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Single-Session Therapies: Intrinsic Integration?

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Between one-quarter and one-half of all clients are seen for only a single visit. This holds true across a wide variety of settings and regardless of the therapeutic orientation of the therapist. On follow-up, many of these clients show surprisingly good outcomes. Rather than regard clients who come in for only a single visit as psychotherapy dropouts, it is possible to regard them as single-session therapies. Because single-session therapies are naturalistic phenomena that adhere to no particular "school" of psychotherapy, they offer a potentially useful vehicle for studying psychotherapy integration, particularly the relative contributions of specific techniques, common factors, and nonspecific effects. Three case examples are presented to illustrate some of the issues involved in single-session therapies.

KEY WORDS: Single-session therapy; brief therapy; psychotherapy integration.

INTRODUCTION

Between 20% and 60% of all clients who come in to a clinic for psychotherapy do not return after their first visit (Baekeland & Lundwall, 1975). Bloom's excellent (1981) review concluded that in community mental health centers'and family agencies, approximately one third of clients are seen only once; in private and university settings the figure is somewhat lower, but at least 20% of clients in those settings do not return after a single visit.

These figures confirm the obvious: many times, we only have the opportunity to see a client for a single session. This being the case, therapists have a special responsibility to maximize the effect of the first treatment session, knowing it may be the last. Every therapist has had the experience of seeing a client for only a single visit; most therapists can recall a single-session encounter in which they felt things had gone well. After an initial good session, therapists are often surprised or dismayed if the client does not return, and tend to assume something went wrong. Thus, clients seen for only a single visit are often confounded with clients who drop out of psychotherapy, regardless of whether or not the single treatment session seemed helpful.

The frequency of dropouts cited in the psychotherapy research literature seems to be in the same range as the frequencies for single-session visits cited above. A recent meta-analysis (Wierzbicki & Pekarik, 1993) placed the overall dropout rate for psychotherapy at 47%; rates were higher for minority clients, as well as for clients with lower levels of income and education. Most of this literature defines psychotherapy dropout either as client failure to continue past a certain number of sessions (usually 3-4), or uses therapist evaluations that a client has terminated treatment prematurely. However, most of these studies of dropouts failed to contact the clients themselves to determine actual outcome.

The dropout literature presumes that therapy requires a certain minimum number of sessions to be successful. The very term "psychotherapy dropout" conveys an implication that clients who do not continue therapy past a certain point are either dissatisfied with or resistant to therapy, and do not complete enough treatment to obtain significant benefit. In fact, there is a substantial body of literature that indicates quite a different state of affairs. First of all, while therapists may assume that clients who come only for a single session drop out of therapy due to resistance or dissatisfaction, research indicates that in a large proportion of cases reality-based factors (e.g., lack of money or time, moving to a different city, conflicts with job) are the reason for noncontinuation (Kogan, 1957). More important, when clients who came in for only a single treatment session are contacted on

follow-up, they show a high degree of satisfaction with the therapy they received; not only do they not rate therapy services differently than clients who completed an entire course of treatment, but in a large proportion of cases (79%) they report that the problems which brought them to the mental health center have been resolved (Littlepage, Kosloski, SchneUe, McNees, & Gendrich, 1976; Silverman & Beech. 1979). Malan, Heath, Bacal, & Balfour, (1975) found that 51% of what he called his "untreated" patients (i.e., those who had only an intake interview, and then dropped out of his study of psychodynamic brief therapy) showed significant symptomatic improvement on later follow-up; half of these patients showed not only symptom remission, but also important personality changes that met his criteria for structural psychodynamic change years after the single session.

The degree to which clients can be affected by brief therapeutic contact can be impressive. Cummings and Follette's (1976) study is typical: it found that when medical practitioners merely provided an additional 5-10 minutes of attention and support, there was a dramatic improvement in patient functioning and a corresponding drop in medical utilization. Within the field of psychotherapy, the extent to which a single session can constitute a meaningful intervention to the client, and not just an "information-gathering intake evaluation," is clear in the following quotation (taken from one of Malan's patients contacted for follow-up several years after his single contact): .

> My first [and only] interview here was like having to do a very complex algebraic problem, and somebody sits down with you and tells you how to work it out and get the answer. I didnt realize that my feelings were quite so strong and that my father was there behind things. Since that time I have been able to see it. This has helped. .. . The interview .. . made a tremendous impression on me ... [it] upset me, not because someone told me something I didn't want to know, but I felt as if I had been *run over*. You know, if you have a small accident, you feel sort of shaky afterwards. (Malan et at., 1975, p. 121, italics in the original)

These kinds of reports indicate that clients who do not return after a single session are not necessarily treatment dropouts or failures; seeing a client for only a solitary meeting may not represent a "no treatment" condition, but rather a single-session therapy that, like any therapy, can vary in its effect. The tendency to assume that such cases are treatment failures may derive from some combination of preconceived theoretical notions of what therapy "should" consist of, combined with the difficulties of obtaining follow-up data on such cases. However, when roughly one-third to one-half of all client visits in outpatient clinics are single sessions, it is surprising that so little attention has been paid to these cases. This may be due to a kind of "resistance" based not just in rational skepticism, but also in a need to maintain a particular kind of professional identity or personal self-image (Rosenbaum, 1988).

Therapist resistances to brief therapy in general have been characterized by Hoyt (1985) and Winokur and Dasberg (1983). They include theoretically derived philosophical positions (e.g., "for therapy to be effective, 'deep' character changes must be accomplished"), unexamined assumptions (e.g., "more is better," a common bromide of capitalist societies), considerations based on personal self-interest (e.g., the therapist's intellectual desire to understand the etiology of a client's difficulties, even if such' understanding may not be necessary to provide a resolution of the problem), and economic realities (e.g., anxieties about earning an income if there is too much turnover in one's practice). These "resistances" appear to apply with even more force to single-session therapy. There is also a kind of psychological inertia: we become attached to certain ways of doing things, and these procedures then become a statement about ourselves. To be willing to entertain the idea that clients can change even in a single session, we must be willing to entertain changes in our images of ourselves as therapists.

