# *Capturing the Moment*

## *Single Session Therapy and Walk-In Services*

**Edited by**

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*Shalom*

("Hello, Peace, Goodbye")

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*Chapter One*

# *Editors' Introduction: Single Session Therapy and Walk-In Services*

*Michael F. Hoyt and Moshe Talmon*

Could one therapy session be enough for some people? Collaborating with our esteemed colleague, Robert Rosenbaum, in the 1980s we began a series of studies to explore the possibility of a single therapy session being adequate and appropriate for some client/patients. We became curious when we noticed that, in the clinic where we were then working, about one-third of patients did not come back after their initial intake appointment. At first, we thought these must all be dissatisfied customers and therapeutic failures. Reviewing the existing literature, however, we found studies reporting both the negative effects of so-called "drop-outs" as well as numerous anecdotes describing one session successes from many of the "who's who" names in the psychotherapy field, including Freud's single session treatment of Katarina and his cure of Gustav Mahler's impotency during a long walk (see Kuehn, 1965; Rosenbaum, et al., 1990).[1] We also read the reports of David Malan, et al. (1968, 1975) from the Tavistock Clinic in London, in which a series of patients who made significant improvements after a single diagnostic interview were studied; as well as Bernard Bloom's fine 1981 paper,"Focused Single Session Therapy: Initial Development and Evaluation," in

1. See Appendix A for a listing of recent single session therapy case reports plus a summary of the research literature.

**which he cited numerous one session clinical reports and several preliminary research investigations, and concluded:**

> There is no question but that mental health professionals tend to view early and unilateral termination by clients as a sign of therapeutic failure and client dissatisfaction. Thus, it may be reassuring to know that empirical studies of client satisfaction and length of treatment (with particular reference to single session therapy), consistently fail to support this view. (p. 171)

Bloom (1981, 1992a) also offered some valuable suggestions for possible SSTs:

1. Identify a focal problem.
2. Do not underestimate clients' strengths.
3. Be prudently active.
4. Explore, then present interpretations tentatively.
5. Encourage the expression of affect.
6. Use the interview to start a problem-solving process.
7. Keep track of time.
8. Do not be overambitious.
9. Keep factual questions to a minimum.
10. Do not be overly concerned about the precipitating event.
11. Avoid detours.
12. Do not overestimate a client's self-awareness (i.e., don't ignore what may seem obvious).
13. Help mobilize social supports.
14. Educate when patients appear to lack information.
15. Build in a follow-up plan.

We then reviewed the charts and called 200 patients who had been seen for only one intake visit in our Psychiatry Department—and were pleasantly surprised by how many of them reported improvement and satisfaction. Encouraged by these retrospective findings, we approached our employer at the time (Kaiser Permanente) and received a grant to do a prospective study of potential single session therapy. In our middle- and working-class HMO clinic, we saw a series of 58 consecutive outpatients, ages 8 to 80, having a wide variety of diagnoses and presenting problems. With

some of the cases, we called them in advance of their appointment and asked them, *a la* de Shazer's (1988) Skeleton Key Question, to notice what was going on in their lives that they would want to have continue to happen. At the beginning of each in-office session (which included consent forms and videotaping when clients gave their approval), we essentially said: "The purpose of our meeting today is to work together to find a solution to the problem that has brought you here. We may be able to do it in one visit, but if not, we can schedule more sessions. Are you interested in that?" The therapy was thus not necessarily single session, but the seed for such an option was planted. We elected not to employ a single protocol or methodology. Each of the three therapists (and their respective clients) used whatever skills, theories, and techniques they might bring to bear. At the end of the initial therapy session, we asked clients if they wanted to make another appointment or if the one session had been helpful and adequate for now. Regardless of the clients' choice, we followed up by telephone with all clients (SST and on-going therapy) anywhere from three months to two years after the last session.

We found that 34 of 58 (58.6%) elected to complete their therapy in the one visit. When we followed up with them by telephone, we found that most reported significant improvements in both their original "presenting complaint" (88%) as well as in related ("ripple") areas of functioning (65%). SST clients were as satisfied and as improved as the on-going clients, despite the fact that we were much better trained in on-going and relatively long-term therapy than we were in conducting SST.

We first described these findings at the large Brief Therapy Conference, sponsored by the Milton H. Erickson Foundation and held in San Francisco in December 1988, then at the 1989 annual convention of the American Psychological Association (held in New Orleans that year); and then in two full-length books, *Single Session Therapy: Maximizing the Effect of the First (and Often Only) Therapeutic Encounter* and *Single Session Solutions: A Guide to Practical, Effective, and Affordable Therapy* (Talmon, 1990, 1993) and in a series of papers (e.g., Hoyt, et al., 1992; Hoyt, 1994a, 2000; Rosenbaum, et al., 1990/1995; Rosenbaum, 1993, 1994). We also developed a training videotape (Talmon, Hoyt, Rosenbaum, and Short, 1990) that was based on transcripts from SST sessions that were recorded with clients' full permission.

