

SINGLE-SESSION THERAPY: WHEN THE FIRST SESSION MAY BE THE LAST

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BRIEF THERAPY DEFINITIONS (Hoyt, 2009)

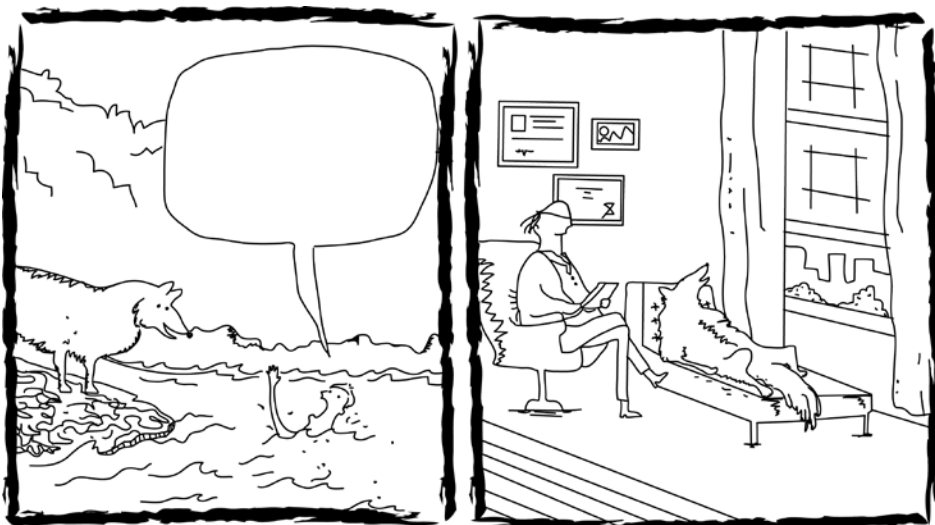
1. "Time-sensitive treatment to relieve psychological distress and/ or promote growth"

or

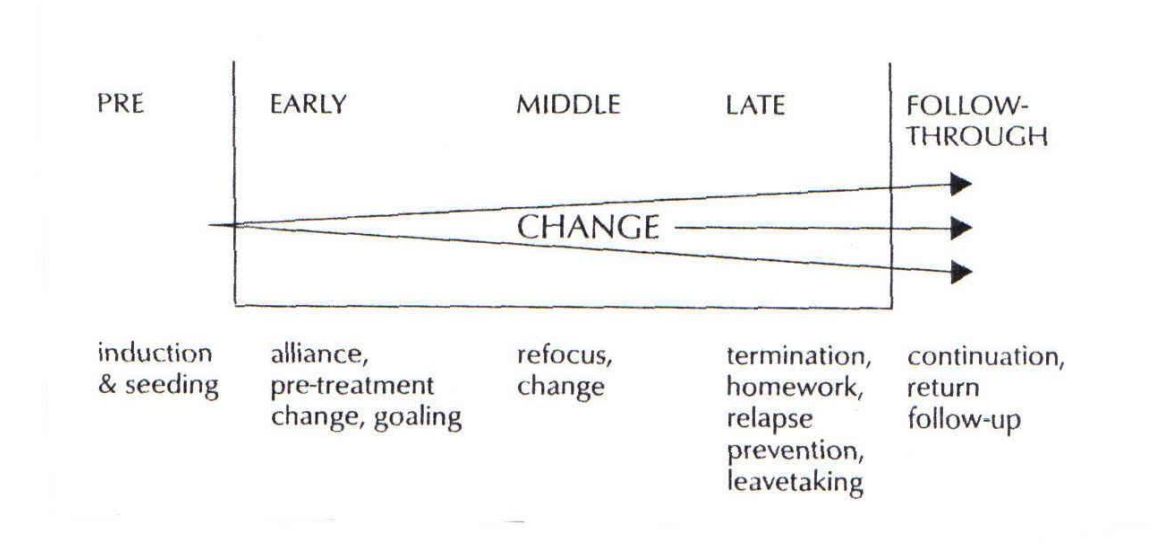
2. "The development of a collaborative alliance and an emphasis on patient/ client strengths in the service of an efficient attainment of co-created goals"

