The Single-Session Therapy Mindset In Supervision

Seattle, May 2024

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Supervision *interrupts* practice.

It wakes us up to what we're doing.

When we are alive to what is happening now we wake up to what *is,* instead of falling asleep in the comfort stories of our clinical routines and daily practices.

[My italics]

–Sheila Ryan (2004). *Vital Practice.* Portland, Dorset, UK: Sea Change: UK. p. 49.

Quoted in Rycroft, P. (2018). *Capturing the Moment in Supervision.* In *Single-Session Therapy by Walk-in or Appointment.* M. Hoyt, M. Bobele, S. Slive, J. Young and M. Talmon (Eds). New York: Routledge, 334-346.

There are risks in ongoing supervision

- Becoming comfortable, feeling we know our supervisees' strengths, weaknesses, foibles.
  - If it's just validation and support for the supervisee we can fall into "we love them and they love us"
  - If it's just focused on "what's the right thing to do for this client" we can fall into a critical, technical mindset
  - Either way, we can cease to be surprised, challenged, disrupted.
  - Adopting a Single-Session mindset for supervision
    helps us negotiate what is important in the here-and-now of each supervision session. Then we wake up to endless possibilities -

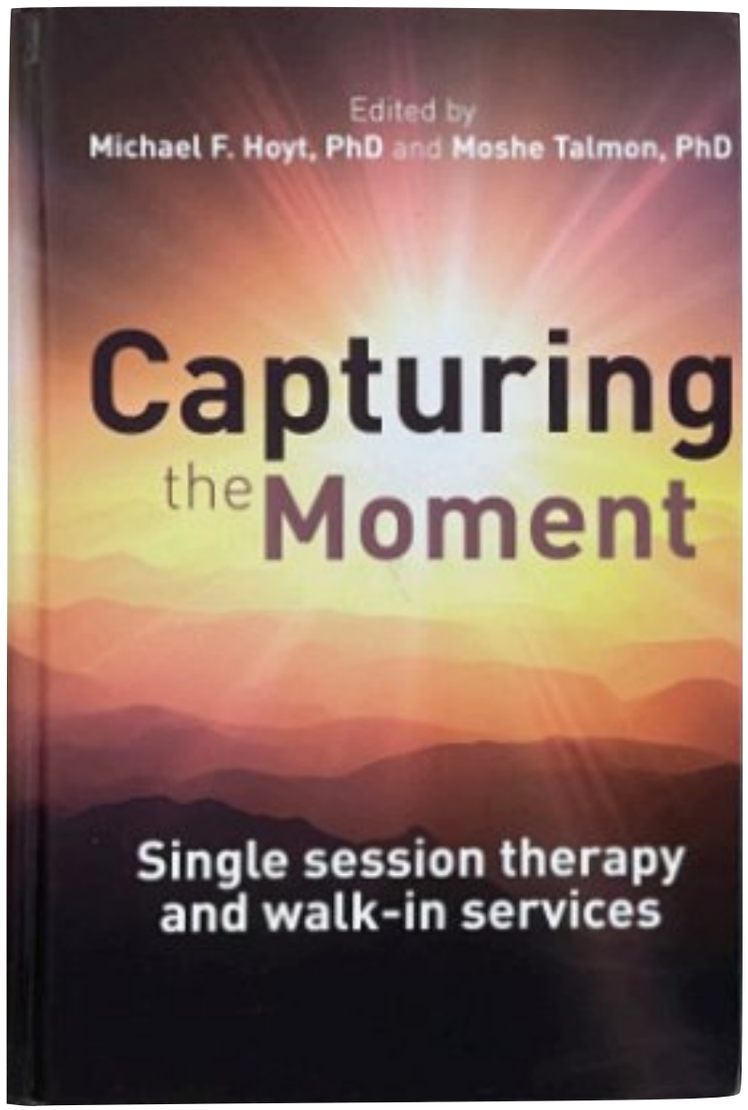
★ prepare to be surprised!

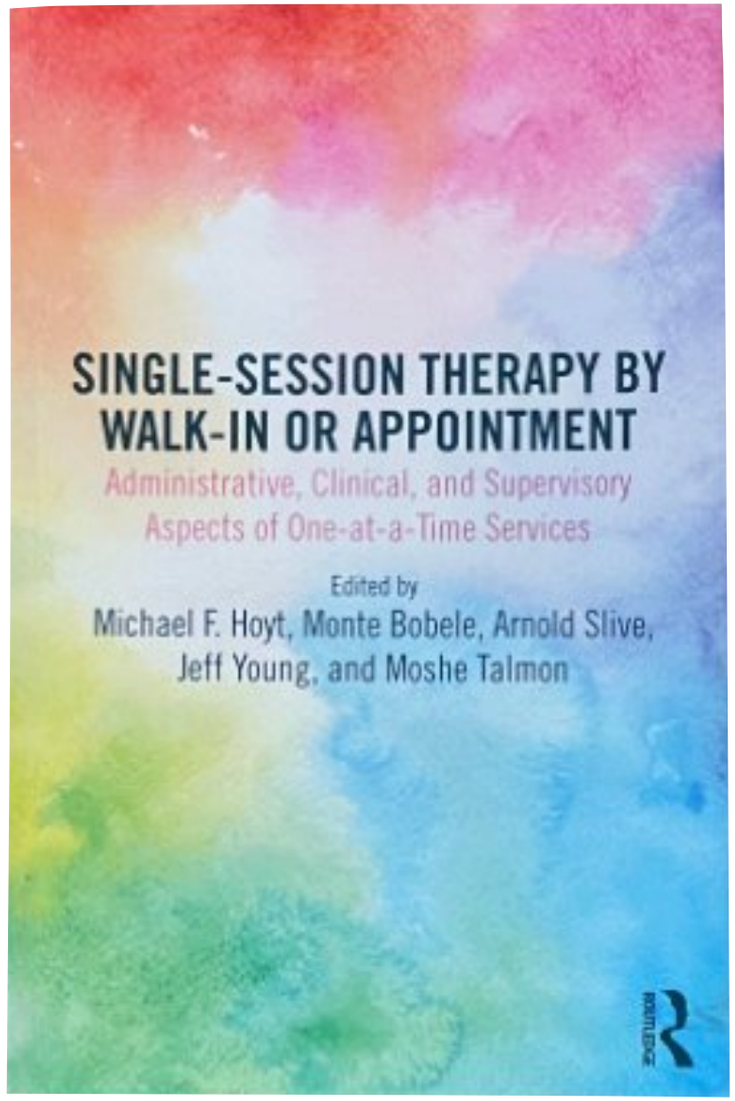
Rycroft, P. (2018). Capturing the Moment in Supervision. In *Single-Session Therapy by Walk-in or Appointment.* M. Hoyt, M. Bobele, S. Slive, J. Young and M. Talmon (Eds). New York: Routledge, 334-346.

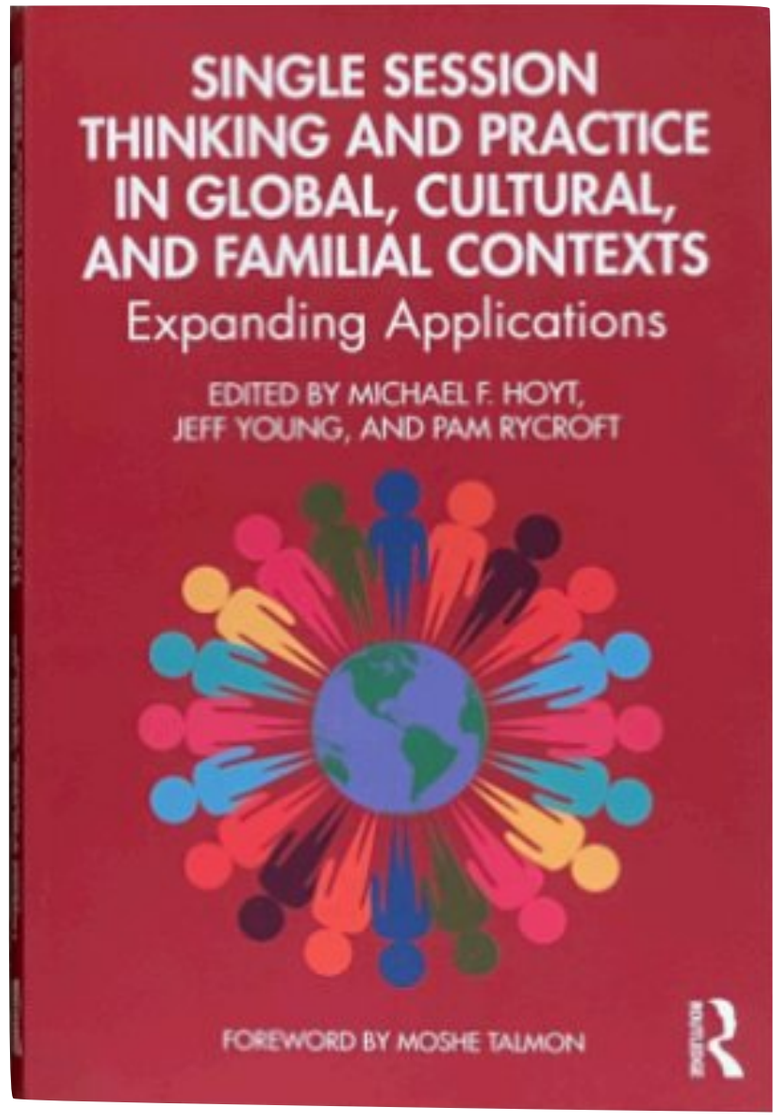
Single-Session Therapy: Some Background

Disclosures

No remuneration from any SST materials







Some of my articles on Single-Session Therapy, including chapters from these books, are available to read or download (free) on my website at https://www.robertrosenbaumphd.com/Rosenbaum%20Articles/

SINGLE SESSIONS….THE BASIC FACTS:

- Single session therapies occur frequently and naturally

- Single session therapies are about as effective as multi-session psychotherapies

- Single session therapies are not necessarily ultra-brief therapy. They can be open-ended, long or short:

SST is simply one-session-at-a-time therapy

- so <u>every</u> visit is a potential single session therapy

Background

Moshe Talmon learned *every* therapist in our clinic (including himself) had a high number of patients who only came in once

Moshe called his clients who had only come once and asked them why they hadn't returned

most said: "I didn't feel I needed any more"

Moshe then invited me and Michael Hoyt to join him in a research study of planned single-sessions

We found earlier references to single-session therapies

- Freud described several cases which were single-session
- Baekeland & Lundwal, (1975)
  - 20% to 60% of clinic clients are single visit
- Bloom (1981)
  - 1/3 of clients in community clinics seen only once
  - 20% of clients seen privately or in universities seen only once
- Littlepage et. al. 1976; Silverman & Beech, 1979)
  - 79% of early "drop-out" clients reported symptoms resolved
  - High level of satisfaction amongst "drop-outs," no different from continuers
- Malan et. al. (1975)
  - 51% of "untreated" (single session) clients had symptom improvement
  - Half of those patients showed *structural* psychodynamic change

My first [and only] interview here .. . made a tremendous impression on me ... I didn't realize that my feelings were quite so strong ...