Rather than assume that single-session visits inevitably represent treatment failures, my colleagues and I decided to study the issue with 58 consecutive clients at our outpatient clinic at Kaiser-Permanente. Full descriptions and results of that study are reported in Talmon (1991), Rosenbaum, Hoyt, and Talmon (1990), and Hoyt, Rosenbaum, and Talmon (1992). In our project, we approached each first interview as if it could be a complete therapy, and at the end of the session offered clients a choice between "single-session therapy" and continuing in ordinary brief treatment. Clients for whom a single visit was obviously contraindicated (severely suicidal or psychotic clients; clients with substance abuse) were excluded. We altered only three parameters from the standard treatments offered:

1. We set aside additional time for the session, usually 90-120 minutes instead of the usual 50-minute hour. (Although we wanted to leave room for the unexpected, and did not want to feel rushed, in fact the actual psychotherapy sessions almost invariably ran the "standard" 45 to 60 minutes, without any special effort on our part.)

2. We began each session with a statement like the following:

> We've found a large number of our clients can benefit from a single visit here. Of course, if you need more therapy, we will provide it. But I want to let you know that Tm willing to work hard with you today to help you resolve your problem quickly, perhaps even in this single visit, as long as you are ready to work hard at that today. Would you like to do that?

Obviously, this kind of opening statement on the part of the therapist attempts to structure client expectations toward the possibility of rapid change, while still leaving options available should single-session therapy not be sufficient. We were aided in this endeavor in that most of our clients had never seen a therapist before, were relatively psychologically naive, and therefore open to many possibilities. When asked whether they would like to "work hard to resolve the problem quickly," virtually all the clients in our study answered "yes," with one exception: the clients who were mental health professionals, and who therefore "knew" they needed more than one session.

3. We ended each session with a statement like the following:

> So, today you've . . . (brief summary of the therapeutic work begun or accomplished). How do you feel now? Is what we've done today enough? Or would you' like to schedule another appointment? We can schedule another appointment now, or if you'd like, you can think about it, or by out what you've learned here, and call me to make another appointment later. Which would you prefer?

If the client wanted another appointment, we would schedule it at this point. If the client did not want another appointment at this point, we would go on to say:

> OK, you can always call again later, or if something else comes up. Incidentally, since I am interested in how this is working for you, if I don't hear from you in the next 3-4 weeks, would it be OK for me or one of my associates to call you, and find out how things are going with you?

We found that when the single session was framed in this fashion, 58% of our clients felt the single psychotherapeutic session was sufficient, and chose to not come back for further treatment with us or another clinician during the one-year period of the study. When an independent evaluator contacted the clients by phone for a follow-up 3-12 months later, the 34 clients seen for a single session did not differ on any of our outcome measures from the 24 clients seen for a complete course of brief therapy. Both groups were doing well; 88% of the single-session clients rated the presenting problem as much improved or improved. An additional 65% of the single-session clients reported

other areas of their life, beyond the presenting problem, had also improved in a kind of "ripple effect." .

Obviously, these results can only be regarded as preliminary. Although we utilized independent evaluators on follow-up, and employed a modified version of an individualized (target behavior) outcome rating scale, the results relied heavily on client self-reports. In part this was due to the pilot nature of our work; in part this represents a deliberate research strategy. When studying single-session therapies in which clients are seen for a total of perhaps 60 or 75 minutes, it does not make sense to have the client spend an additional 60 minutes filling out objective measures and questionnaires. Nonetheless, the very high proportion of positive outcomes is suggestive, at the least, that we cannot automatically assume all single-session visits to be treatment failures.

Here is a verbatim transcription of a typical client report at one-year follow-up after a single-session therapy for anxiety and depression secondary to family problems, illustrating how a single therapy session can be effective not only for the presenting problem, but can also lead to wider changes in a client's life:

> I remember at the time I came in I was feeling overwhelmed, the kids were getting under my skin. I bad been a 24-hour-a-day mother for five years. I felt I was isolated, the only mother with such problems.
>
> I remember the session well... I took your suggestion [making an appointment with herself, away from home]. Every month I make two appointments with myself of two hours each. I get my nails done, meet with • friend in a cafe, and we chat about everything except the kids. If I feel the kids are getting under my skin, I take a walk or switch to some other activity.
>
> I realized nobody can be a 24-hour-a-day mother. We all need time and space. When I topped feeling the kid* were getting under my skin, I started feeling better as a mother. That freed me to take care of other parts of myself; like, I started paying more attention to taking care of my looks. That led me to start feeling better about myself. And that seem* to have made my marriage better. *You see how the little things make a big difference?* (Talmon, 1991)

SINGLE.SESSION THERAPIES AND PSYCHOTHERAPY INTEGRATION

If we do not discount them out of hand, and are willing to regard single visits as potentially self-contained psychotherapies, single-session therapies can offer a special opportunity for therapists interested in psychotherapy. integration. For one thing, the phenomenon of single-session therapies seems to cross theoretical lines. My colleagues and I began studying the phenomenon of single-session therapies after being intrigued to discover that all of the 40 therapists at our clinic had roughly the same proportion of single-session cases, regardless of their theoretical orientation.[3] In our outcome study, the 3 therapists had roughly equal success rates, despite different theoretical orientations and treatment techniques. This is not surprising, given the general trend of psychotherapy outcome research comparing different schools of treatment, but it is interesting to see that these findings seem to apply even at the single-session level.

The great advantage of studying single-session therapies for those of us interested in psychotherapy integration is that they occur too rapidly to allow therapists' ideas about what they think they are doing to get in the way of seeing what actually happens in therapy. Virtually all existing theories of psychotherapy posit a therapeutic process that requires multiple sessions to be enacted. Whether one believes that therapy works through analyzing transference, deconstructing irrational beliefs, or altering family structures, it strains credulity to maintain that these rather complex activities can be set up, carried forth, and consummated within a single session in the way the theories posit. In a single session, there simply is no time for the therapist to come to a detailed formulation and enact in full a sequenced plan of intervention. The vast majority of clients seem to get better anyway, at rates comparable to the improvement rate for all

types

The major orientations of the 40 clinicians in the clinic were representative of the major orientations of most United States clinics: psychoanalytically oriented psychotherapy, hypnotherapy, family systems/strategic therapy, and cognitive behavior therapy, with many therapists using an eclectic mixture.of psychotherapy, and above the rate that would be expected from placebos or spontaneous improvement alone.