BASIC FEATURES OF BRIEF THERAPY (Budman, Hoyt & Friedman, 1992; Hoyt, 1995, 2009, 2017)

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 producing hope
5. Novelty (change viewing and doing)
6. Here-and-now (and next) orientation
7. Time sensitivity/intermittency



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



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 it work?
- When the problem isn't present (or isn't bad), what is going on differently?
- Please notice between now and when we meet, so that you can describe to me, when the problem isn't so bad, 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 the 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 have been through, how have you managed to cope as well as you have?
- If we work 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 dissolved. When you awaken tomorrow, how will you first notice the miracle has happened? What will be the first sign that things are better? And next? And then?

In the Middle of Treatment and the Middle of Each Session

We keep track of the clients' 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 question such as these:

- How did that work?
- Is this being helpful to you?
- 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 when you first came in- what would you need to do 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 increase the odds that things will work out OK even if you were no to come in for a while?
- Who will be glad to hear about your progress? Who in your present or past [family, friends, colleagues] would support your efforts?

Leave-taking

- Would you like to make our appointment for 3 weeks, 6 weeks, or wait a bit longer?
- What is the longest you can imagine handling things on your own?

STAGES OF CHANGE (Prochaska, 1999)

"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)

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 behavior criteria. Individuals in this stage are intending to take action immediately and report some small behavioral changes.

Action is the stage that combines intention and behavior, experiences, and/or environment in the order to overcome their problems.

Maintenance is the final stage in which people work to prevent relapse and consolidate the 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 (Hoyt & Miller, 2000):

Precontemplation: Suggest that the client “think about it” and provide information and education.

Contemplation: Encourage thinking, recommend and observation task in which the client is asked to join with the client’s lack of commitment to action with a “Go slow” directive.

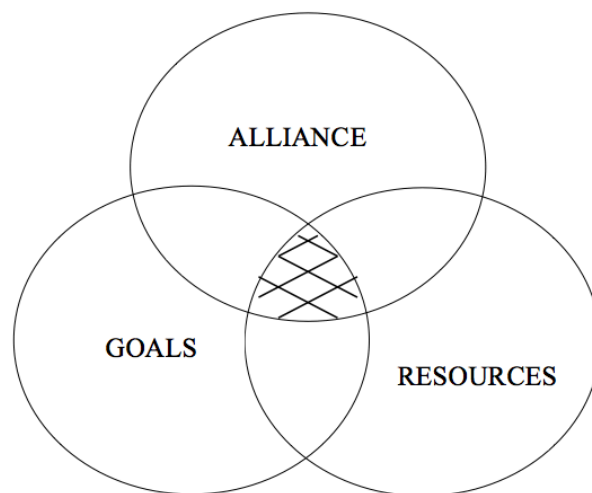
Preparation: Offer treatment options, invite the client to choose from viable alternatives.

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.

“Context of Competence”





*"Basically, there's nothing wrong with you that
what's right with you can't cure."*

Talmon (1990) – Kaiser Permanente study (N = 58). Basic quantitative findings:

- Over half of the patients (58.6%) elected to complete their therapy in one session even when more sessions were available;
- more than 88% reported significant improvement in their original “presenting complaint” and more than 65% also reported “ripple” improvements in related areas of functioning; and
- and while not experimentally assigned to one-session or longer, on follow-up there was no difference in satisfaction and outcome scores between those who chose to stop after one visit (SST) versus those who continued for more sessions.

SINGLE-SESSION SOLUTIONS

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 success, 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 world view 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 inclusions 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.

THREE THEMES (Hoyt & Talmon, 2014)

1. Mindset/expectation
2. Time
3. Empowerment

SINGLE SESSION THERAPY: EXERCISES

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, 1988): "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 are 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).

Exercise 3: Closing the Session (Finishing and Follow-Through)

Some items to address:

1. Giving feedback—emphasizing patient’s strengths and capacities.
2. Asking 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.



Not SST!

Tasks in Brief Therapy

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 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.