[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.

Kaiser Permanente Study (Talmon, Rosenbaum, Hoyt, 1990)

Setting

- Psych clinic on-site in HMO medical center
- Prepaid plan covered up to 20 sessions of psychotherapy ($5 co-pay)
- Evaluation session followed by variable number of psychotherapy sessions
  - often 4-12 sessions recommended
- Unplanned: Under standard care, 33% of clients came in only once

Study Procedure

- No division between intake and therapy
- Introduction of possibility of SST at outset
- At end of session, asked client whether the session was helpful
- Gave client choices for future appointment

Statement of Possibility of at Outset

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 I’m 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?

No-fault Choice at Session's End

During end of session inquiry, client offered choice of making another appointment or stopping but leaving the door open for further contact

So, today you've. . . (brief summary of 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 try out what you've learned here, and call me to make another appointment later.

Which would you prefer?

No-fault Choice at Session's End

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?

Kaiser Permanente Study (Talmon, Rosenbaum, Hoyt, 1990)

Psych clinic on-site in HMO medical center, prepaid plan covered 20 sessions of psychotherapy ($5 co-pay)

- Standard care: 33% of clients were seen for only a single session
- When SST was offered in a planned fashion, 50% of clients chose to be seen only once *even when given an option to be seen for more*

Outcome Assessment

- Three months to one year later
- Interview done by independent evaluator
- Ten-Point Individualized Problem Rating Scale

Group Comparisons

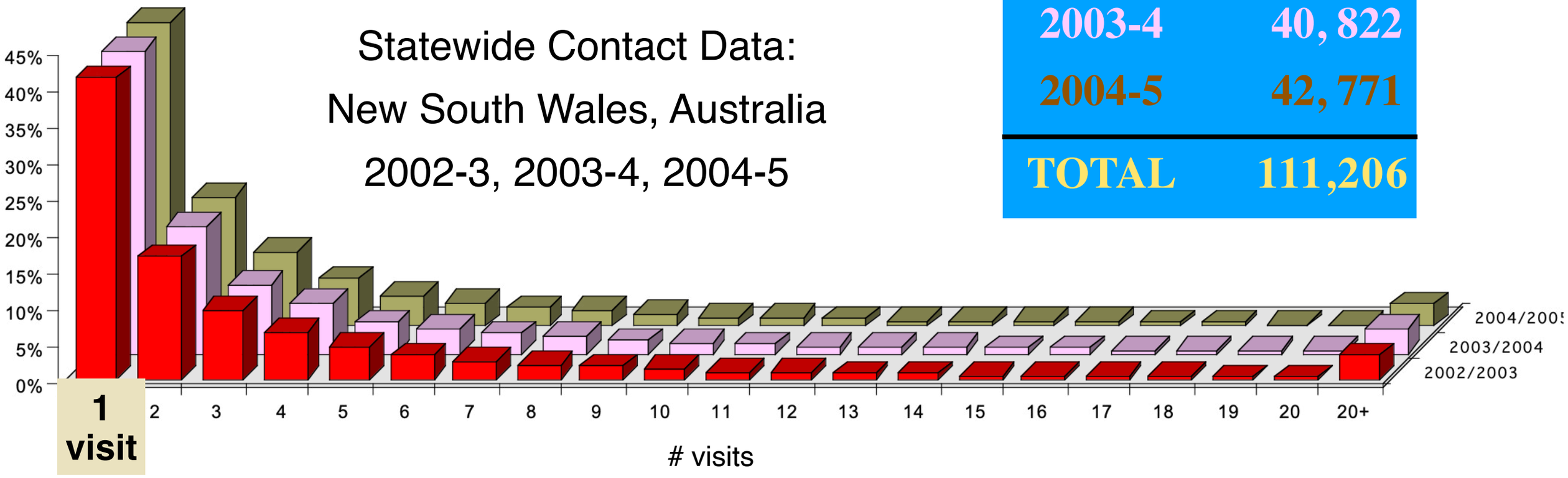
No significant difference in client satisfaction or outcome between people seen for a single session and people seen for multiple sessions

SST Clients, Pre-Post

- 88% symptom improvement
- Of those who improved, 66% "ripple effect"

Single session therapies are about as effective as multi-session psychotherapies

1996 - Adoption of SST by Bouverie Clinic
LaTrobe University, Melbourne, Australia



Statewide Contact Data:

New South Wales, Australia

2002-3, 2003-4, 2004-5

Total Contacts	
2002-3	31, 613
2003-4	40, 822
2004-5	42, 771
TOTAL	111,206

Young, J., & Rycroft, P. (2006). Single Session Therapy – The Bouverie Centre Professional Development Training Workbooks. Melbourne, Australia.

In the last 30 Years....

- SST widely adopted throughout Victoria and New South Wales in Australia
- 50+ walk-in SST clinics in Canada, Wisconsin, Texas
- SST implemented by university counseling centers in California
- SST clinics in United Kingdom, Mexico, Cambodia, China, Italy, New Zealand, Sweden, Great Britain
- Many research studies demonstrating SST efficacy

Scheduled (Planned) SST

Authors	Setting	Type	Results
Boyhan (1996).	Bouverie Family Therapy Centre, Melbourne,Australia.	Pre-post outcome study.	**53% found single-session sufficient,** 81% rated helpfulness of session as >7.5/10 78% positive outcome (56% problem "significantly improved," 22% "a little better").
Campbell (1999).	Child and Adolescent Mental Health Services, Tasmania, Australia.	Pre-post outcome study.	Significant reduction in the presenting problem; Significant increase in level of coping;
Coverley et al. (1995).	**Primary care health settings,** UK.Frequently attending mothers of children with psych disorders	Pre-post outcome study.	64% reported session had been markedly or extremely helpful. **Annual primary care visits decreased from 6.5 visits to 2.8 afterwards.**
Denner and Reeves (1997).	Community mental health centre, UK.	Pre-post outcome study.	Significant decrease in anxiety, depression 75% of clients did not require additional therapy
Gawrysiak et al. (2009).	University of Tennessee Counselling Center, Knoxville, Tennessee, USA.	Randomized control trial.	Significant reduction in depressive symptoms and increased environmental reward.
Hampson et al. (1999).	Child and Adolescent Mental Health, Australia.	Post-intervention outcome study	1994 Evaluation: **84% were satisfied with service;** 80% reported session helpful; 71% reported problem improvement 1996 Follow-up: **96% satisfied; 88% reported session helpful.**
Lamprecht et al. (2007).	**Community hospital, UK.** Pts presenting with self-harm for the first time	Post-intervention outcome study	78% of treatment group identified immediate postsession change. **After 1 year, 6% of treatment group repeated self-harm compared to 13% of comparison group.**
Perkins (2006).	Out-patient child and adolescent mental health clinic, Australia.	Randomized control trial.	Significant change in severity and frequency of presenting problem. 74% of treatment group improved at least 1 on 5-point scale vs. 42% in control group.
Perkins and Scarlett (2008).	Out-patient child and adolescent mental health clinic, Australia.	Follow-up study to randomized controlled trial.	**Initial benefits of single session maintained 18 months later.** 60.5% of clients had received no further help 18 months later.
Sommers-Flanagan (2007)	Community mental health agency, USA. Parents, age 22-41	Pre-post outcome study.	Parents felt less stressed about parenting performance, less overwhelmed by child's needs or behaviours. Parents very satisfied.

Source: Hymmen P, Stalker CA, Cait CA. (2013). The case for single-session therapy: does the empirical evidence support the increased prevalence of this service delivery model? *J Ment Health.22*(1): 60-71.

Walk-in SST

Authors	Setting	Type	Results
Harper-Jaques et al. (2008).	SCHC and Eastside Family Centre (EFC), Calgary, Alberta Canada.	Pre-post outcome study	Significant reduction of distress levels (no standardized outcome measure) 86% - 94% of clients mostly or very satisfied with session;
Josling & Cait (2018)	Ontario youth/young adult services	Pre-post outcome study; 3 month FU	Improvements in coping, functioning; significant decrease in problem severity 86% of clients reported using ideas, strategies from the session 80% reported having "aha" moments in the single session **Strong therapeutic alliance arose quickly: avg session rating 35.16 out of 40**
Miller (2008).	EFC, Calgary, Alberta, Canada.	Satisfaction ratings	81.9% either satisfied or very satisfied
Miller & Slive (2004)	EFC, Calgary, Alberta, Canada.	Post-intervention outcome study	67.5% improved or much improved; 44.3% found single-session sufficient; 74.4% satisfied or very satisfied with session;
Price (1994)	Child and Family Care, Australia.	Post-intervention outcome study	63% reported problems much better or little better; 78% described service as very helpful or somewhat helpful; 45% felt single-session sufficient.
Slive et al. (1995).	EFC, Calgary, Alberta, Canada.	Post-intervention outcome study	>60% reported single-session sufficient. 89% satisfied with the service.
Young (2018)	KW Counseling Services - ethnically diverse, low-income	Pre-post outcome study; 4 month FU	**lost days of work declined by 79% on four month follow-up** **80% had resumed normal activities on four month follow-up** **19% said they would have visited ER if walk-in clinic unavailable**

JAMA Network Open

Original Investigation | Physical Medicine and Rehabilitation

Comparison of a Single-Session Pain Management Skills Intervention with a Single-Session Health Education Intervention and 8 Sessions of Cognitive Behavioral Therapy in Adults With Chronic Low Back Pain: A Randomized Clinical Trial

Beth D. Darnall, PhD; Anuradha Roy, MSc; Abby L. Chen, BS; Maisa S. Ziadni, PhD; Ryan T. Keane, MA; Dokyoung S. You, PhD; Kristen Slater, PsyD; Heather Poupore-King, PhD; Ian Mackey, BA; Ming-Chih Kao, PhD, MD; Karon F. Cook, PhD; Kate Lorig, DrPH; Dongxue Zhang, MS; Juliette Hong, MS, MEd; Lu Tian, PhD; Sean C. Mackey, MD, PhD

JAMA Network Open. 2021;4(8):e2113401. doi:10.1001/jamanetworkopen.2021.13401

Question: Is a single-session pain relief class noninferior to 8 sessions of cognitive behavioral therapy (CBT) at 3 months after treatment?

3-arm randomized clinical trial
263 adults with chronic low back pain

CBT:
Eight 2-hour sessions specific to pain management

Health Education:
One 2-hour class that included warning signs of back pain, when to speak with a physician, general nutrition, and medication managment

SST: Empowered Relief
One 2-hour class that included pain neuroscience education, mindfulness principles, and CBT skills (identifying distressing thoughts and emotions, cognitive reframing, a relaxation response exercise, and a self-soothing action plan).