Based on our findings, we described some possible indications and contraindications, sketched some sample cases, and offered a series of general principles:

1. Expect change.
2. View each encounter as a whole, complete in itself.
3. Do not rush or try to be brilliant.
4. Emphasize abilities and strengths rather than pathology.
5. Life, not therapy, is the great teacher.
6. More is not necessarily better. Often less is more. In any case, better is indeed better.
7. Big problems do not always require big solutions. Clients with serious problems are often not as psychologically minded as their therapists and such clients are usually seeking pragmatic help rather than wanting to explore the nooks and crannies of psychosocial and psychosexual development. "Avoid the poor," advised Haley (1969) tongue-in-cheek, "because they will insist upon results and cannot be distracted with insightful conversations" (p. 76).
8. The essence of therapy is more about helping clients to help themselves than about the therapist's need to be needed.
9. Most clients (as well as healthcare organizations) have limited resources (time and money) and these should be preserved and respected.
10. Terminate in a way that allows the client to realize useful implications. "In terminating the session, the . . . therapist may help a client remember to remember, forget to remember, remember to forget, or forget to remember . . . The degree of closure appropriate to a termination covers a wide range and is influenced by the extent to which the therapy was seeking resolution of some issue or attempting to open up new possibilities" (Rosenbaum, et al., 1990, pp. 184–185).

These led to some clinical guidelines:

1. "Seed" change through induction and preparation.
2. Develop an alliance by co-creating, with the client, obtainable treatment goals.
3. Allow enough time for the session to be a complete process or intervention.

4. Look for ways to meet the clients in their worldview while, at the same time, offering a new perspective or hope about the possibility of seeing and acting differently.
5. Go slowly and look for the clients' strengths and resources.
6. Focus on "pivot chords," ambiguous or conflictual situations that can be reframed in therapeutic ways.
7. Practice solutions experientially, using the session to help clients rehearse solutions, thus inspiring hope, readiness for change, and forward movement.
8. Consider taking a time-out, break, or pause during the session to think, consult, focus, prepare, and punctuate.
9. Allow time for last-minute issues, to help clients have the sense that the session has been complete and satisfactory.
10. Give feedback, emphasizing the client's understanding and competency to make changes.
11. Leave the door open, follow up, and let the client decide if the session has been sufficiently helpful or if another session (or more) is needed.

Nevertheless, we emphasized that there is no single method or goal for attempting SST other than being with patients and using the skills that patient and therapist bring to the endeavor. As Hoyt (2009) has noted:

> Treatments may be as varied as the patients (and therapists) and what they come to accomplish. Single session therapies, like all forms of psychotherapy, can occur either by default (usually when the patient stops unilaterally) or by design (when patient and therapist mutually agree that additional sessions are not then indicated). The choice of a single session (or more, or less) should, whenever possible and appropriate, be left to the patient. "Let's see what we can get done today" is much more "user friendly" and likely to succeed than the resistance-stimulating "We're only going to meet one time." Most effective SST is thus *not* time-limited therapy—it is open-ended, the therapist may mention the possibility of one session perhaps being enough, and the patient may elect to stop after one visit. (p. 63)

Our results were generally well received, and we were gratified when Jay Haley wrote (see Talmon, 1993, flyleaf): "We once

assumed that long-term therapy was the base from which all therapy was to be judged. Now it appears that therapy of a single interview could become the standard for estimating how long and how successful therapy should be." The results also stirred controversy (see Cummings, 2000), since they challenged the notion that effective therapy needs to be a prolonged, expensive (read: lucrative) process. Some readers misinterpreted us to be saying that people should only get one session, or that one session was best for everyone, or that one session was all that was needed and more were inappropriate. (They didn't seem to attend to the word *may* when we said about potential SSTs that "the first session may be the last.") Still, many people—especially patients and professionals in healthcare organizations, community clinics, emergency room and primary-care physician offices, as well as hospital inpatient medical departments and insurance agencies—embraced the ideas and requested our training.