THE ENDING (TERMINATION) PHASE OF TREATMENT (AND SESSIONS): SUBTRACTING THE THERAPIST FROM THE SUCCESSFUL EQUATION

<ul style="list-style-type: none">• Initiation of ending• Goal assessment• Tasks/ homework• Relapse prevention• Aftercare planning• Leavetaking	<ul style="list-style-type: none">• Continued progress• Monitoring• Return as needed
LATE	FOLLOW-THROUGH

“Fifty Ways Not to Leave Your Client” (Hoyt, 2000)

You just insist they come back, Jack
Make a new treatment, 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

ERICKSONIAN ESSENCES

1. Nonpathology-Based Model
2. Utilization
3. Indirection
4. Action
5. Strategic
6. Future Orientation
7. Enchantment

The Basic Ericksonian Footprint (S. Lankton)

Stage	Summary Statement about the General Goal for Each Stage
Matching	Increasing rapport
Blending	Reducing resistance
Utilizing	Allowing client to use existing skills and resources
Elaborating Ambiguity	Unbalancing; creating a search for 'ground'
Reframing	Increasing perceptual options or engaging the meaning first discovered
Co-Creating Outcomes	Including unique clients' needs, resources, values

Six Core Strategies (D. Short, et al., 2005)

- * **Distraction** – shift attention
- * **Partitioning** – break don into smaller parts
- * **Progression** –build on small gains
- * **Suggestion** – guiding client's expectation and expenditure of energy
- * **Reorientation** – new perspective (reframing)
- * **Utilization** – using their energy, preferences, point of view, skills, etc.

REDECISION THERAPY: THE POWER IS IN THE PATIENT

Robert Goulding & Mary Goulding Thinking Structure (Goulding & Goulding, 1979)

- 1) Contact
- 2) Contract
- 3) Con—First and Subsequent (vs. Autonomy)
- 4) Chronic Bad
 - a) Feeling
 - b) Thinking
 - c) Behavior
 - D) Body
- 5) Games/ Fantasies/ Belief Systems
- 6) Childhood Decisions
 - A) Resolution
 - 1) Injunction and Redecision
 - 2) Ego State Decontamination and Reconstruction
 - 3) Self-Parenting
 - 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 function)

willing (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)

SOLUTION-FOCUSED THERAPY BASIC QUESTIONS (de Shazer, 1985, 1988, 1991; Berg & Miller, 1992)

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

Skeleton Key Question: “Between now and next time we meet, I would you 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 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 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 worse 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?”

SFBT THREE BASIC RULES:

1. If it ain’t broke, don’t fix it!
2. Once you know what works, do more of it!
3. If it doesn’t work, don’t do it again—do something else!

PSYCHOTHERAPY IN ORGANIZED HEALTHCARE (Hoyt, 1995, 2009)

Features	Comments
1. Specific problem-solving	Why now has the patient come to therapy? Impairments and Axis I diagnoses justifying medical/ clinical necessity. Identification with the patient of achievable,measurable goals.
2. Rapid responses and early intervention	The therapy begins right away, engaging the patient as soon as possible, including amplifying useful pretreatment progress.
3. Clear definition of patients and therapists responsibilities	The therapist structures treatment contacts, conducts particular interventions and involves significant others as needed. The patient is encouraged to participate actively, including doing “homework assignments” and making behavioral changes outside of the therapy sessions.
4. Time is used flexibly and creatively	The length, frequency and timing of sessions vary according to patient needs, with the idea being the most parsimonious intervention likely to have positive effects in a given situation.
5. Interdisciplinary cooperation	Medical and psychological involvement blend into a more holistic view of the patient.
6. Multiple formats and modalities	Allied health professionals may be used as indicated, as may appropriate medication. Individual, group and/or marital/ family therapy may be used in sequential or current combinations and participation in various community resources (including self-help, 12-step and support groups) may be vigorously encouraged.
7. Intermittent treatment or a “family practitioner” model	The idea of once-and-for-all “cure” gives way to a more realistic view that patients can return for “serial”, “disturbed”, “allotted”, rationed”, or “catalytic” treatment as needed, often focused around developmental issues throughout life cycle. The therapist-patient relationship may be long-term although frequently abeyant.
8. Results orientation and accountability	Is treatment helping? Outcomes measurement helps define what works best. Utilization review and quality assurance function as complementary procedures, efficacious relief of symptoms being in the best interests of the patient as well as the company.