Yes!

Findings

a single-session
pain management skills class was

- noninferior to 8 weeks of CBT and
- superior to a health education class

"For patients with chronic low back pain, a single-session pain relief skills class showed comparable efficacy to CBT in pain catastrophizing, pain intensity, pain interference and other outcomes at 3 months after treatment."

Note: while decreases in pain catastrophizing and pain intensity both were statistically significant, decrease decreases in pain *intensity* were not *clinically* significant
(4.9 →3.2 on 10-point pain scale)

Psychological Intervention for Patients Presenting to ED with Panic Attacks

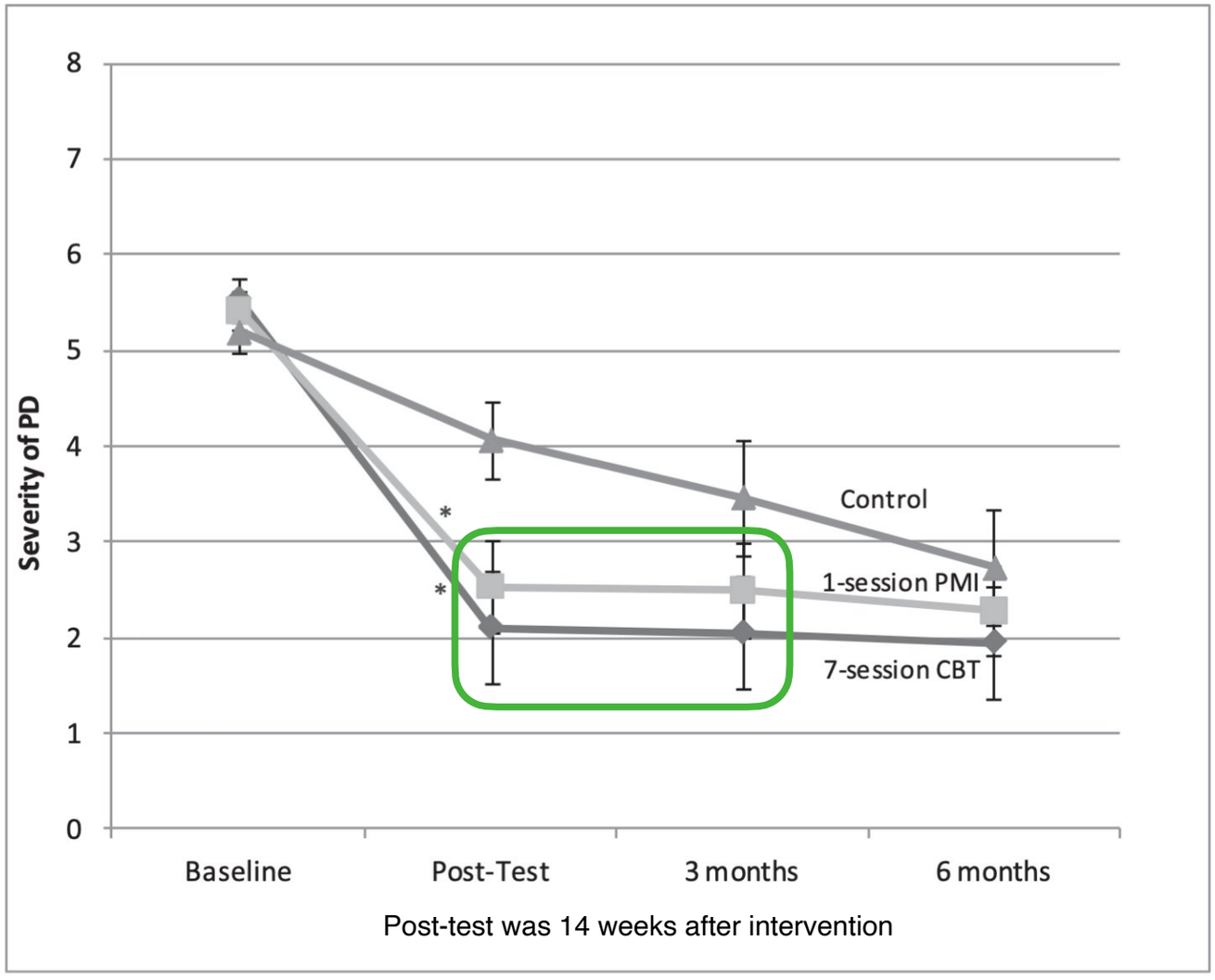
Dyckman & Rosenbaum (1999) found a single 20-30 minute intervention in the ER for patients presenting with non-cardiac chest pain diagnosed as panic attacks decreased subsequent ER us while increasing follow-up with psych services.

Dyckman, J., Rosenbaum, R., Hartmeyer, R. & Walter, L. (1999). Effects of psychological intervention on panic attack patients in the emergency department. *Psychosomatics, 40*(5), 422-427

Lessard et. al. (2011) found single session intervention for patients presenting to ER with non-cardiac chest pain diagnosed as panic attacks was as effective as 7-session CBT

58 patients
Random assignment to:
1-session panic management intervention (PMI) (23),
7-session CBT (14)
usual care (13)

significant reduction in PD severity following both interventions compared
to usual care control condition, but with neither showing superiority compared to the other.



* Significant time effect between baseline and post-test at $p < 0.05$

Figure 3. Severity of PD (ADIS-IV) over time

Lessard et. al. (2011). Comparing Two Brief Psychological Interventions to Usual Care in Panic Disorder Patients Presenting to the Emergency Department with Chest Pain. *Behavioural and Cognitive Psychotherapy 40*(2):129-47 . DOI: 10.1017/S1352465811000506

SST and Frequent Attenders

Luutonen, S; Santalahti, S'; Makinen, M.; Vahlberg, T & Rautava, P. (2019) One-session cognitive behavior treatment for long-term frequent attenders in primary care: randomized controlled trial. *Scandinavian Journal of Primary Health Care, 37*:1, 98-104, DOI: 10.1080/02813432.2019.1569371

"The aim of the study was to find out if a single CBT session for long-term frequent attenders in primary care affected attendance frequency and mental well-being of the patients."

Methods:

- **Long Term Frequent Attenders defined as having at least 10 GP visits in 2008 + at least 10 GP visits in one (or more) of the preceding three years**
- 89% of patients had a diagnosed medical condition
- 37.5% of patients had a diagnosed psychiatric condition
- Patients were randomized into receiving a single (60-90 min.) individual CBT session or usual care

Measures:

- Beck Depression Inventory (BDI)
- Orientation to Life Questionnaire (SOC-13)
- Somatization subscale of the Symptom Check List 90 (SCL-SOM)
- Whiteley Index (WI)
- # GP visits/year at baseline and at one year follow-up.
- Mini International Neuropsychiatric Interview (MINI) and the section for somatoform disorders from the Structured Clinical Interview for DSM (SCID)

Results:

attendance frequency decreased in *both* SST-CBT and Usual Care (control)

- no significant difference between the groups.
- changes in mental functioning (BDI, SOC-13, SCL-90, WI) did not differ between the groups.

Conclusion

- *A single session of CBT is not useful in reducing GP visits or improving mental well-being of long-term frequent attenders.*
- *Frequent attenders without a psychiatric disorder may benefit from this kind of intervention.*

Note: all study patients came in for a "baseline interview" and a 6 month follow-up interview, using the MINI and SCID - these take about an hour to administer, and research shows clients perceive these as an intervention. So it's not surprising there was no difference between the groups.

Note: all CBT interventions were performed "by a resident in psychiatry who had no formal psychotherapy education, but had attended some CBT workshops as part of the training program for residents in psychiatry"
- cannot be considered a skilled intervention

SST and Frequent Attenders

Martin, A; Rauh, E.; Fichter, M. Rief, W. (2007). A **One-Session Treatment** for Patients Suffering From Medically Unexplained Symptoms in Primary Care:A Randomized Clinical Trial. *Psychosomatics, 48:* 294-303

Methods

- ***140 primary-care patients with multiple somatoform symptoms***
  - defined as at least 2 medically unexplained symptoms within the last 6 months resulting in significant clinical distress.
  - No current or ongoing medical condition; no psychosis, no substance abuse.
- Randomized to "standard medical care" (waiting list for medical treatment) vs 1-session group CBT (4 hour class: included psychophysiological explanation of symptoms; role of cognitions; relaxation; activity instead of avoidance; advice on healthcare utilization + info on treatment options)
- Assessments at study enrollment, at 4-weeks, and at 6-month follow-up

Measures:

- Beck Depression Inventory (BDI)
- **Somatization Severity (BSI-SOM)**
- Global Severity Index (BSI-GSI)
- # Somatoform symptoms, last 7 days (SOMS-7)
- Whiteley Index Health Anxiety (WI)
- **Health Care Utilization**
- **# Sick leave days**
- Health-related internal control (KKG-I)

These measures were NS

Measures in blue were statistically significant

Conclusion

- Both groups improved.
- ***Significantly stronger reduction in doctor visits and somatization severity in one session of CBT versus standard care.***
- General acceptance of CBT was high (positive session evaluations)

Outcome Variable	Assessment	CBT Group (N=70)	Control Group (N=70)	
Somatization Severity (BSI-SOM)	Baseline 6 month FU	0.79 (0.75) 0.59 (0.59) **-0.2**	0.60 (0.53) 0.61 (0.63) **+0.2**	p<.05
Sick-leave days last month	Baseline 6 month FU	3.8 (8.6) 1.6 (5.1) **-2.2**	2.8 (7.2) 3.7 (9.0) **+0.9**	p<.10
# doctor visits last 6 months	Baseline 6 month FU	13.4 (14.1) 8.5 (9.2) **-4.9**	11.5 (8.8) 10.2 (8.0) **-1.3**	p<.05
# psychotherapy visits last 6 months	Baseline 6 month FU	3.7 (9.4) 1.8 (5.1) **-1.9**	1.9 (7.7) 0.9 (3.5) **-1.0**	ns
Days of medication use last 6 months	Baseline 6 month FU	501.9 (493.8) 398.1 (431.4) **-113.8**	503.0 (373.4) 492.3 (411.1) **-10.7**	p<.05

IMO, this decrease in days of medication use in the SST-CBT condition is stunning

Meta-Analysis of Single-Session Interventions for Youth Psychiatric Problems
Brief Treatments, Promising Effects

Schleider, JL & Weisz, JR (2017). Little Treatments, Promising Effects? Meta-Analysis of Single-Session Interventions for Youth Psychiatric Problems. *J Am Acad Child Adolesc Psychiatry, 56*(2):107-115. PMID: 28117056 doi: 10.1016/j.jaac.2016.11.007. Epub 2016 Nov 25.

