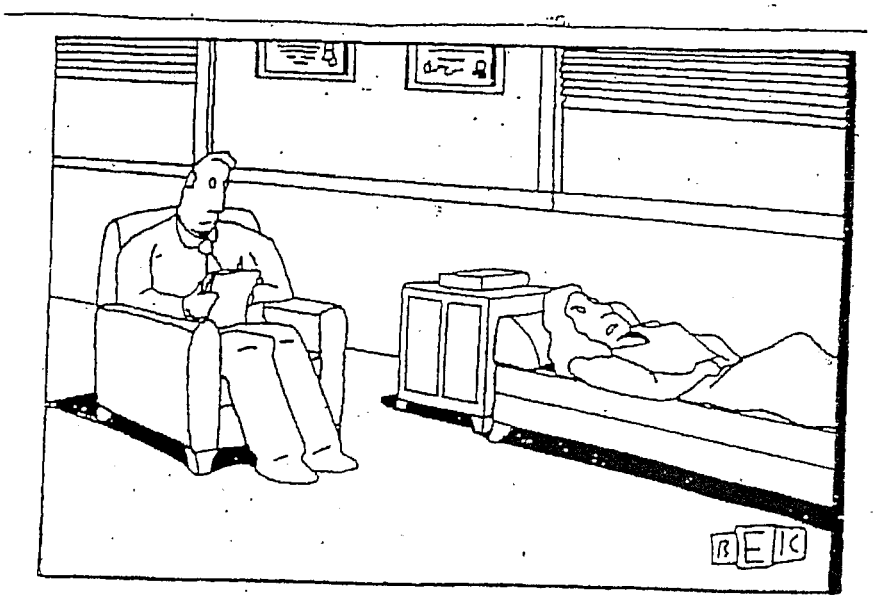
1

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."

2

THE STRUCTURE OF BRIEF THERAPY:
TASKS AND SKILLS ASSOCIATED WITH DIFFERENT PHASES OF SESSIONS AND TREATMENTS

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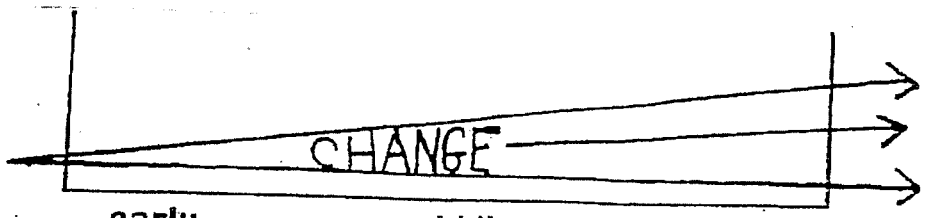

Pretreatment

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 presession 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—"reframing" 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.

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Exercise 1: Pre-Session Contact (Phone Call)

Some questions to consider:

1. What's the problem? What is the situation now? (suicidal/homocidal/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).

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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, 1998; 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

de Shazer, S. (1985) *Keys to Solution in Brief Therapy.* New York: Norton.

de Shazer, S. (1991) *Putting Difference to Work.* New York: Norton.

Levy, R.L., & Shelton, J.L. (1998) Tasks in brief therapy. In R.A. Wells & V.J. Giannetti (Eds.), *Handbook of the Brief Psychotherapies.* New York: Plenum.

Mahrer, A.R., Nordin, S., & Miller, L.S. (1995) If a client has this kind of problem, prescribe that kind of post-session behavior. *Psychotherapy*, 32, 194-203.

Meichenbaum, D., & Turk, D. (1987) *Facilitating Treatment Adherence: A Practitioner's Guidebook.* New York: Plenum.

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CAPTURING THE MOMENT: SINGLE-SESSION THERAPY AND WALK-IN SERVICES

Michael F. Hoyt & Moshe Talmon, Editors

Bethel, CT: Crown House Publishers, 2014