We saw ourselves as part of a larger movement (e.g., Haley, 1973; Fisch, Weakland, & Segal, 1982; de Shazer, 1985, 1988; O'Hanlon & Weiner-Davis, 1989; Ray & Keeney, 1994; White & Epston, 1990; also see Hoyt, 1994b, 1996, 1998, 2009; Hubble, Duncan, & Miller, 1999; Wampold, 2001) toward focusing more on people's strengths and resources rather than on their weaknesses and problems—some of this spirit originated in the innovative work of Milton Erickson, which highlighted using clients' positive strengths for problem-solving action (see Erickson, 1980; Haley, 1973, 1994, 2010). In 1993, Talmon wrote: "These concepts represent an alternative to the traditional model in psychiatry and psychotherapy: psychohealth replacing psychopathology, solutions replacing problems, and partnership replacing patronization, domination, and hierarchy" (p. 73). Privileging clients' ways of knowing, and their competencies to help them achieve outcomes they defined as successful, heralded a paradigm shift (see Hoyt, 2011). We were upsetting the psychiatric-industrial complex, asking: *Who's in charge here? Whose therapy is it? Who really holds the keys and the power? And how will therapists make enough money if their clients only come one time?*

We began to receive more and more calls to teach and do trainings on single session therapy (and brief therapy) from all around the world. We also continued to see our own clients, often for "one session at a time." Some felt one session was sufficient, others elected to meet with us intermittently, while others elected to be seen for regular, ongoing therapy.

## *Multiple Branches and Roots*

Other colleagues were doing related work in other vineyards. Recognition was given to the idea that one could have a single session deliberately, that is, the client and therapist have the advance understanding that they will only meet once—e.g., when clients come to a clinic expecting a complete-unto-itself, self-contained one-visit experience (Slive, et al., 1995—see Chapters 5 and 6 this volume) or when they volunteer to be a therapy demonstration subject at a workshop (Barber, 1990) or for a training videotape (e.g., Carlson & Kjos, 2000). A deliberate single session could also occur when a patient seeing another clinician meets with a different therapist as an understood one-time ("second opinion") consultation, sometimes in a "trouble-shooting" or supervision clinic (see Chapters 23 and 24 this volume; also see Gustafson, 1995, 2005, and Chapter 19 this volume); or when family members are brought in for a single meeting in the course of a patient's longer therapy (sometimes in inpatient and residential settings, as well as in outpatient offices) or in the course of a patient's medical treatment (see Chapter 18 this volume).

Walk-in SST has also been found very useful in humanitarian-emergency situations, where limited resources and somewhat chaotic conditions make return visits unlikely. The one meeting is it. In his excellent report on single session disaster mental health counseling in the wake of Hurricane Katrina, for example, John Miller (2011) recommends:

- Therapy begins at the first moment of meeting, often focused by the first question: "What is the single most important concern that you have right now?"
- Seeking client resources, often with questions such as: "What things have you tried?" and "What inner strengths would it be useful for us to know about?"
- Helping clients prioritize problems and goals, as guided by the question: "What will be the smallest change to show you that things are heading in the right direction?"
- Focusing on pragmatism versus any specific model of intervention, evaluation of results being based on whether the session was able to meet the client's stated goal, not on whether the problem was entirely resolved. Helping clients to adjust to and deal with the range of needs and emotions that emerge from the trauma is primary.

- Fostering a relationship with the service rather than an individual therapist by informing clients at the end of the session that they could return as needed and desired, and that another worker would be available and would welcome talking with them.

In addition to echoing these general suggestions and guidelines, Paul and van Ommeren (2013) also provide a valuable primer on the potential application of walk-in SSTs in acute emergency settings (they cite Hurricane Katrina, Haiti, and providing services in the midst of Colombia's internal armed conflict as examples). Their advice, which can apply to a range of SSTs, not just ones occurring in disaster situations, includes:

- Use various evidence-based approaches and techniques that fit your training, skill level, experience, and the client's presenting needs.
- Ensure the approaches and techniques fit within the culture or context.
- Keep the client focused on what is happening in the moment.
- Recognize that a single session is good for some people, but not always enough for many.
- Allow couples, individuals and small groups to participate in a session together.
- Help clients create a relationship with the service rather than the individual professional.
- Consider how providing single session services can help strengthen the existing mental healthcare delivery system.
- Provide the service in an accessible location where those who need help can access it at the time of need (community halls, schools, information centers, etc.).
- Ensure cooperation between single session service provides and professionals within the broader mental healthcare and psychosocial support system.