50 RCTs representing 10,508 youths

Comparison groups

wait list, no- treatment or placebo

waitlist + “active” controls (psychotherapy, psychoeducation)

SST (and full-length therapy) showed significant beneficial effect in the small-to-medium range for treating anxiety, conduct problems but not depression

	Effect Size	
	Single Session	Full-length Therapy
Anxiety	0.56	0.61
Conduct	0.54	0.46
Depression	0.21	0.29

Results

- Effects of SST in same range as full-length therapy
- Effects consistent regardless of problem *severity*
- Effects vary with problem

Effectiveness of single-session therapy for adult common mental disorders: a systematic review

Jongtae Kim, Namgil Ryu and Dixon Chibanda *BMC Psychology* (2023) 11:373, https://doi.org/10.1186/40359-023-01410-0

Reviewed 2,130 studies. Excluded 2,124 due to potential bias, lack of outcome data, age range, etc.,

Analyzed six RCTs involving 298 participants for the review.

Participants had “common mental disorders” in non-clinical settings

Five of six RCTs showed positive results for depression

<u>Impressive results, given that:</u>

- all participants were limited to a single session, without an option for more: *this is <u>not</u> the SST model*

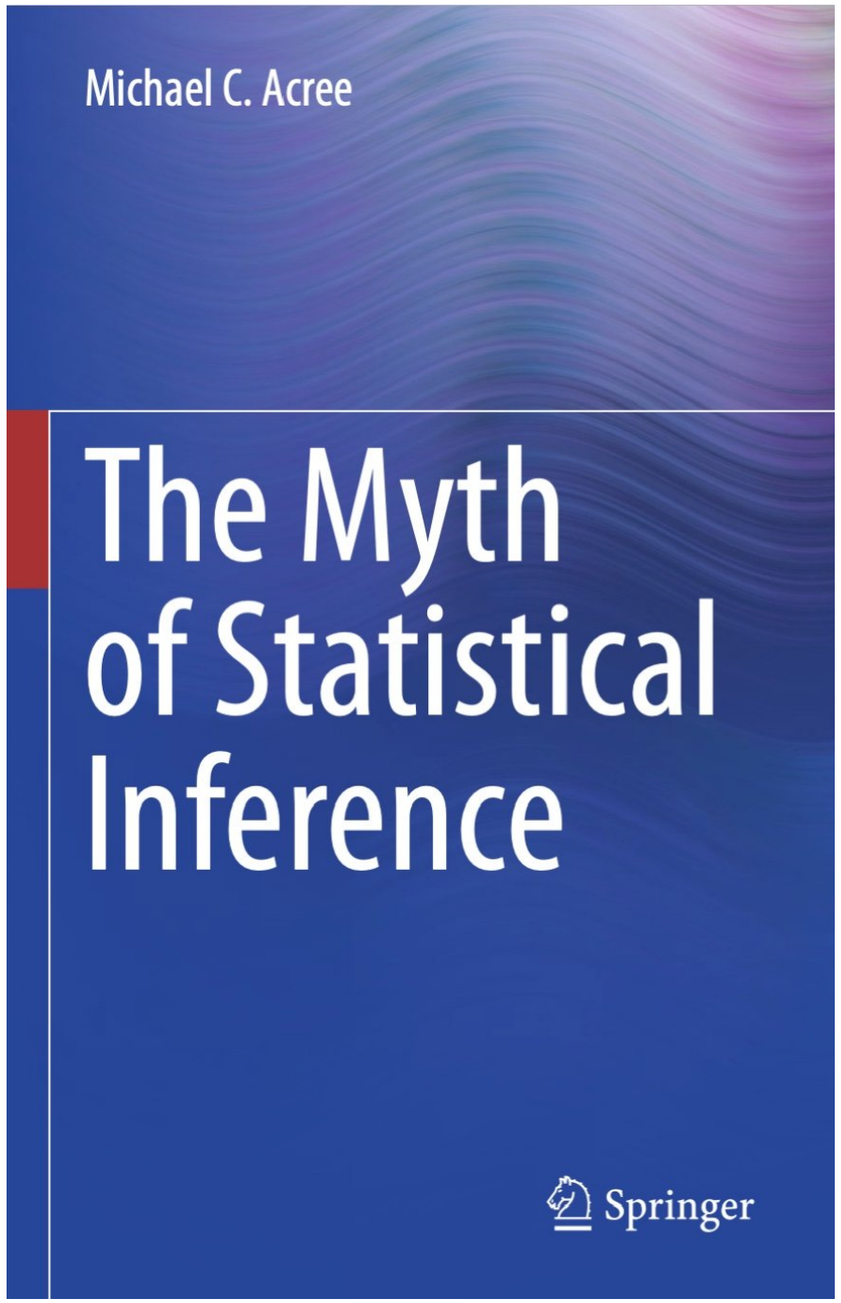
- Participants had non-severe symptoms at baseline - creating floor effects for outcome
  Participants were in non-clinical settings:
  In three of the six studies, participants were college students - mostly introductory psych students

“Only one study showed positive result for anxiety”

— In four of the six studies, interventions were behavioral activation
  - a rather “meh” intervention (and not one that would be expected to improve anxiety)

— The other two studies
  - One compared solution-focused vs problem-focused intervention - *both* improved anxiety
  - One compared DBT vs relaxation training - *both* improved anxiety
  - The lack of a treatment x time interaction (no superiority of either treatment) does not justify the authors’ conclusion that the study did not show any effect on anxiety

Research Critique



- Numbers are signs, not proofs. Statistics is a language, not an argument.
- Norms are abnormal - your sample of the population is very individual.
- don’t confuse probability with credibility; statistical significance ≠ clinical significance

Research Critique

Most statistical models were developed for the physical sciences, with data like these

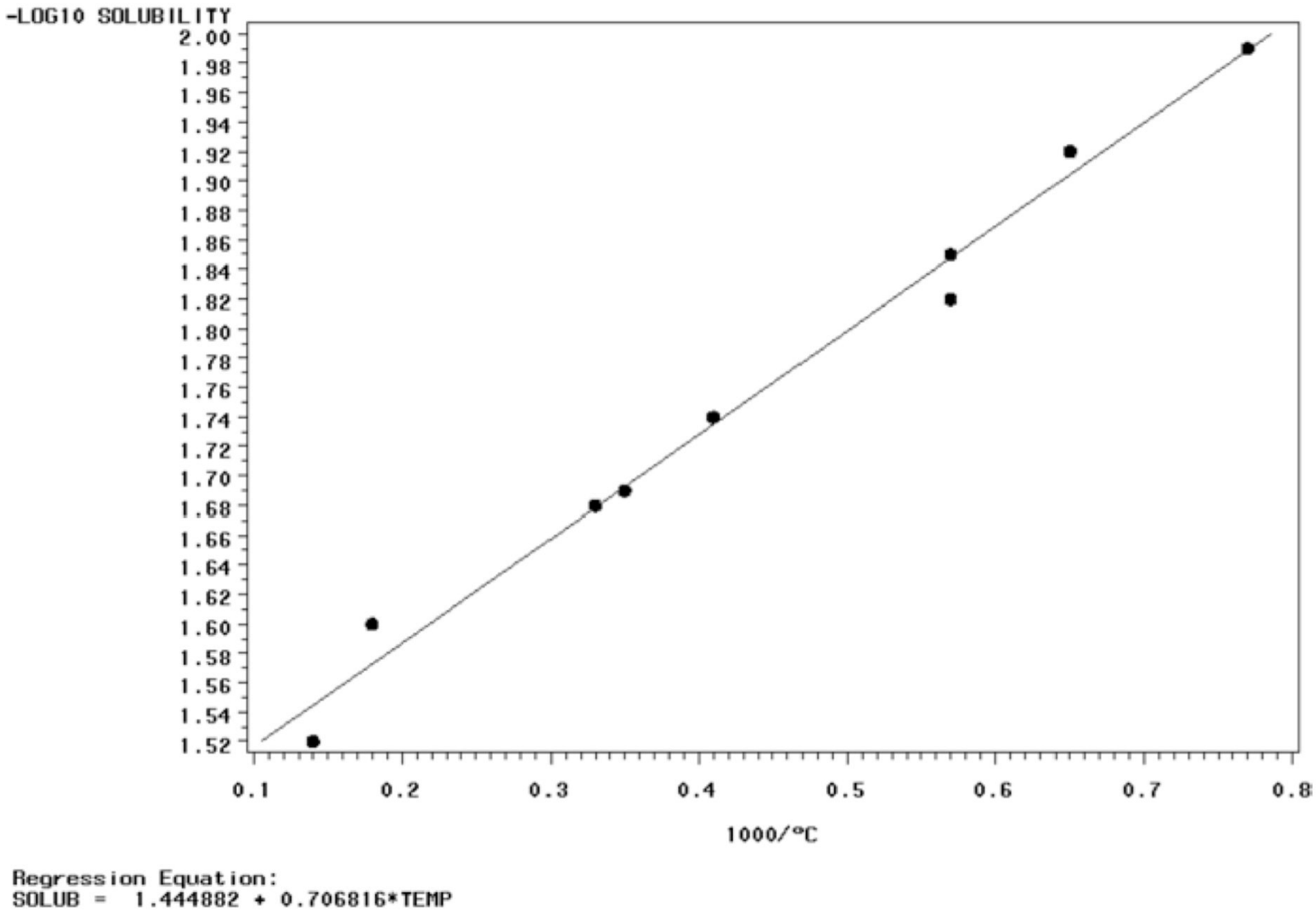


Fig. 11.1 Solubility of plutonium fluoride as a function of temperature

Research Critique

Most *clinical* data is highly scattered -
Does it really make sense to throw out the outliers (they're the most interesting cases!) and draw a regression line through the other points?