This is not to say that technique is unimportant. In everyday life, language is an imperfect medium that never allows us to express ourselves fully; nonetheless, we must use language to communicate. In a similar fashion, technique provides the medium through which therapists express themselves. At the very least, technique provides guidelines for the therapist that not only orient the therapist to attend to the client in certain ways rather than others, but also helps the therapist avoid feeling overly anxious. Technique provides a vehicle by which therapists encounter clients; in the process, clients can leam both specific new skills and new ways of relating.

To the extent that single-session encounters are actual therapies, they surely partake of the common factors and nonspecific effects that psychotherapy research is constantly alluding to as constituting a large part of the variance in therapeutic outcome (Lambert. 1986). Recently, a growing number of researchers and clinicians have been advocating that we pay more attention to both nonspecific effects and common factors (Castonguay, 1993; Goldfried & Castonguay, 1992; Butler & Strupp, 1986). Certainly, single-session therapies provide a healing setting, a helpful relationship, a way of framing and explaining clients' problems that conveys a sense of hope and the possibility of change, and a kind of ritual enactment that therapist and client both believe will restore the client to functioning well (Frank, 1973). However, it remains problematic to specify more concretely just what potentiates "nonspecific effects" or how "common factors" seem to operate effectively in some cases but not others.

It may be instructive for theorists and therapists interested in psychotherapy integration to examine what occurs in both successful and unsuccessful single-session therapies. By providing a kind of therapy in miniature, single-session therapies may offer a window on therapeutic change events that is less influenced by the claims of existing schools of therapy, but that is more ecologically valid than analogue studies. Since therapeutic techniques, common, factors, and nonspecific effects must occur in their most rudimentary forms in single-session therapies, we may be able to obtain clues as to the nature of these factors and the relative contributions each makes to the process of change. Furthermore, if we think about the kinds of research tools we currently use to analyze psychotherapy, and consider how these are (or are not) applicable to single-session therapies, we. may discover new methods that are less dependent on old theories for studying the "basic stuff' of psychotherapy. Applying a phenomenological analysis , to single-session therapies, during which we bracket our preconceived notions, may allow us to discover the fundamentel processes that underlie much of our therapeutic work.

At this point, while we have videotaped a number of single-session therapies, we have not yet had an opportunity to analyze the cases intensively. My colleagues do not offer answers to the questions raised above, but rather an invitation to explore what seems to be a robust phenomenon for clues to the foundations of the therapeutic experience. I will therefore present some case material from clients I have seen, in the hope that this will stimulate further exploration by others of single-session therapies.

EXAMPLE 1: A CASE OF HEAVY IDEALS

A 28-year-old single woman requested hypnosis to help her lose weight. She seemed mildly depressed to the therapist, and on inquiry, it turned out that she had discontinued several activities that previously had been a source of pleasure, and moved back in with

her parents. Still, she denied any difficulties or need for any treatment besides hypnosis for weight control. After about 15 minutes of getting to know the client, exploring her presenting problem and background, the following interchange occurred:

T: I think the problem is not so much that you should lose weight, but that once you do lose weight you should be able to stay and be the way that you want to be.

C: Okay, they are both right. I think one of my biggest problems right now is my mother. And, I have always been very confident being overweight. I dress nice. I look good. A lot of men did find me attractive, but lately I feel that she is influencing me; she is kind of pulling me down. Not intentionally, she just wants the best for me, and she feels that in society being overweight is a negative thing. ... And, I guess she is concerned about my health. She says certain things to me that, I have a complex because of this. My friends notice it, and I have noticed it. I tried to explain it to her, but she says "'Oh no, no, no, I am not doing that to you. You are doing that to yourself."

T: Does she sort of offer you advice just kind of out of the blue, or does she call you up, or ...

C: Well, she will say things like—I said one day to her, "Oh my fingers are a lot like daddy's, just the way they are made." "Oh well, they used to be thinner, when you were thinner, they were like mine." Things like that. ... I know she means well, but at the same time it doesn't help my self-image.

T: So when she says something like that, you react.

C; I get depressed. And I tend to go, I guess maybe it's a rebellious thing, I'll go out and get something to eat.

T: Do you ever say anything to her?

C: ... I'm tired of defending myself, a lot of times. So, I tend not to say things because of this.

T: How often do you see her?

C: We live together.

T: You live together?

C: So a lot of times I will stay up in my room if I'm home because I just don't want that kind of interaction. I know that I have been huh, I'd say like, I'm going on a diet. And the next thing, she turns around and I'm not doing diet things, that type of thing, and she will comment on that. It's the way she looks at me. I think, in a way, I wish 1 could move out. I can't afford it right now, but I think probably I need to be at a distance because I feel that I am not really being accepted. I'm not meeting up to her potential, I mean, what she expects me to be. And, I think that is some of my problem too, that I don't feel that I'm successful enough. So, I'm an overachiever. I want to be at the top.

T: Uh-huh. You know, I am curious. If you did do just what your mom wanted and lost the weight and did the things she wanted, do you really think she would be happy, or do you think she would find something else to find fault with?

C: I don't know. I have a brother, as you know, and I have always had the weight ot being the ideal child. [This statement was made very matter-of-factly by the client, but did not seem to stand out in any way to her. To the therapist, the statement was crucial. It summarised she problem in one sentence, and also offered an avenue to its solution. It therefore can function as a "pivot chord," a .psychological space where a solution can emerge from what appears to be a problem (Rosenbaum, 1990)]. He is a drug addict, and his .life has declined in the past two or three years, and I have always been the one to get the good grades. I have never been a problem child. The only problem that I have had is being overweight, so ...

T: Gee, everyone is entitled to some problems, aren't they?

C: Yes, oh yes, yes. And, I figure being overweight is my only problem, and that's not too bad.

T: Uh-huh.

C; But, I think to a certain degree, I had most pressure. I think, of trying to be better. Like I said, it is partly me, and then partly not ... [There followed more discussion of family circumstances. Father was portrayed as a neutral figure. No other salient factors emerged.]

T: Well, let me ask the question then, if you had a choice between getting your mom off your back or losing weight, which would come first? [The therapist senses that, while the client has desires to be more autonomous, she is conflicted in this area. To push for more autonomy may meet with resistance. This question, posed as a choice, is a diagnostic probe.]

C: I don't think your mother can ever be off your back.

T: No, really?