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SURPRISED BY JOY, OR WERE YOU EXPECTING HER/HIM? WHAT CAN WE LEARN FROM OUR INTERNALIZED CLIENTS?

Introduction: The practice of *internalized other questioning* refers to the idea that the “self” is made up of a person’s internalized community of significant other. One can “step into” the experience of the other by being addressed by the name of the other person and being asked a series of questions. What can our internalized clients offer to nurture and sustain us?

Invitation: Break into small groups. Now, think of a specific person (client) you have worked with that had a significant impact on you and your work as a therapist. Imagine that person as best you can—the way they talked, what they said, their intonation, how they sat, how they looked, and so forth. Immerse yourself in the experience. Now, using the practice of internalized other questioning, have your partner interview you as your client. The interviewer should function like a reporter of journalist, simply trying to get “the story”. He or she should attempt to draw out specific details and particulars to increase verisimilitude, but should not attempt to “therapize” (change or modify) the client-therapist interviewee. The following are some questions that you may use as guideposts (feel free to devise and ask your own questions). Interview from the internalized other position for about 10-15 minutes.

- What impact did your therapist, _____, have on you? What did you value most about her or him, as a therapist and as a person?
- What would you want your therapist to know about your work together? Were there some things you wish you would have said to her/him? What else? What kept you from sharing this with your therapist?
- What did your therapist do that helped your sense of hope and optimism? What else?
- What submerged strengths and energy did your therapist touch? What “latent joy” did she or he miss?
- Was there a “critical moment” or situation that especially captures or symbolizes how your therapist worked with you in helpful ways? What was said? What happened?
- If you were to tell your therapist something she/he may not have known (or not fully appreciated) about her/his effect on you, what would that be? What would you say?
- Did your therapist share what positive effects your work had on her/him? If so, what was that like? If not, how would you have experienced that?

Now, step out of your client's experience and return to begin interviewed as yourself (10-15 minutes). Have somebody ask these questions (or invent your own):

- When you get in touch with your client's experience you, what counseling abilities do you most appreciate about yourself?
- What effect will it have on your work knowing how much you impacted your client's life?
- How does getting in touch with these abilities and effects fit with why you became a therapist?
- What colleague/ friends/ previous supervisors/ clients support these intentions? How? Who would be glad, even honored, to know of your work with the client? What would they say—what words might they use?
- What did your client stimulate in you that you want to nurture and expand? Where is your sense of humor in your clinical work? Your spirit of adventure?
- Do clients get inspired by your sense of hope and passion? How?
- What about your client's experience invigorates you? What gives you joy?
- How will you remember and recall what you have been learning here? When you feel tired or frustrated, what about this client's experience will help encourage you? When you need it, how will you remember?

Now switch roles: The interviewer becomes the interviewee, and vice versa. Again, work through the internalized other questions for 10-15 minutes; then interview as self for 10-15 minutes.

Before Closing: The exercise invites a greater awareness of one's influence and the need for accountability and clarity about personal ethics. It is not intended to be a solipsistic stroll through a hermetically sealed hall of mirrors, nor is it intended to indulge clinical incompetence of a self-congratulatory sense of grandiosity or arrogance. Discussing the experience of the exercise with colleagues is very important, lest one become isolated without recourse to extra-self input. Questions to consider might include:

- Why was this client chosen to reflect upon?
- How do we know the client's wishes and autonomy were honored?
- What ideas might the interviewer and/or other colleagues contribute to help further the therapeutic endeavor?

From: M.F. Hoyt & D. Nylund, "The Joy of Narrative: An exercise for learning from our internalized clients." *Journal of Systemic Therapies*, 1997, 16(4), 361-366. Adapted and reprinted in M.F. Hoyt (2000), *Some Stories Are Better than Others*. Philadelphia: Brunner/Mazel.