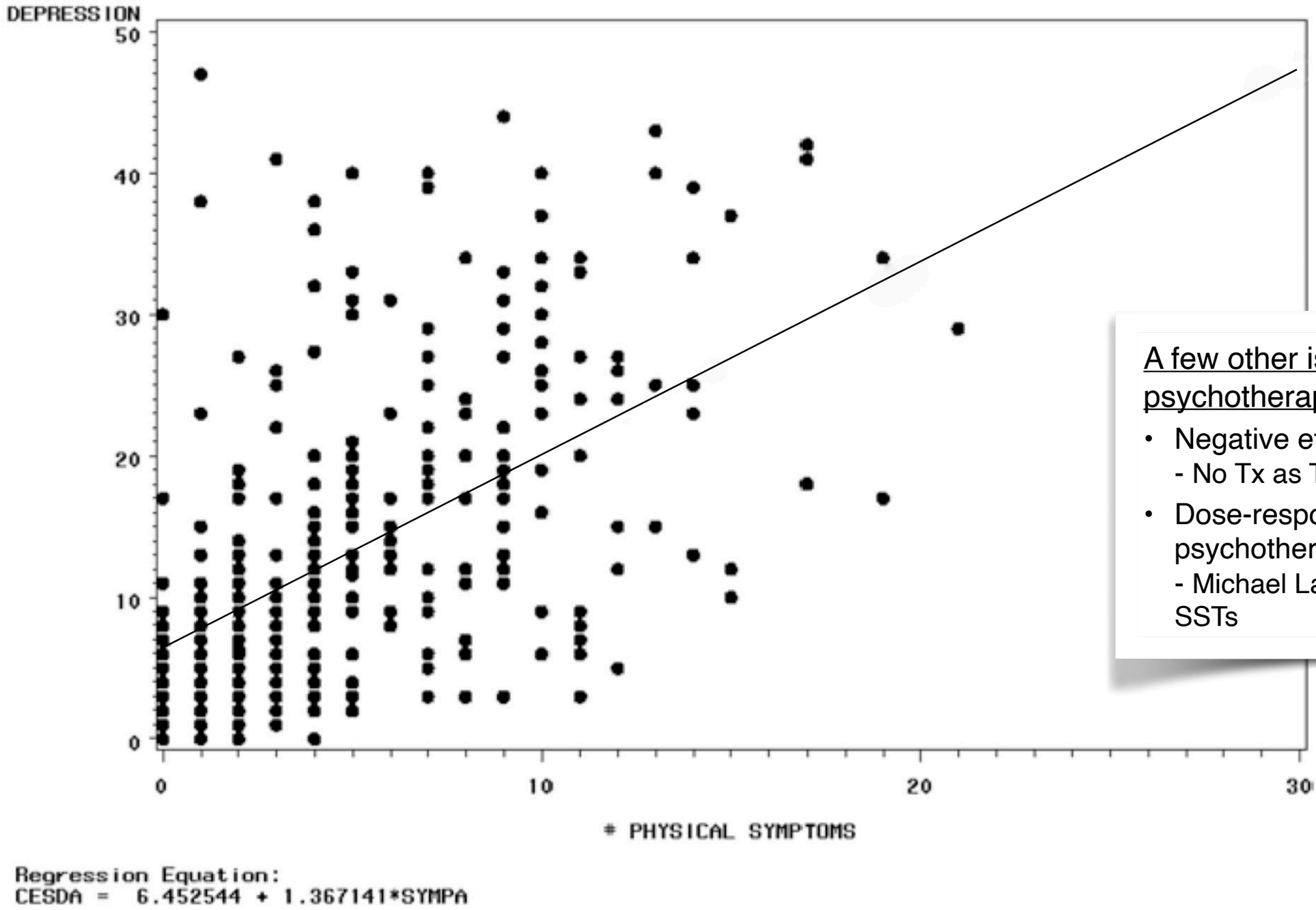


Fig. 11.2 Depression as a function of number of physical symptoms in 296 maternal caregivers

A few other issues re: psychotherapy outcome

- Negative effects of psychotherapy
  - No Tx as Tx of Choice
- Dose-response curve of psychotherapy
  - Michael Lambet's work excluded SSTs

Single Sessions….The Research Is Clear:

- Single session therapies occur frequently and naturally
- Single session therapies have high levels of client acceptance and satisfaction
- Single session therapies are often as effective as multi-session psychotherapies

Single Session Therapy: A Misnomer

SST is simply one-session-at-a-time therapy

- so *every* visit is a potential single session therapy!

Single session therapy is not necessarily one-shot therapy.

Single sessions can be done intermittently, done in an open-ended sequence or in a set number of sessions.

SSTs can be walk-ins, or scheduled as-needed.

Any therapy can be viewed as a SST

if it responds to this question:

ANECDOTES

- **Trauma and Transformation**
  - Personal example - a family tree
  - Clinical example - holocaust dreams
- **Facilitating a Medical Intervention**
  - Personal example - a family tree
  - Clinical example - holocaust dreams
- **Saving a Life**
  - The surfer
- **Dissolving Anger**
  - Personal example - couples tx
  - Clinical example - after CBT, the tongue
- **Easing self-criticism**
  - Personal example - the pencil
  - Clinical example - the chickens

EXERCISE

Think of a “single-session” event you experienced which was not obviously dramatic, but where something shifted abruptly for you.

It may have come in a familiar or an unusual situation.

It may have occurred while you were doing something, or it may have been something you heard, or saw, or felt.

It may have been something you heard someone else say, or saw someone else do - perhaps a teacher, or a friend or family member, a role model, a casual acquaintance or a stranger.

Single Session Therapy
is NOT

SSTs are not a mandate to do one session
SSTs are an *option*. Clients determine if they want or need more. Also, SST can be done serially - one session every few years is hardly a failure!

SST is not a way of restricting treatment
- a large percentage people come to therapy expecting one or just a few sessions

SSTs are not a superficial bandaid.
Diagnosis, problem complexity or severity, do not predict outcome. Making the most of each session can benefit anyone

SST are not a matter of technique.
As in all therapy, client factors and the relationship are far more powerful than specific techniques.

SSTs are not for "master" therapists.
Therapist charisma and brilliance are not important.

SST is not a model
- it influences how therapists apply their training and experience, but therapists are free to use any model

Single Session Therapy
IS

Always *one session at a time*

A way of meeting clients where they are

Often helpful for long-standing, complex issues

A meeting of minds and hearts

Deeply ordinary
all therapists can be effective

A mind-set
conducive to many forms of service delivery

adapted from J. Young (2018). SST: The misunderstood gift that keeps on giving. In *Single Session Therapy by Walk-in or Appointment*

Helpful Mind-Sets for SST

A mind-set
conducive to many forms of service delivery

- **Enough really is enough**
- **No need to be brilliant**
- **Expect change**
- **Treat the Person, Not the Diagnosis**
- **Emotions are Constructed**
- **Time is Not a Tick**

Helpful Attitudes for SST

- **Enough really is enough** (more is not necessarily better)
  - Helping people quickly is practical and ethical
  - Sometimes a little more ruins a good piece of work.
  - Depth does not equate with cure- *goal is change, not cure*

> How far your eyes may pierce I cannot tell.
> Striving to better, oft we mar what's well.
>
> William Shakespeare
> *King Lear,* Act I, Scene 4

> No curse is worse than grasping at more
> The contentment that comes from knowing enough is enough
> Is abiding contentment in truth.
>
> Tao Te Ching
> Verse 46

Helpful Attitudes for SST

- **Enough really is enough** (more is not necessarily better)
- **No need to be brilliant -** Ordinary mind is the way
  - Big problems don't require big solutions
  - Small changes can make a big difference
  - Life, not therapy, is the great teacher

Sometimes I'll see a person many years after our SST and ask them if they remember anything from our session.

Often they'll remember only one sentence from our one hour conversation, at times only one word, Yet that one thing was remembered as an anchor, a pivot chord that led to a big changes in their life and sometimes in the life of other people.

- Moshe Talmon

Helpful Attitudes for SST

- **Enough really is enough** (more is not necessarily better)
- **No need to be brilliant -** Ordinary mind is the way
  - Big problems don't require big solutions
  - Small changes can make a big difference
  - Life, not therapy, is the great teacher

I remember at the time I came in I was feeling overwhelmed, the kids were getting under my skin. I had been a 24-hour-a-day mother for 5 years. I felt I was isolated, the only mother with such problems.

I remember the session well. ... I took your suggestion:. Every month I make two appointments with myself of 2 hours each. I get my nails done, meet with a friend in a cafe, and we chat about every thing 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.

I stopped feeling the kids 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 seems to have made my marriage better.

You see how the little things make a big difference?

Helpful Attitudes for SST

- **Enough really is enough** (more is not necessarily better)
- **No need to be brilliant -** Ordinary mind is the way
- **Expect change**
  - Change and stability are co-dependent and constant
    - All stability is maintained by change;
      all change relies on stability.
    - Even relatively constant processes fluctuate around
      a calibration point.
  - ***Self is fluid, not fixed (nor fixable)***

Helpful Attitudes for SST

- **Enough really is enough** (more is not necessarily better)
- **No need to be brilliant -** Ordinary mind is the way
- **Expect change**
  - ***Self is fluid, not fixed (nor fixable)***

Self is recursive

- We arise being touched by touching and by touching ourselves touching
- When I say "I'm not myself," who is speaking?

Self is not unitary, but multiple

- We are different in different social situations, and at different times
- "I'm *me* - I'm not what *happened* to me"

Self resides in relationships

- Self and other mutually complete each other - "No she, no me"
- We and the world arise together, linked in mutual need and love

Self finds itself in activity

- No separate doer and deed, rather "doing": Embodied, Enacted, Embedded, Extended
- O body swayed to music, O brightening glance, How can we know the dancer from the dance?

Self is not a thing, but a process - moment to moment, non-stop flow

- A horizoning: not inside, not outside, but both and neither
- I am what I am - and what I am not

You are perfect as you are…

AND you could use a little improvement

Helpful Attitudes for SST

- **Enough really is enough** (more is not necessarily better)
- **No need to be brilliant -** Ordinary mind is the way
- **Expect change - self is fluid**
- **Tweak rather than toil - go distal**
    - Avoid direct attacks on a problem
    - If it's difficult, break it down into small bits
    - Changing the surrounding context alters the perception of the problem, leading to new possibilities

The Problem is Not the Problem

How is the problem a problem?

Supervisees tend to be anxious to get the right diagnosis and provide the right treatment technique

Forgetting the most important contributor to psychotherapy outcome…….