C: No, I don't think mothers will ever be off their daughters' backs. I have friends that their mothers have said certain things to them—"Well, you're not as pretty, you know," as this other girl that she might be competing with. My friends, it is really interesting, some of the mothers are very nice, and they don't bother them about weight, or not having a. boyfriend, or whatever, but then I think on the whole, most women do hear from their mothers from time to time.

[*Given this statement, the therapist fell that the client would probably not be interested in direct talk about*

"individuating from mother." The therapist went on to explore the specifics of the client's interactions with her parents. There were some attempts at cognitive restructuring targeted at the client's perfectionism, which seemed unsuccessful The therapist then employed a metaphor, drawing on the client's interest in singing, to offer an indirect suggestion to encourage both autonomy and weight loss by finding her own voice through experimenting with singing "High and low" until a comfortable key is found. The therapist then returned to the client's desire to lose weight, attempting to emphasize that it had to be something she did for herself rather than for her mother.]

T: So, whatever weight you decide to be, it is going to be your weight and not hers.
C: That's right. I don't know. I always see that the only way to get her off my back, about the weight, is to lose weight and let her see that I am trying.
T: I don't know. You sound like such a good daughter. [*Empowering and adopting client's values while subtly questioning them through exaggeration*.]
C: Ha, ha. I've got flaws, but yeah, pretty good.
T: Okay. I think that there are a few things we can work on together which would be helpful for you, and hypnosis is one of them, and we can do that today, but I think lot the hypnosis to work, there are going to be a few other thing* that you are going to have to do in terms of the dieting. Just as you know that hypnosis won't work without dieting, right. Well, dieting won't work without doing a few other things. I don't want to treat you with hypnosis now unless we can get an agreement to do these other things. [*This an "anticipation" technique in which the "cure" precedes the treatment technique (Rosenbaum. 1991). It is rather like syncopation in music. Getting the client to agree to this technique will essentially solve the problem before any "treatment" (ie., hypnosis) is administered since it will indicate the client has already made a fundamental change in altitude*.] Now, I want to run them by you.
C: Okay.
T: This isn't going to be a blank slate. [*Encouraging autonomy, implying the client will have to make her own decisions about the therapeutic program*.] The first thing is, in terms of the progress of any kind of weight low you have, okay. Have you thought about how you are going to set this up with your mom, and what you are going to tell her, and what pan she is going to play in all this?
C: No.
T: What have you done in the past?
C: I usually, sometimes, I will tell her to try to help me along, and then at times I don't ask her because if I go off, and go on a binge, or whatever, I don't really need that force coming at me saying, "You know, you are supposed to be on a diet, or you should be on the diet," that type of thing. So, I have decided that I would not involve her when I made up my mind to diet. I'd just start it, do it, and not worry about telling her.
T: Think she'll notice?
S Oh, yah.
T: Do you think she will say something when you start doing this?
C: She probably will.
T: You see, I think that's a problem with the strategy that you have. The idea behind this strategy, I think, is wonderful, and to do it on your own for yourself. But in practice, when you're in the house with another person who has her eyes on you, like glue, it is going to be hard to do it.
C: Yes.
T: Hiding it doesn't work.
C: No.
T: Because it's going to be visible as you lose weight. [*Not "if" you lose weight, but "when" you lose weight, the language used presumes change.*] Enlisting her isn't going to work because that's going to make her be part of it. But, I will tell you what idea I have on this, which is, I think you should announce to your mom that you're going, when you are ready but not before, but when you are really ready to lose weight and keep it off [*interposing an indirect suggestion*], then I think you should announce to your mom that you are going on a diet, and 1 think that you should tell her that you are going to post a schedule of the number of calories that you have eaten each day and your weight each day on the refrigerator, [*the client starts to protest*] Okay—Let me finish. And, I want you to fill that chart in each day, and ask her to check it, but when you fill in the chart, I want you to lie.*[*Alleviating the weight of being the ideal child by having her do something bad" (keeping a secret), which is also "good" (listening to her mother and going on a diet to lose weight)*.] I want you to give her the information, but give her wrong information.
C: Okay . . . [*smiles*]
T. So that she doesn't know what's happening, but she thinks she does. Now that's true of parents anyway. Now your brother knows how to do this already.
C: Oh yeah, he's good at it.
T: He's good at it. That's right. You might even learn a little something about him because I will tell you a

secret. To be a good hospital administrator [the client's career goal], you may have to learn how to do this. Okay. So this is good practice. Now, I have a prediction that when you do that you are going to get flustered and guilty, *[It is always useful to anticipate any difficulties so that, should they come up, the client will feel prepared.]*

C: You are probably right.

T: Am I right?

C: Uh-huh.

T: So, it is better practice yet, then. But, I want to form this way of your doing this, so that you will have mom off your back, and whatever she says you know it's not going to affect you as much because you know it is based on false information.

C: Oh, okay. So lie [*smiling broadly*]. [1]

T: What do you think about that?

C: That sounds pretty good, actually.

T: But let me say something that I kind of notice, as I am saying this, your face, your eyes look a little teary. [*Monitoring affect, looking for resistance and subsidiary issues that could interfere with the intervention.]*

C: Yeah but, I don't know what they're teary about.

T: What's that about?

C: I know I'm not crying or anything, ... I guess.

T: Hum, hum, you know what?

C: What?

T: I think that it is going to be a little sad to grow up and leave your mom behind, which is what this is. •

C: Oh yeah, oh yeah. It was hard for me to come back and live with them.

T: Was it? When did that start?

C: In '84. ...

T: Do you think they'll feel sad when you finally do move out and they'll be off on their own? [*This is an interpretation made without a whole lot of evidence. The statement is made as a probe, to examine (and defuse) any guilt the client might feel about leaving her parents*.]

C: Back again. Well, yeah. They were on their own for about five years.