In an early review, Rockwell and Pinkerton (1982, p. 39) wrote: "The therapist must be alert to the possibility [of SST occurring], must assess quickly when s/he has a [potential SST] case in hand, set the process in motion, and determine a satisfactory stopping point." Eric Berne (originator of Transactional Analysis; quoted by Goulding

& Goulding, 1979, p. 4) said that he approached every group therapy session with the thought, "How can I cure everyone in this room *today*?" Mary and Bob Goulding (1979), recognizing that the power is ultimately in the patient and wanting to develop Berne's concept of *contractual therapy* to respect clients' stated treatment goals, would start their Redecision Therapy sessions by asking, "What are you willing to change today?" Jay Haley asked, "*If* I told you we're only going to meet one time, what would you want to talk about?" (see Hoyt, 2002). K.K. Lewin (1970, pp. 49–69) observed: "If a patient is seen even for a single interview, it should be a therapeutic experience. Sometimes it is not enough to offer the patient a mirror in which to see himself; often he must be encouraged to open his eyes and be shown where to look.... [T]he interview becomes an awakening, an intense stimulation of mind and spirit, and hopefully a corrective emotional experience." D.W. Winnicott's (1971) *Therapeutic Consultations in Child Psychiatry* featured one session interviews. Stephen Appelbaum (1975) articulated Parkinson's Law in Psychotherapy: work expands or contracts to fit the time allotted. Wells and Phelps (1990, p. 16) noted the economic pressures for briefer, more efficient treatment and predicted "The Survival of the Shortest." Bernard Bloom (1992a, 2001; see his Foreword this volume) updated his review of focused single session therapy and published (1992b) *Planned Short-Term Psychotherapy: A Clinical Handbook*.

Brief strategic approaches were developed in Palo Alto (Watzlawick, et al., 1974; Fisch, et al., 1982), Milwaukee (de Shazer, 1982, 1985) and Milan (Boscolo, et al., 1987). Bill O'Hanlon and Michele Weiner-Davis (1989) authored *In Search of Solutions* and wrote (pp. 77–78): "We have observed enough 'one-session cures' to be utterly convinced that they are neither flukes, miracles, nor magic. Rather, something powerfully therapeutic occurs in the interaction between therapist and client during these sessions." Budman, Hoyt, and Friedman (1992) edited *The First Session in Brief Therapy*. Nick Cummings (Cummings & Sayama, 1995) wrote about brief (including one session) focused intermittent treatment episodes throughout the life cycle. Pollin (1995, p. 128) discussed seeing "one-time-only patients" in medical crisis counseling. Irvin Yalom (Yalom & Leszcz, 2005, p. 488) noted that the composition of inpatient psychiatric groups changes rapidly: "I believe that the inpatient group therapist must consider the life of the group to be only a single session." Long ago, William James (1902) studied life-changing moments; almost a century later, Miller and C'de Baca (2001) wrote *Quantum*

*Change: When Epiphanies and Sudden Insights Transform Ordinary Lives*. Jim Gustafson (2005) published *Very Brief Psychotherapy*, and Rubin Battino (2006) published *Expectation: The Very Brief Therapy Book*—the latter two authors' chapters follow herein.

In the mid-1960s, the Haight-Ashbury Free Clinic was established in San Francisco (Smith, 1971), and then a few years later, the Walk-In Counseling Center was opened in Minneapolis, Minnesota (Schoener, 2011). Kupers (1981) called for a different way to treat patients in public mental health clinics to help reduce the high "no-show" rate. In Calgary, Alberta, Canada, the Wood's Homes Eastside Family Centre began in 1990 to provide walk-in single session community-based mental health services (Clements, et al., 2011; Slive, et al., 1995, Slive, et al., 2008; see also Chapters 5, 6, and 10 this volume). The walk-in movement in Canada has proliferated (see Clouthier, et al., 1996; Bhanot-Malhotra, Livingstone, & Stalker, 2010) and continues to grow. In Toronto, Ontario, Canada, Karen Young and her colleagues at the Reach Out Centre for Kids (ROCK) began to provide innovative and effective walk-in services based on narrative therapy practices (Young, 2011a, 2011b; Young, et al., 2008). In the early 1990s, Monte Bobele made a fortuitous site visit to Calgary, saw the innovative walk-in single session work being done, brought the idea back to Our Lady of the Lake University in San Antonio, Texas, and began to establish training and service provision programs there.

Fast forwarding to 2011, our colleagues Arnie Slive and Monte Bobele (who have contributed two fine chapters to this volume) edited a book entitled, *When One Hour is All You Have: Effective Therapy for Walk-In Clients,* in which they highlighted the practice of having clinics in which a client could walk in for therapy with the expectation that it would be a one-visit encounter (what our Aussie and British colleagues might call a "one-off"). As Slive, et al. (2009, p. 6) wrote in an earlier article:

> Developed…as a result of community demands for greater accessibility to mental health services, walk-in therapy enables clients to meet with a mental health professional at their moment of choosing. There is no red tape, no triage, no intake process, no waiting list, and no wait. There is no formal assessment, no formal diagnostic process, just one hour of therapy focused on clients' stated wants. As well as meeting client needs, walk-in therapy is highly rewarding to professionals due to the simple fact