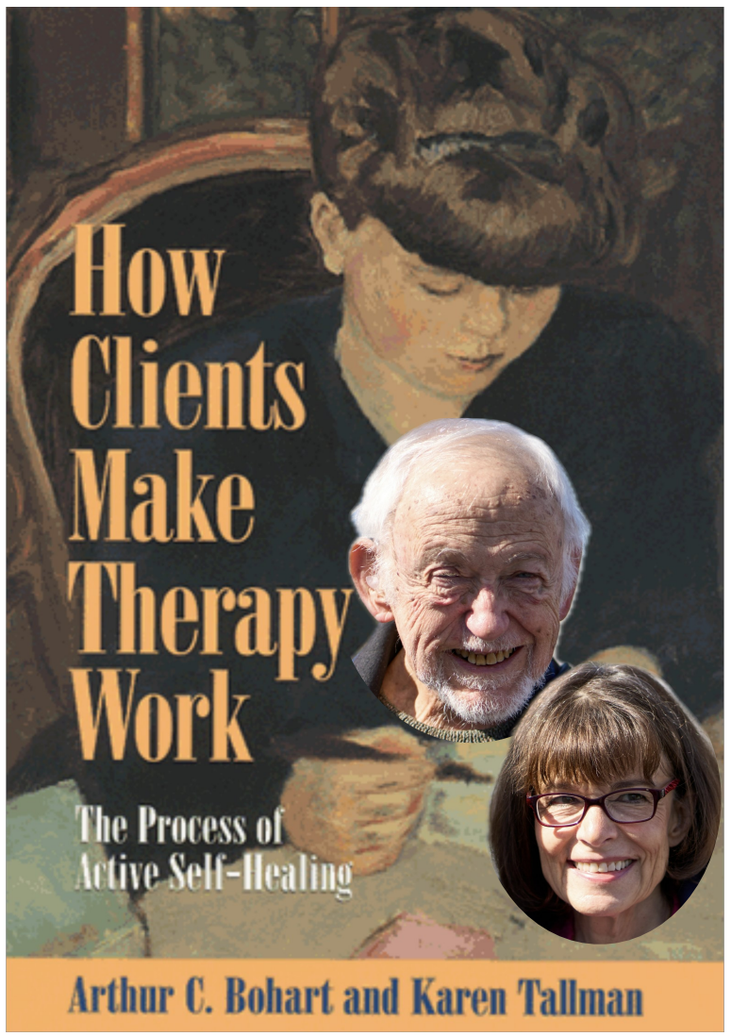
Contributors to Psychotherapy Outcome

1. Techniques are the least important
   - At most **15%** of the outcome variance in psychotherapy, per Lambert's frequently cited estimate
   - Wampold's review suggests techniques may contribute as little as 2% (!) of the variance

2. the *relationship* between therapist and client
   - contributes about a third (**33%**) of the variance in outcome)

The Most Important Factor in Therapy:

3. *client factors and events in the client's life*
   ("extratherapeutic factors")
   - Account for between **40% to 87%** of outcome.

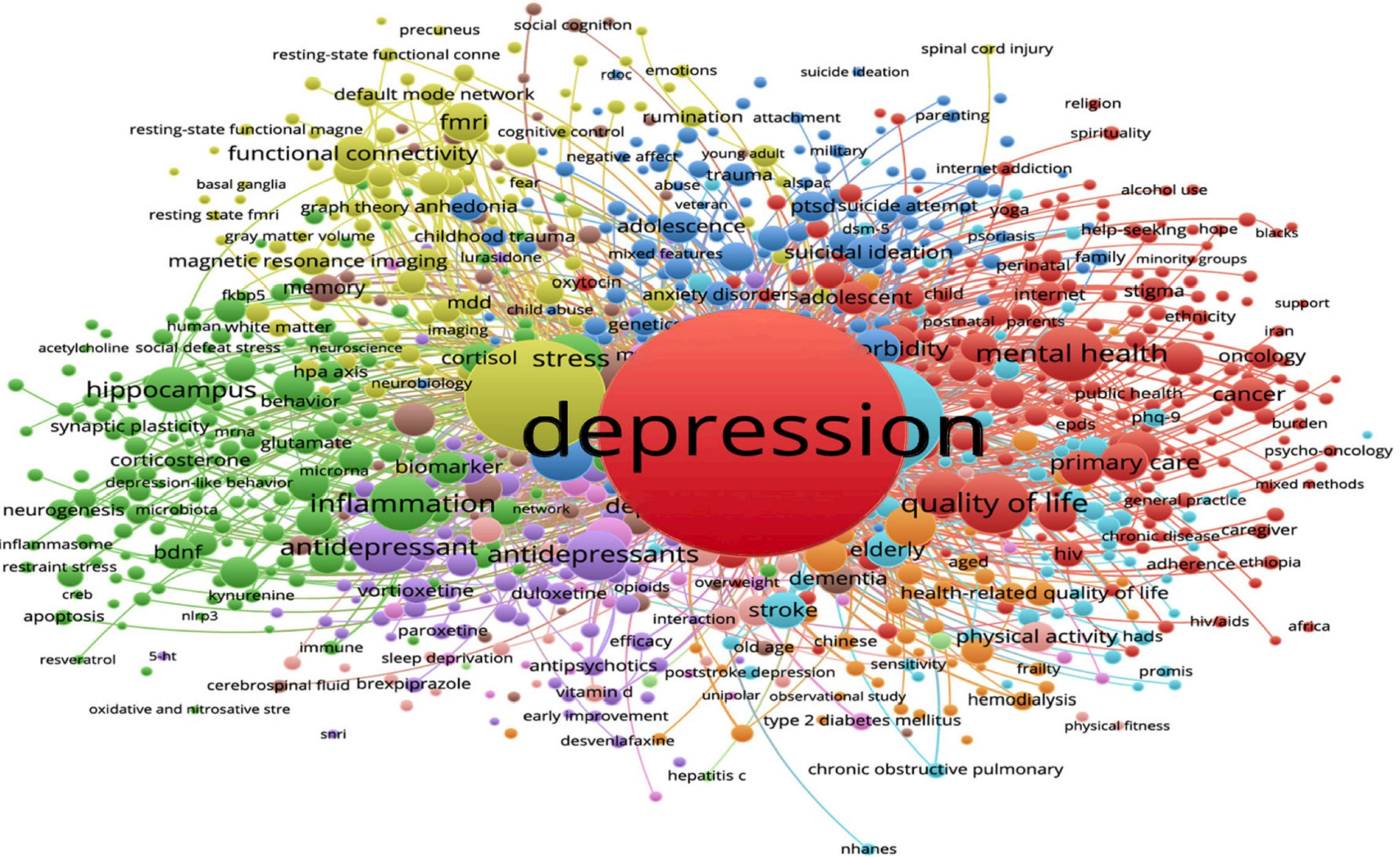


Helpful Attitudes for SST

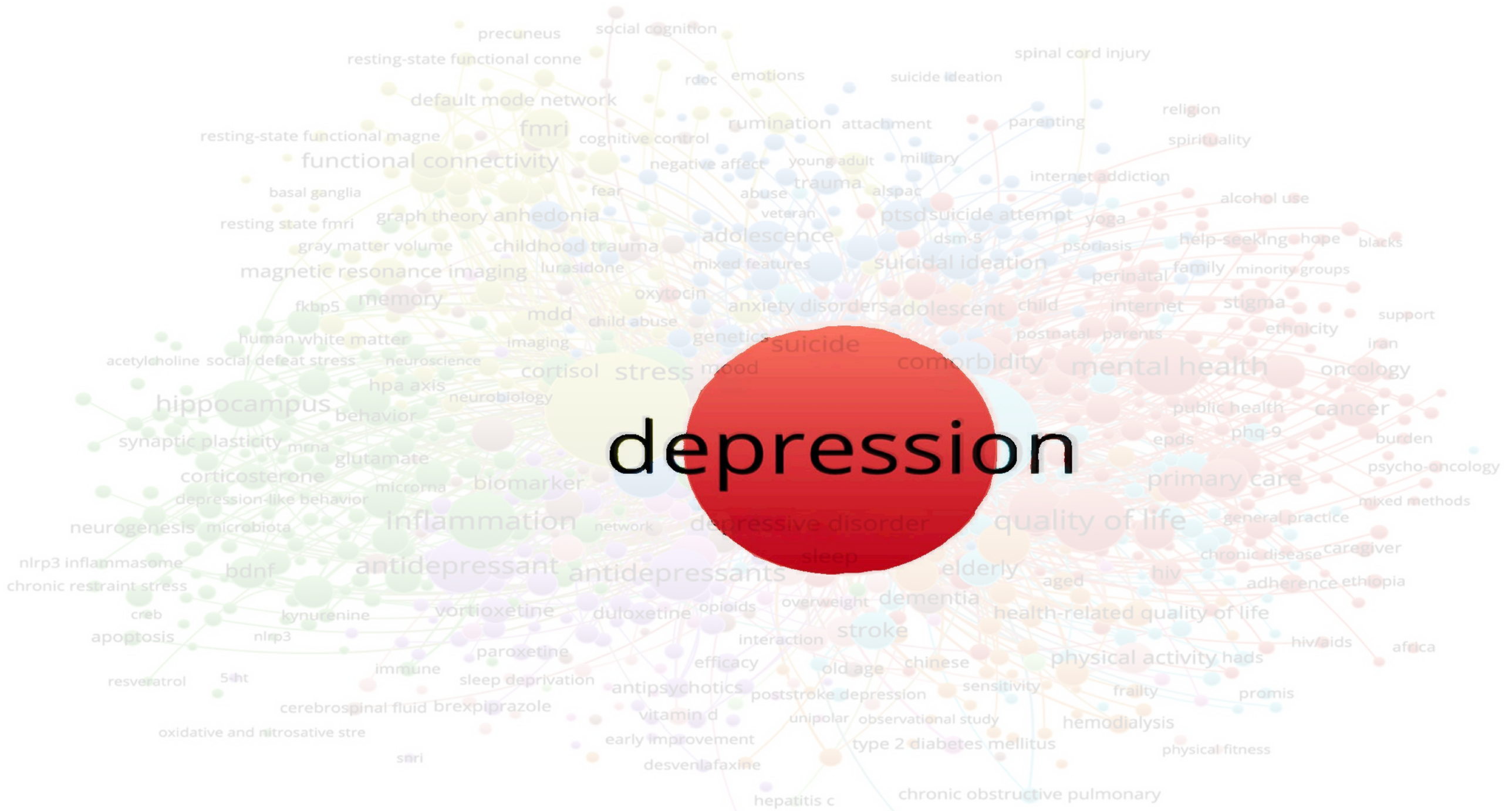
- **Enough really is enough** (more is not necessarily better)
- **No need to be brilliant -** Ordinary mind is the way
- **Expect change**
- **Treat the Person not the Diagnosis**
  - Treat the person via the problem and its present-ation
  - Don’t dither over diagnosis and dormitive principles

Example:

“DEPRESSION” IS COMPLEX AND MULTI-FACETED



BUT WHEN IT'S ISOLATED FROM ALL ITS COMPONENTS



"DEPRESSION" BECOMES A DORMITIVE PRINCIPLE

A label pretending to be an explanation

A tautology in which an item is explained in terms of the item itself, only put in different (more abstract) words.