T: Now, I don't want you to do this unless it makes sense. [*The client has been able to leave home successfully before, so the therapist gets back to the task at hand. There is simply not enough time during a single session to cover everything; the therapist has promised the client to provide hypnosis,*

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[1] When I first reviewed this session, I was shocked to discover that I had suggested to the client that she lie. As a religious penon, I have taken vows to not speak falsely. Yet during the session, and even now, this did not feel mendacious nor unethical. In trying to explain this to myself and excuse it to others, several factors seem important. (1) First, the intent of the intervention was to build a boundary between the client and her mother around the issue of weight loss. Since the client was living with her parents and eating at the same table, it would have been difficult to do this by simply having the client tell her mother not to interfere; the client could not help but display, through her behavior, what she was doing about her weight, and the mother could not help but observe and comment (if only by silence and a clenched jaw). It was necessary to create a behavior that would *actively* "jam" the usual interaction between client and mother. The particular behavior chosen—providing misinformation on a calorie chart—had no element of maliciousness or causing harm to the other. (2) Second, it seemed important to give a "shocking" message to the client that explicitly gave her permission to incorporate the "bad" sides to herself; this accommodation with the negative aspects of life seemed crucial to the therapy, altering both the client's self-image and her role in the family. (3) This encouraged the client to act in some way other than being the ideal child. Nobody can be an ideal child all the time: everybody must live his or her own life. To act *as if* the client could play the role of an ideal child is itself a kind of lie: perhaps it needed to be countered by another lie, to provide freedom of action to the client. (4) Finally, the nonverbal qualities of the interaction, not apparent in the transcript, presented the assignment in a playful manner. It invited the client to approach weight loss not as a grim task to be undertaken dutifully under the eyes of a watchful overseer, but rather as a kind of game that could have some fun to It. Games often require • a person to set rules in which he/she pretends to be something to another person that he/she is not. Perhaps if I had framed the intervention to the client as "pretending" to her mother, it would have looked better ethically; but I confess it feels that the use of the term "lie" seemed crucial to opening up a door for the client to behave more authentically. Can such “lies" help promote "truths?"

and time is running out, An important issue has been touched on; the therapist hopes the client has registered this and can continue to work it through on her own. If, at the end of the session, it seems more treatment will be necessary, another session will be scheduled.]

The therapist then obtained the client's agreement to resume some pleasurable activities (singing, dancing) she had previously enjoyed but had let drop. After exacting these agreements as the "price" of hypnosis, the therapist hypnotized the client. Following an induction that utilized the client's interest in music and singing, and that focused on attending to sensations accompanying her deep breathing, the client went into a light trance. A metaphor was introduced: the client was instructed to go shopping with her mother; then—leaving her mother outside—the client entered a changing room to try on some clothes. Within the changing room, the client took off layers of clothes and put them on, repeatedly, until she reached a point where "having found what's comfortable to take off, from now on you can keep them off." The attempt was to both emphasize autonomy while giving indirect suggestions for weight loss.

Six months later, as part of the single-cession research project, the client was contacted by telephone by an independent research associate ("R" below).

R: How are you doing now?
C: The problem is much improved. I lost weight again, and I've kept it off. I feel more focused and busy. I am going to graduate school, and plan to move to a better place which will give me more interesting job opportunities.
R: What do you think made the changes possible?
C. Making a firm decision, which is mine, and trusting my will power.
R: What do you remember from the session?
C: I remember the whole session. I went only once. The talking and the relaxation helped a lot.
R: Do you recall anything that was particularly helpful?
C: The insight. Realising that any attempts to please my mother and her expectations of me put a heavy weight on me. After the session, I realized that the only time in my life when I did not feel this need was when I went away from home to college. So I decided to go back to school again and in this way to become myself again. The rest felt into place relatively easily, because I was able to stand up behind my own decisions.
R: Did you find the single session sufficient?
C: Oh, yes.

Comment

When at the onset of the session the client said she came in for hypnosis for weight control, my heart sank. I do not generally do hypnosis for weight control (since I do not think it works that well), and in fact psychotherapy of any sort for weight loss is excluded by the clinic. So this seemed, perforce, destined to be a single-session treatment; I knew I would not be seeing this client again unless I found some diagnosable psychological problem. However, I did not feel comfortable "fishing" for psychological difficulties, since I feel it is generally a bad idea to have a client come in for psychotherapy and have the therapist convince the client she has more problems than she thought she had before making the appointment!

As it turned out, the central issue was stated elegantly by the client:

she had the weight of being the ideal child. The client said this without apparently making a connection between her weight difficulties and her interpersonal ones. This illustrates an important point for therapists: connections that may be clear to the therapist may be obtuse to the client. It is important to not ignore the obvious. Some therapists may have elected to interpret the statement to the client directly. Although it may not appear obvious from the transcript, it seemed to me that this client was heavily invested in

keeping the session circumscribed to issues concerning weight loss, and would have responded poorly to interventions that insisted the client become self-consciously aware of her conflicts with her mother. Whether or not this was a correct assessment is difficult to say; on follow-up, the client stated that the insight she received from the session was crucial to her. This does not, however, necessarily mean that a more direct approach would have been more successful. Perhaps this case indicates the latitude a therapist has to intervene in a variety of different modalities. In any event, I elected to intervene strategically, using the client's statement as a "pivot chord." In music, the pivot chord is an ambiguous chord that contains notes common to more than one key, and so can imply several "directions" to the music and facilitate the transition from one key to another. Similarly, it is important in all psychotherapy, and especially in single-session treatments, to find a way to create a situation in which the client's difficulty can become a fulcrum for change.

As can be seen from the transcript above, the client brought out most of the important issues, and it was the therapist's job not to get in die way. In all probability, the client had a wider agenda than just losing weight, although she may not have been particularly aware of this wider agenda (and insisted that weight was her only concern). The therapy consisted of clearing the field to allow the client to work further in a direction toward which she was already headed; the art came in striking the right balance. Overly focusing on the weight issue would have deprived the client of an opportunity to explore the autonomy issues; ignoring the weight issue would have forced the client to confront the autonomy issues more directly than she appeared willing to do at the time. The specific technique—hypnosis —functioned almost as a pretext, rather than an instigator, of change. The strategic intervention that the therapist offered probably served two functions: it helped alleviate the therapist's anxiety, by making him feel he was "doing something," and it legitimized for the client an opportunity to be less than an ideal child. Whether or not the client actually performed the actions was as irrelevant as whether the hypnosis "worked" for weight control. It is also impossible to tell how much the client would have benefited from such techniques if they had not been sprinkled with reflective listening, interpretation, and insight at selected points (such as where the client became tearful).

Simply listening to the client has a great deal of power. One of the dangers of doing single-session therapies is the tendency of the therapist to feel the need to "do" something quickly. In fact, it is best to avoid any attempt to be brilliant or work too quickly, as illustrated by the following case.

