

Single Session Therapy: What's in a Name?

The term 'single session therapy' (SST) is a great misnomer, given that almost universally, it would seem, about half the clients who are seen within this approach go on to engage in further therapy work, with a small percentage engaging in long-term therapy. It is not, as some critics (and researchers) assume, the same as offering only one session of therapy. So why call it single session therapy?

The term has served us well at Bouverie, despite (and sometimes because of) its obvious connotation. We have stuck with it, partly out of loyalty to Moshe Talmon's original (1990) book title (though he tells us that this was his publisher's rather than his own preferred title!), and partly because we have failed to find a term that encompasses what we are trying to offer in this work: the possibility that clients can be helped in a single encounter, as well as the possibility that it may well be useful for client families to engage in further work, and that this decision is best made not by the therapist alone, but in consultation with our clients.

It is now 18 years since we at The Bouverie Centre heard about the idea of inviting clients for a planned single family therapy session, with the option of either a further single session or ongoing work, decided between therapist and clients together at a follow-up phone call. At that time, our service was struggling with long waiting times and inequities for families, in that some managed to receive urgent allocation while others languished on the waiting list without complaining. Because of this, a lot of staff time was spent 'gate-keeping' in an attempt to rationalise the often scarce clinical resource. There were long and often toughly debated intake-allocation meetings, often resulting in families being called back with a 'sorry' and re-referral options only. A common experience was that the clinician who had spoken with the family at intake (and having clearly engaged with them) argued strongly on their behalf, while other staff, conscious of the burden of the waiting list, held a tougher line, and argued against their being seen at Bouverie. We have reflected often, both then and since, that if the time put to gate-keeping and debating those issues had been spent with the families, perhaps we could have been clearer more quickly about the appropriateness of their being seen at Bouverie, and been somewhat helpful, even if ultimately it was felt a referral on was needed.

However, back then the idea that some families could do well with a single clinical contact and follow-up surprised and even shocked some of us. It was only with time and learning from our clients that we came to trust that this was not only a valid option for service delivery, but a client-centred, efficient and effective way to manage a clinical service — especially given that it also allowed for useful longer-term work with those families who needed and did well with more.

We had heard about the work at Dalmar Child and Family Services, inspired by Laurie McKinnon's consultation (Laurie having been a colleague of Arnie Slive's in Canada). We also knew that the Canberra Child and Adolescent Mental Health Service was utilising a single-session approach, and that it had cut down waiting times for clients dramatically.

We were not sure that this therapy was for us. However, through the work of Pat Boyhan, a Masters student on placement at the time, we evaluated our own initial planned single-session project (Boyhan, 1996). We found ourselves convinced not only of the economies of such an approach (e.g. freeing up a resource to allow some families to engage in quite long-term work), but also of the clinical value inherent in the philosophy of a client-led process. We began to take greater care to work with the client's agenda, to check in that we were focusing on what was important to them, to utilise whatever resources we had available in the moment, to trust our clients to let us know what they needed, and to listen very carefully to their feedback. We think it is fair to say that this philosophy of practice has influenced Bouverie's family therapy work across the board.

Since then, Bouverie's single session therapy training has become one of the most enduring and popular on our calendar. We believe that this is not just about the appeal to efficiency and the possibility of cutting down waiting lists, but also that the therapy embodies the client-led philosophy, which leads to truly collaborative, client-centred, good practice. It has become clear, too, that many therapists, counsellors, support workers, social workers in general hospital settings, outreach workers, and others only get one 'go' at being helpful with clients, and the idea of making the most of any encounter fits really well for them.

This edition of our journal takes the opportunity to focus on the history, clinical developments, and research in this particular approach to practice. It coincides with a symposium to be held at Phillip Island, near Melbourne, in which a large number of now well-known names associated with single session and walk-in therapy, both local and international, will be sharing their ideas and experiences of using these approaches within different service settings over time. It is hoped that this might spark some future collaborations, and form the beginning of an international network of single session and walk-in therapy practitioners.

Moshe Talmon opens with a reflection on 25 years of working from his single-session philosophy, and makes the important point that his goal has always been to make the most of every therapeutic session, whether he is seeing a client only once or over a long period. He presents to us what he believes to be the 'DNA' of good single session therapy, which, he says, is very similar to that of any effective psychotherapy.

Alistair Campbell, who had carried out his own evaluation of SST published in this journal (Campbell, 1999) reviews the last 15 years of research on this approach. Despite his concern about a lack of rigour in much of the existing research, he finds encouragement in particular findings and invites us, rather than engage in more and more broad outcome studies, to consider that SST offers a rich research possibility in investigating what therapists actually do in a session that actually works.

In his article, Alistair comments on the work of Arnie Slive and others at the Eastside Clinic in Calgary, Canada. His walk-in service cuts through all form-filling, assessment-dependent waiting list management, and offers clients the opportunity to

see a therapist, generally within 20 minutes of walking into the service. There is no assumption of further therapy, and no follow-up, but clients are able to come back at any time. This work has a rich history, and continues successfully in Canada and Texas. It is summarised for us by Dr Slive and his colleague, Monte Bobele.

Then follow a number of accounts of SST in various service settings. Debbie Plath and Jill Gibbons write about the number of naturally occurring single encounters with patients and their families for social workers in general hospitals; Denise Fry writes about the current framework within her Child and Youth Mental Health (CYMH) setting that utilises a reflective team approach to single sessions with families; Imogen O'Neill and Naomi Rottem give account of The Bouverie Centre's own implementation of SST, in particular of the move from it having been a therapist-guided choice to employing SST as an agency-wide response to all new referrals. Finally Jeff Young, Shane Weir, and Pam Rycroft address the question of what it takes to introduce a new way of working across a state-wide service system.

We hope you enjoy reading these accounts, from some SST 'elders' as well as some newer to these ideas. Whether you are an SST sceptic (which is how most of us started out), a convert, or not sure, this set of articles should provide an interesting kaleidoscope on this sometimes extremely controversial, but always stimulating, approach.

References

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Jeff Young and Pam Rycroft