When “DEPRESSION” BECOMES A DORMITIVE PRINCIPLE

you run into a wall, making it difficult to deal with

- so it’s not surprising treatment often

isn’t tremendously effective

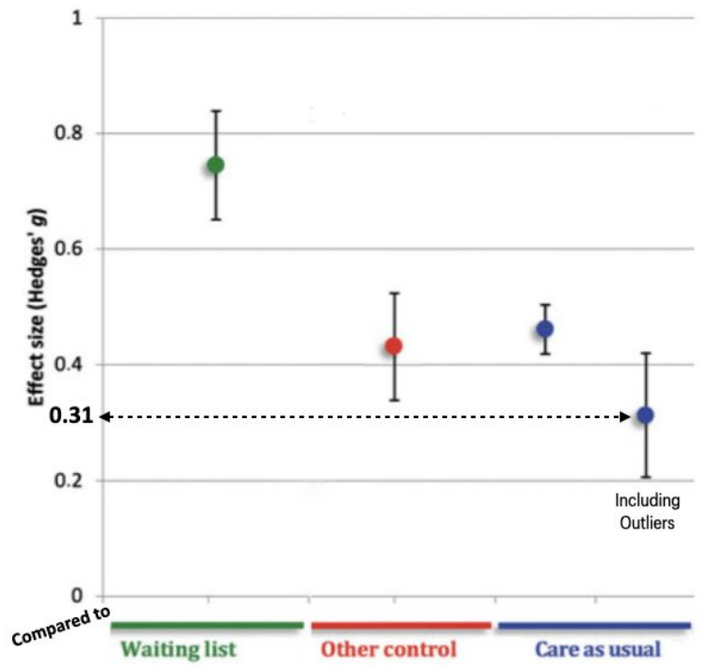
Efficacy of Treatments for Depression

Pharmacological treatment response is sub-optimal in ~1/3 to 1/2 of depressed patients

- 1/3 to 2/3 of depressed patients do not respond satisfactorily to initial antidepressant treatment
- After full treatment course
  - 10-15% no improvement
  - 30-40% partial improvement

Tundo A, de Filippis R, Proietti L. Pharmacologic approaches to treatment resistant depression: Evidences and personal experience. World J Psychiatr 2015; 5(3): 330-341 Available from: URL: http://www.wjgnet.com/2220-3206/full/v5/i3/330.htm DOI: http://dx.doi.org/10.5498/wjp.v5.i3.330

Overall effect size for all psychotherapies is about 0.3



- While overall pooled effect size is higher compared to wait list controls, it shrinks markedly when compared to other treatments and after correcting for publication bias and outliers
- *An effect size of 0.3 suggests around half of patients will show either only partial improvement or no improvement - similar to meds*

Cuipers, P; Karyotaki, E; De Wit, L & Ebert, DD. (2020)/ The effects of fifteen evidence-supported therapies for adult depression: A meta-analytic review. *Psychotherapy Research, 30*(3), 279-293. https://doi.org/10.1080/10503307.2019.1649732

Munder T, Fluckiger C, Leichsenring F, Abbass AA, et. al. (2019). Is psychotherapy effective? A re-analysis of treatments for depression. *Epidemiology and Psychiatric Sciences 28*, 268-274. https://doi.org/10.1017/S2045796018000355

THE NEUROBIOLOGY OF "DEPRESSION" IS EXTREMELY COMPLEX AND MULTI-FACETED

Neurobiologically, converging lines of evidence suggest MDD is a matrix of pathophysiological mechanisms that encompass altered cellular neurochemistry and neurocircuitry as well as tissue- and organ-level pathology:

Neurochemistry

Stress-Response Syndrome

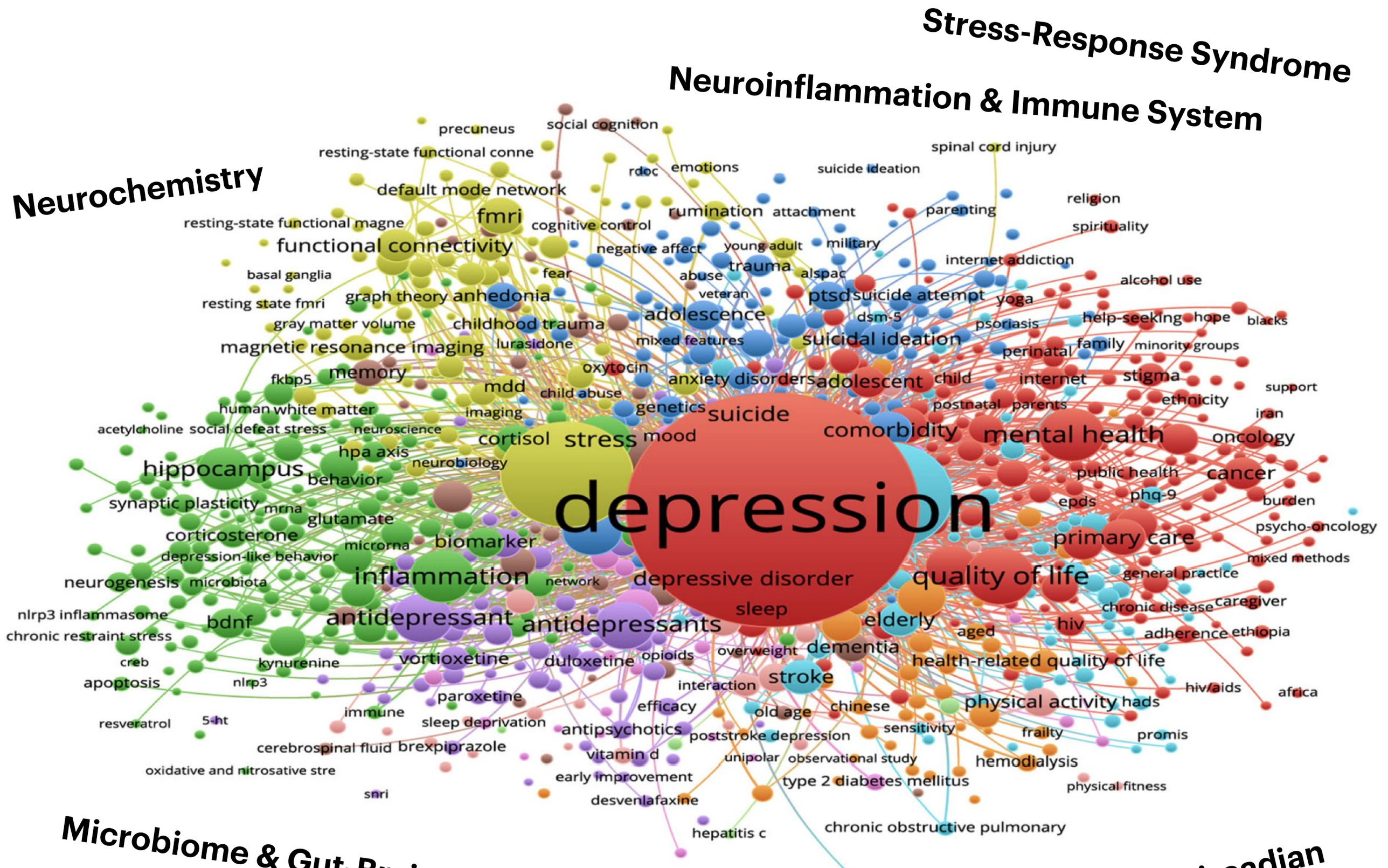
Neuroinflammation & Immune System

Decreased neurogenesis, neuroplasticity

Microbiome & Gut-Brain Axis

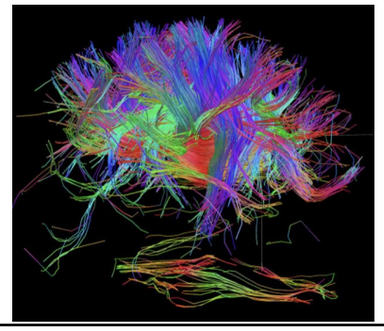
Glia, Oxidative, Mitochondria, Circadian

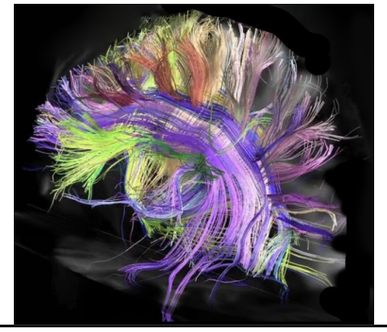
Structural & Functional Neurocircuitry


Stress-Response Syndrome
Neuroinflammation & Immune System
Neurochemistry
precuneus
social cognition
resting-state functional conne
spinal cord injury
rdoc
emotions
suicide ideation
default mode network
religion
rumination
attachment
parenting
fmri
resting-state functional magne
cognitive control
spirituality
functional connectivity
negative affect
young adult
military
internet addiction
trauma
basal ganglia
fear
abuse
alspac
alcohol use
graph theory
anhedonia
veteran
ptsd
suicide attempt
yoga
resting state fmri
adolescence
dsm-5
help-seeking
hope
blacks
gray matter volume
childhood trauma
psoriasis
magnetic resonance imaging
lurasidone
mixed features
suicidal ideation
family
minority groups
perinatal
oxytocin
memory
fkbp5
anxiety disorders
adolescent
child
internet
stigma
support
mdd
child abuse
ethnicity
human white matter
genetics
suicide
postnatal
parents
iran
imaging
acetylcholine
social defeat stress
neuroscience
comorbidity
mental health
oncology
cortisol
stress
mood
hpa axis
hippocampus
neurobiology
public health
cancer
behavior
synaptic plasticity
mrna
glutamate
epds
phq-9
burden
corticosterone
microrna
biomarker
primary care
psycho-oncology
depression-like behavior
mixed methods
inflammation
network
depressive disorder
quality of life
general practice
neurogenesis
microbiota
sleep
chronic disease
caregiver
nlrp3 inflammasome
antidepressant
bdnf
antidepressants
elderly
hiv
adherence
ethiopia
chronic restraint stress
aged
overweight
dementia
creb
kynurenine
vortioxetine
duloxetine
opioids
health-related quality of life
apoptosis
nlrp3
stroke
interaction
hiv/aids
africa
paroxetine
physical activity
hads
efficacy
old age
chinese
immune
resveratrol
5-ht
sleep deprivation
sensitivity
frailty
promis
antipsychotics
poststroke depression
cerebrospinal fluid
brexpiprazole
vitamin d
unipolar
observational study
hemodialysis
oxidative and nitrosative stre
early improvement
type 2 diabetes mellitus
physical fitness
snri
desvenlafaxine
hepatitis c
chronic obstructive pulmonary
nhanes
Microbiome & Gut-Brain Axis
Decreased neurogenesis, neuroplasticity
Glia, Oxidative, Mitochondria, Circadian
Neurocircuitry

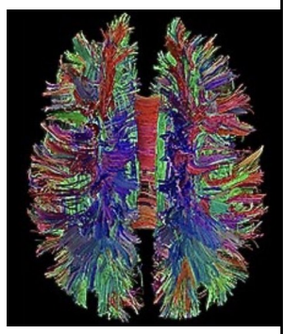
Neurocircuitry

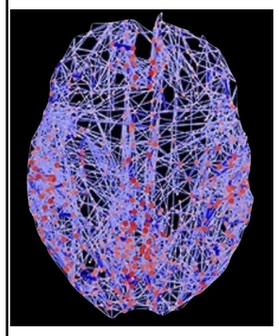
- **<u>Structural</u>** MRI shows widespread changes in the thickness of gray matter and brain morphology
  - damaged gray matter, decreased volume the frontal lobe, anterior cingulate gyrus, hippocampus, putamen, thalamus, and amygdala, white matter microstructure changes, probable glial cell involvement
  - Brain biology is looking less at brain locations and more at brain *functional network changes*

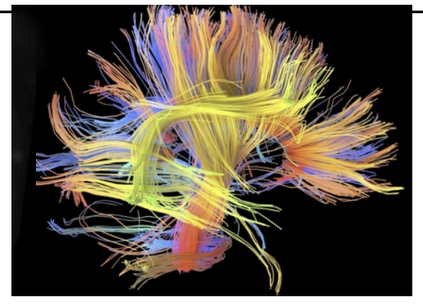


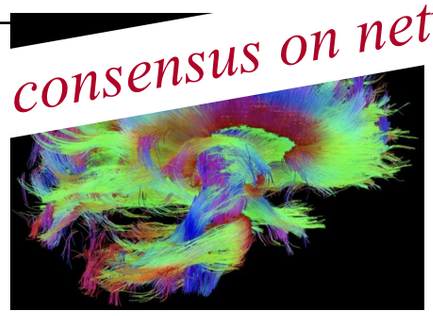


- **<u>Functional</u>** MRI (fMRI), shows brain network dysfunction in depression
  - Seen in functional brain responses to cognitive stimuli
  - Seen in white matter tracts in response to emotional stimuli
  - disruption of the default mode, salience, affective, reward, attention, and cognitive control circuits
  - intra-circuit as well as inter-circuit connectivity dysfunctions in depression
  - Besides connection issues, coordination/"rhythm" issues
  - *Multiple networks involved*









but no consensus on network delineations

Given the multiplicity of biological pathways to depression,

does it make any sense to diagnose "depression"

according to DSM Criteria?

pick a label!