EXAMPLE 2; THE CASE OF RAMBLING ROSE

A 60-year-old woman was referred by her physician, who had successfully treated her breast cancer two years ago. Ever since that time, however, the client had been chronically anxious, fearful of a recurrence of her cancer, and hypervigilant to all aches and pains. She had never been to a therapist before, and was skeptical about the psychotherapeutic enterprise. The therapist, on hearing the presenting complaint, and noting the patient's apparent minimal psychological-mindedness and motivation for insight, quickly made a decision to treat the somatic preoccupations with hypnosis, a technique he had found useful in similar cases. The patient talked so rapidly and "rambled" so much that the therapist was unable for quite some time to get a word in edgewise to either establish a treatment focus or initiate a trance. This turned out to be fortunate.

The patient mentioned that her elderly mother was living with her. The therapist asked how that was for the patient, and the patient reported that she had been taking care

of her mother since she (the patient) was 14-years-old when her mother had ejected her alcoholic husband from the home. A simple question from the therapist, inquiring about the patient's father, elicited a tearful response. The patient described how much she had cared for her father, and how hard it had been to see him die on Skid Row shortly after the divorce. She had been her father's favorite and had been angry at her mother for leaving her father, but had never expressed these feelings. Instead, she had gone to great lengths to take care of her mother, at considerable self-sacrifice. The patient would not go out by herself because the mother would demand to be taken along. The patient had many things she wanted to do, especially travel with her husband who was due to retire, but feared that, obligated to her mother, she might die or become ill before she had the opportunity to travel and enjoy herself as she had dreamed.

The patient stated that she felt guilty about her resentment of her mother, and that she hid these feelings; she was fearful that admitting to her anger would cause her to take actions that would be overly hurtful to her mother. It became clear that she had never had the opportunity to discuss these feelings with anyone, including her husband. The therapist implicitly gave her permission to do so through quietly listening, and occasionally encouraged her directly to continue exploring her feelings, commenting: "You have the right to figure this out." This was the only major "intervention" by the therapist. The remainder of the session involved working through, in affective imagery and detailed planning, how the patient could carve space for herself and deal with her mother in a fashion that was both assertive and caring. In all of this, the therapist's interventions were minimal as the patient used the opportunity to think through her situation in a way that had not been available to her previously.

Since the therapist said very little, he was surprised when, at the end of the session, the patient said, "So what you're really saying, Doctor, is, I have to look out for myself more." The therapist simply replied, "Right."

The patient then said that instead of going directly from. the session to pick up her mother, she would take a little time for herself. On follow-up, the patient had worked out a viable arrangement to allow herself the freedom to engage in some of the activities she had wished for, while still taking appropriate care of her mother. The anxiety symptoms and somatic preoccupations had remitted completely.

Comment

If the therapist had jumped in with hypnosis too soon, the patient might have achieved some relief from her somatic preoccupations, but would have been denied a significant experience of dealing with a difficult interpersonal dynamic she had felt burdened by throughout her life. The therapist did not attempt to offer any interpretations. By simply listening, the therapist provided an opportunity for the patient to "ramble" herself free.

In other situations, the client may be less articulate or able to see his or her way to new actions. Then it becomes the therapist's job to intervene more actively, as in the following case.

EXAMPLE 3: A CASE OF RESPONSIBILITY, RESIGNATION, AND RAGE

A 23-year-old man came to the clinic complaining of "stress and problems at work." A blue-collar worker, he spoke in a dull tone of voice that was almost a monotone. He appeared quite depressed. At the start of the session he indicated that he really did not know whether therapy could be much help, and shrugged his shoulders fatalistically. He seemed to be "going through the motions" of coming to therapy at his wife's instigation.

C: [Shrugs]. I've never talked to anyone like a doctor about my problems and I'm not sure it'll help me. But my wife, she really thought I should speak to you. I'm under a lot of pressure and feel ready to explode.

T: [Shrugs]. Well, sometimes talking about things can help. [Said somewhat skeptically, in order to both join the client in his doubt about therapy, while also holding out the possibility of assistance.} Many people who come here and talk about their problems find that just one time can help a lot. Anyway, I'm willing to work hard today [an appeal to client's rather obvious work ethic] to help you get a better handle on things. Does that sound like something you'd like to do? [Seeing if the client will engage in therapy if it's framed this ways.]

C: Sure, O.K., I guess. [Not enthusiastic, but not completely unwilling.]

T: So, what seems to be the problem?

C: I don't know. It just seems like everything is building up. There's lots of pressure on me and nobody understands.

T: Could you give me an example?

C: Well, it's mostly work, I guess. My supervisor at work just won't get off my back. It all started about a year ago when he wanted to make me a foreman at the warehouse. That meant I'd have to do things to the other guys at work and I wasn't willing to do that. When the other guys saw my supervisor trying to make me a foreman, they all started getting on my case. I told my supervisor I didn't want any part of it. Ever since then he's been giving me a hard time. He tells me I should be more of a man and he gives me all kinds of advice.

T: He gives you advice?

C: Yeah, he tells me that because I've got a new baby, I have to support him and all. My boss makes me so mad, sometimes I just want to hit him.

T: Do you have a new baby? [*Since the therapist doesn't have an alliance with the client yet, it's important to inquire about a potentially crucial life event to build the alliance before addressing problematical issues, such as any potential for acting-out. The risk potential can be assessed later in the session.*]

C: Yeah, a son. He's about five-months-old.

T: Your first?

C: Yeah.

T: What's it like to be a father?

C: I really love the kid, but there's lots to worry about. My brothers, they all tell me to lighten up, but they don't understand how when you have a kid you can't fool around any more.

T: It sounds like you feel you have to be extra responsible now.

C: Yeah. Everything has changed.

[*There follows considerable discussion about being a father and how the client is taking care of his wife and child, and generally being overly responsible, but not doing much for himself.*]

T: It's clear you're able to shoulder responsibility. [*Building rapport*.] It's also important, sometimes, to not take on too much responsibility. [*Support, sending advice for client to take pressure off himself by doing more for himself./* Of course, it's clear you already know how to say "No" to responsibility which isn't right for you, like when you told your boss you didn't want to be a foreman. [*Building on previous ability; also returning to she presenting problem—work stress issue—so that potential for acting out can be assessed and hopefully interdicted. This statement also reminds client of his ability to set boundaries with his boss*]

C: Yeah, but ever since that time he's been on my case. He puts me in lousy jobs.... [There followed considerable discussion of the job situation. The cSent was not planning to harm the boss, but was worried about losing control and striking out. He became most incensed when the boss nagged him, in a critical way, about taking on more job responsibility in order to be a belter provider to his family.]

T: Where does he come off saying things like that? Is he your father or something? [Introducing bridge to allow exploration of possible client projections.] Jesus, he acts like it.

T: What about your real father? Where's he in the picture?

C: My mom left him when I was pretty small. He never took time with me. Now, though, it's funny. Just a little while ago, since I had my son, he looked me up. He was friendly and acted like nothing had happened. What did you do?

C: I didn't do anything. I mean, I felt it was weird for him to be coming around now, and all, but I didn't want to say anything. I just let it be.

T: But it sounds like you had lots of feeling about him not being around before now.

C: Yeah, well, I was about 7 when my parents split up, and it's not like we moved hundreds of miles away. We stayed in the same area. But he just never visited. My brothers, they were pretty well grown up by then. But I mean, I was just getting older. He could have come around sometime.

T: Sounds like you felt pretty mad at him for just dropping you.

C: Yeah ... I think I was.

Maybe you still are.

C: Yeah, I kind of am.
T: Kind of makes it hard knowing how to be a responsible father when your father wasn't responsible at all.
C: Yeah . . . that's right.
T: 'Cause you're a father now, and you really want to be responsible to your son, and consistent, and be there for him, not like your father was for you.
C: Dam right.
[There followed some discussion of client's feelings about his father, and how these have been stirred up by being a new father himself, and how they related to some of his feelings: of overresponsibility.]
T: You sound pretty hurt and mad.
C: Yeah, I didn't realize that I was. But I think that's really been bothering me, about my father.
T: [*diffidently*] You know, it's interesting, I wonder whether some of the anger you're feeling at your supervisor has to do with him acting kind of like a bad father to you. [*The obvious P-C interpretation (Malan, 1976.*]
C: You know, I thought about that. I mean, I didn't really think about it that way before. But I did think, "Where does he come off, acting like he's my father or something?" [*A nice description of how a person can have a thought of this sort but not have insight—i.e. not connect his immediate and past experience.*]
T: Of course he's <u>*not*</u> your father. [The therapist thought that, given the possible impulse control problems in this client, it was worth reemphasizing the reality and discriminating it from the distorted appraisal.] In fact, you're a father yourself now. And you know, whatever happened in the past, you can be the kind of father you decide you want to be. And one way of doing that is to just remind yourself that your supervisor isn't your father. [Direct suggestion, some cognitive restructuring.] And what the hell [purposely adopting client's language as a way of joining with him], you can walk out of his life every day at 5:00 or whenever. [Dynamically, this intentionally suggests a "tit for tat" with the projection of the father: father walked out on him, he can walk out on substitute father. It is important for this client to recognize the reality that, like any other worker, he can leave the job behind. The goal is to transform it to "just a job," without psychodynamic import.] But to be a good father to your boy, it sounds like you need to settle some things about your own father.

The client was willing to do this. A role-play was used to coach the client on how to talk to his father about some of his unfinished business, using both modeling and role-reversal. The client felt uncomfortable initially with the role-play, and this provided useful opportunities to examine some of this feelings in greater depth. At the conclusion of the role-play, the therapist suggested that the client might want to act on what he had learned by talking with his father, or might want to think about it or practice it some more, or could just absorb what he had learned and feel differently. This kind of open-ended suggestion, allowing for many possibilities, is good standard practice, given the limitations on time and the amount of practice that can occur in a single session.

At the end of the session, given the client's issues of abandonment, the therapist was particularly careful to leave the door open for the client to make another appointment. The client chose, however, to "think about it for a bit" without making another appointment.

On follow-up, the client was doing fairly well. He was enjoying his role as a parent, and felt less burdened. He was no longer depressed and tense. However, the situation at work had worsened; the client finally left the job, and was doing temporary work while looking for a more permanent position. When questioned about what, if anything, was helpful during the session, the client stated:

> He pressured me to think about what I needed to do. There was really no way at the time to know how bad things were going to get with my boss, but I wish he had advised me to confront the situation more and get out of there quicker. But when things got tough, it really helped that I remembered that the doctor had told me that no matter what people say, you have a chance to do things in a good way. That helped me deal with it without really losing it.
>
> I really appreciate the effort and you guys following up. It feels better just to talk about it now. It makes me feel like a person.

Comment

This was a moderately good, though unspectacular, outcome. On the external front, it is possible that the therapy helped the client avoid "losing it" (i.e., physically striking out at his supervisor). Since the client is no longer feeling depressed and overburdened by parenting, despite the economic pressures, it is possible that the therapy may have also helped defuse some of the client's internal psychological pressures. However, since the client relates to the therapist as someone who "pressured him" to do something, even if it was positive, it seems unlikely there was a change in psychological structure.

The therapist felt he needed to act as a kind of benign paternal figure to this client. Perhaps this was a response to the client's feelings of anger and depression at having been abandoned by his father in the past. Sometimes, though, clients who have had significant emotional deprivation or abuse need to be approached with less of an offer of an intimate relationship, and more" of a "matter-of-fact" neutrality that allows the client to keep feelings more at a distance, and thus feel safe enough to do the therapeutic work.

The last statement by this client was indicative of how the follow-up interview can be therapeutic. Telephone follow-up whenever possible is an important adjunct to the in-person meeting in single-session therapy. Surprisingly, contacting clients rarely results in fomenting in them a wish to be seen again: simply hearing the clinician's voice, and knowing someone is out there who cares, seems to be sufficient in almost all cases. We have found that when we tried, in a rather self-conscious fashion, to do "complete" single-session therapies without offering future appointments, we had a rather high rate of clients subsequently calling to be seen again. Interestingly, as soon as we began emphasizing, in accordance with our natural inclinations, that clients could call us anytime for another appointment, we had many fewer instances of clients subsequently calling. It seems that when clients know they can touch base, they feel less need to actually do so.

I think of this case as rather typical of the "generic" supportive psychotherapy that plays a large role in any therapist's practice (Pinsker, Rosenthal, & McCullough, 1992). In addition, this was a case where the reality factors in the client's life were crucial, both for the presenting problem, and the nature of the outcome. Such reality factors often play a very large role in psychotherapy outcomes.

CONCLUSION

Single-session therapies are nothing out of the ordinary; they occur with therapists of many different persuasions in many different settings. It can be hard, however, to credit the efficacy of a single therapeutic visit if we think of change as inevitably requiring a gradual evolution. Though we often think of nature as existing continuously and changing in small increments, recent geological evidence suggests that the world has changed not only through gradual evolution, but also through "punctuated evolution" where sudden discrete events such as meteorite strikes cause profound, long-term "structural" changes (Gould, 1980).

When I first was enlisted by my colleagues to work on the single-session therapy project, I had serious doubts about the enterprise. Shortly after beginning the project, I was taking a hike in the mountains. As I walked along, I was musing about the futility of single-session therapies, inspired by the stability of the huge mountains that loomed on either side of the valley I was traversing: "Perhaps some change can occur in a single-session," I thought, "but surely not significant change. Lasting change requires the gradual processes that mold mountains: time, slow erosion, wind and rain sculpting the face of the stone over and over again are required."

At that point, the trail turned around a bend, and I came face to face with a huge

avalanche chute. Half of a mountain, seemingly, had slid down into the valley the previous winter, changing both mountain and valley forever, all in the course of less than 30 seconds.

I decided to take the notion of change occurring in single sessions of therapy more seriously.

The human experience is marked by quantum shifts in being. All our lives begin with a discrete event: birth. Birth provides a model for the emergence of truly new beginnings, where something that was previously only imagined becomes tangible and fully present (Arendt, 1978). There is a gestation period prior to birth, but compared to the life that will follow it, the actual birth process is short. In most cases the birth process proceeds more or less naturally, without undue intervention by medical professionals.

The therapist who is interested in doing single-session therapies can leam a lesson from this. Clients come to us at different stages in the gestation process of changing; some of them will require a certain amount of waiting and preparation before giving birth, but others will be virtually fully dilated. Wherever the client may be in the birth process, it is seldom our task to "do something" to create change; rather, our role is more similar to that of the midwife, who attends the process, eases the transition, and provides a helping hand in case anything gets temporarily stuck. Those of us interested in psychotherapy integration should perhaps direct our attention not so much to how we can combine techniques such as hypnosis, visualization, and Lamaze breathing, but rather to the processes that enable natural childbirth.

Therapy requires a constant, ongoing process where the therapist adjusts to the client, and the client adjusts to this adjustment. This makes the manualizing of therapy precisely the wrong strategy for psychotherapy research: it attempts to mandate a process that to be successful, must proceed with a good deal of spontaneity, in its own fashion, and our goal should be to interfere as little as possible with the client's natural process of growth (Beme, 1964). Viewed this way, psychotherapy becomes an art of facilitating or widening clients' ways of encountering themselves and their worlds (Rosenbaum & Bohart, 1994); as in all art, skilled technique is necessary but not sufficient to produce a genuinely moving experience.

However skilled the poet, all poems are written one poem at a time. However skilled the dancers, all dance occurs one step at a time. Similarly, all therapies are single-session therapies, in that all therapies must take place one meeting at a time (Mahrer, 1989). Sometimes a session may appear quite mundane, uninteresting, or stale; we may think a session is merely a prelude or preparation for significant events that we anticipate will follow later. This often does not fully actualize the potential of the immediate meeting, and may leave the therapist and client waiting for a Godot who will never arrive. If we wait for our life, we will miss it. Psychological transformation does not lie in the future, but in the present; we are always, each moment, creating in this moment what we have been and are becoming. Varela, Thompson, and Rosch (1991) describe this as "laying down a path by walking."

Therapists who are alert to the possibility of single-session therapy approach each session—including the first one—as if it could be the last. This requires a certain attitude on the part of the therapist. Rather than relying on a prepackaged technique as a vehicle for therapeutic change, they recognize that clients (and therapists) are always changing, and always introducing obstacles to change. Hence, change can occur at any moment. Changing time is not clock time: changing time is that time where, as the Diamond Sutra says, the past is gone, the future is not yet, and the present cannot be grasped. Therapy, like life, is always right in front of us, actualizing itself one moment at a time; client and therapist bring their entire selves to each instant of their lives (Rosenbaum, 1992).

Of course, many clients are not ready to do this. This does not mean that clients who feel they need more help than a single session are "sicker" than clients who have

successful single-session therapies. Our impression is that those clients who benefited from single-session therapies were poised and ready to change. Many clients are not ready. How we potentiate clients' "readiness" to change is a crucial issue for psychotherapists. Some clients may simply need more time to prepare themselves to change, or to "ripen" the changes they are already incubating. Some clients need changes in the external circumstances of their lives that will allow them to experiment with changes. Many clients—no matter how fundamentally competent they are —have lost faith in themselves to such an extent that more therapy is needed. Some clients need to acquire specific skills or participate in trans-fonnative relationship experiences. We must always be willing to offer as

much therapy to a client as he or she needs. But we must also always be careful not to give a message to clients that they need more therapy, and cannot function well without it.

We must not peddle an illusion that therapy will somehow provide something to clients that is not already latent as a possibility within themselves. Ultimately, single-session therapies rely on a profound respect and appreciation for clients' potentialities. This is facilitated if we view people as not consisting of collections of fixed character traits, but rather as embodying multiple potentialities that have become temporarily restricted through attachment to an overly restricted view of self (Rosenbaum & Dyckman, 1994). We believe every single session of a therapy must point to rdeasement, in which clients can more fully actualize their true selves.

Single-session therapies, blossoming before client and therapist can mutually impose a rigid structure of expectations on each other, allow for such releasement. For therapists, it involves giving up some preconceptions, and facing our anxieties and uncertainties about our therapeutic arsenals. At the same time, it opens a field in which freedom and creativity can emerge, with a high likelihood of positive effects for client and therapist. When our clients come to therapy, we implicitly ask them to drop some of their old ideas and preconceptions about what can change and how change occurs. Single-session therapies offer a similar challenge to the therapist: to drop our insistence that change must occur in a prescribed linear fashion, and be alert to the changes occurring right now, before, and after the therapy session. Once we drop our preconceptions, we may gain what clients come to therapy seeking: a fresh start. Opening up to these possibilities, we can move forward on a path toward psychotherapy integration that we lay down as we travel through every single session we meet with each client.

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