Disruptive Mood Dysregulation Disorder

Major Depressive Disorder, Single and Recurrent Episodes

Persistent Depressive Disorder (Dysthymia)

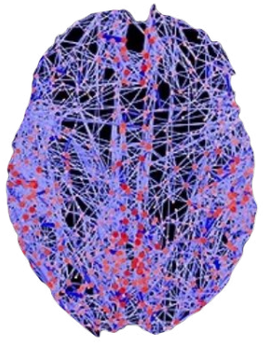
Premenstrual Dysphoric Disorder

Substance/Medication-Induced Depressive Disorder

Depressive Disorder Due to Another Medical Condition

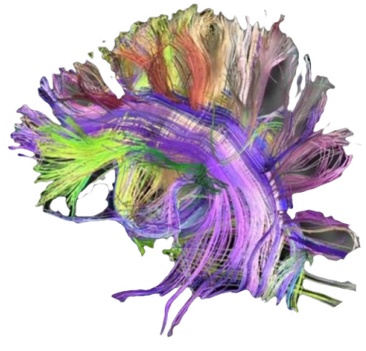
Other Specified Depressive Disorder

Unspecified Depressive Disorder



Instead, how can we apply a *Psychological*

network approach to "Depression"?



A Complex Network Approach to Depression

Approach psychological problems not as expressions of underlying disease entities but as interrelated elements of a complex network.

Use a process-based therapy embracing a bottom-up *idiographic* approach

- understand on a case by case basis how a psychological problem is maintained and how the change process can be initiated.
- therapeutic process as a multi-level network of testable mediators and moderators.
- supplements the patient-therapist relationship and so-called common factors.

Hoffman, SG. (2020). Imagine There Are No Therapy Brands, It Isn't Hard to Do. *Psychother Res. 30*(3): 297–299. doi:10.1080/10503307.2019.1630781.

A Complex Network Approach to Depression

Approach psychological problems not as expressions of underlying disease entities but as interrelated elements of a complex network.

Use a process-based therapy embracing a bottom-up *idiographic* approach

What core biopsychosocial processes should be targeted with this client given this goal in this situation,

and how can they most efficiently and effectively be changed?

SST

Identify a specific target area

Figure out a possible intervention

If it seems promising, pursue it

If it falls flat, try something else

Hoffman, SG. (2020). Imagine There Are No Therapy Brands, It Isn't Hard to Do. *Psychother Res. 30*(3): 297–299. doi:10.1080/10503307.2019.1630781.

Imagine a world without therapy brands.

In this world, we would not be confined by the DSM or the ICD.

The patient's problems would not be seen as…expressions of some latent disease entities. Instead, clinicians would apply a functional analytic approach to understand the…elements of the complex network.

…[These elements] would not be confined to any arbitrary DSM criteria, but could include any aspects that are relevant for the patient.

In the center of this approach would be the person, not the disorder.

Hoffman, SG. (2020). Imagine There Are No Therapy Brands, It Isn't Hard to Do. *Psychother Res. 30*(3): 297–299. doi:10.1080/10503307.2019.1630781.

Helpful Attitudes for SST

- **Enough really is enough** (more is not necessarily better)
- **No need to be brilliant -** Ordinary mind is the way
- **Expect change**
- **Treat the Person not the Diagnosis**

In the center of this approach would be the person, not the disorder.

To put people at the center, we need to understand:

- **Emotions are Not Coercive, but Constructed**
  - Not our *reactions* to the world: our *constructions* of the world
  - Depression and anxiety are not *explanations*
  - Each instance of emotion is unique
    - Classical categorical model being replaced by neurobiological constructivism
    - Most therapists use a categorical model of emotion
    - Emotions are pseudo-explanations that get the blame for how we act

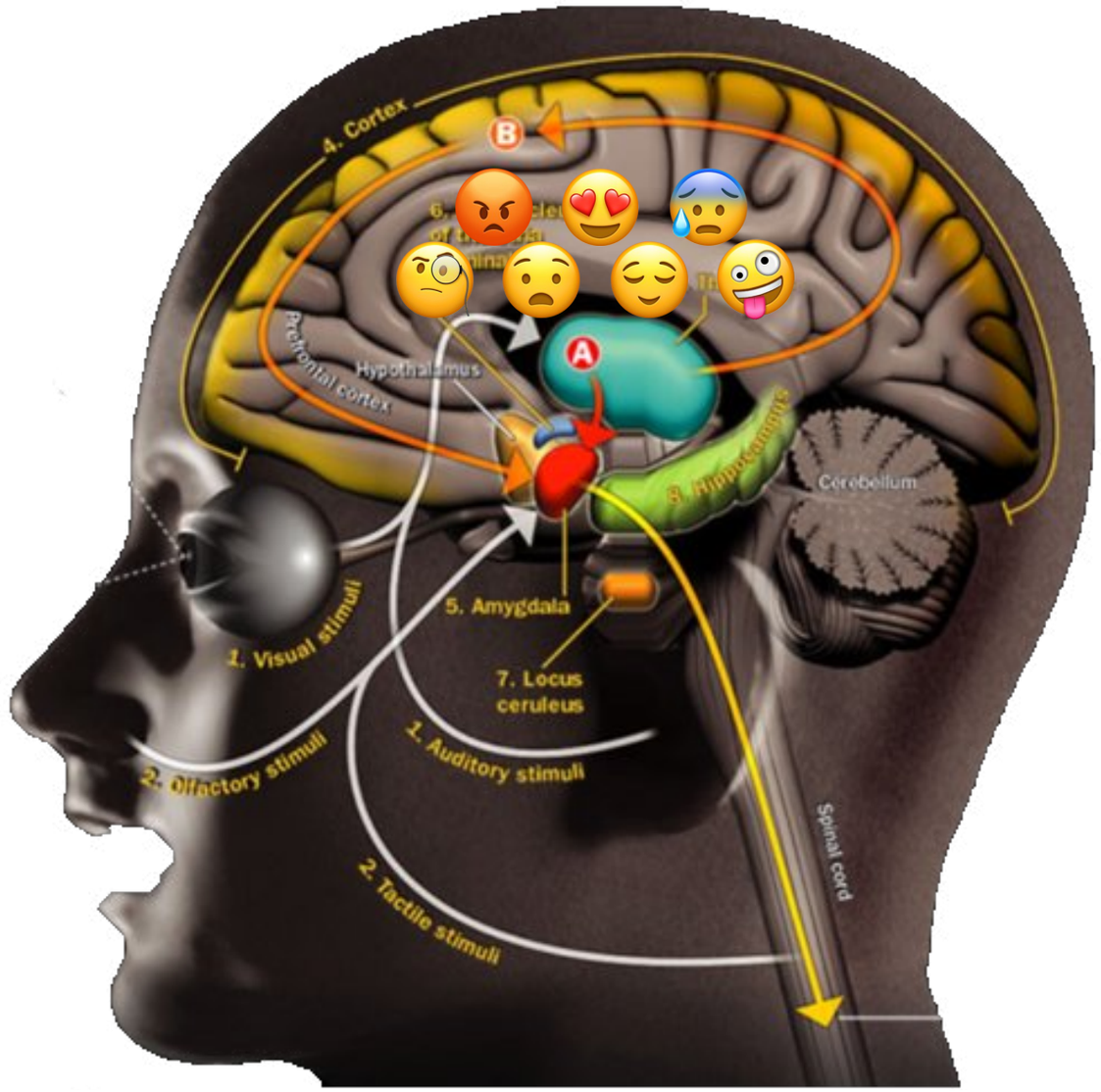
Classical Theory

- Emotions as brute reflex, “lizard brain” vs rational, “cortical processing”

Most people use a categorical "one at a time," "either/or" model of emotion

Classical Theory

- Emotions as brute reflex, "lizard brain" vs rational, "cortical processing"
- A small number of hard-wired, pre-set feelings
- Categorical, each emotion distinct
- Built-in, instinctual
- Universal, hard-wired, built in
- External Event Triggers Internal Feeling
  - Physiological Cascade along specific, localizable channels
- Distinguishable emotional "fingerprints"
  - External expression identifies specific emotion
  - Same internal/external condition leads to same emotion
- Localized brain functions, subcortical modulated cortically



Categorical Emotions' *Overlapping* Neuroanatomy and Neurochemistry

Basic emotion	Key Brain Areas	Key Neuromodulators
General + motivation SEEKING/expectancy	Nucleus accumbens - VTA Mesolimbic mesocortical outputs Lateral hypothalmus-PAG	DA (+), glutamate (+), many neuropeptides, opioids (+), neurotensin
RAGE/anger	Medial amygdala to BNST Medial and perifornical hypothalamus to dorsal PAG	Substance P (+), Ach (+), glutamate (+)
FEAR/anxiety	Central and lateral amygdala to medial hypothalamus and dorsal PAG	Glutamate (+), many neuroneptides, DBI, CRF, CCK, alpha-MSH, NPY
LUST/sexuality	Corticomedial amygdala BNST Preopotic and ventromedial hypothalamus Lateral and ventral PAG	Steroids (+), vasopressin and oxytocin, LH-RH, CCK
CARE/nurturance	Anterior cingulate, BNST Preoptic area, VTA, PAG	Oxytocin (+), prolactin (+), DA (+), opioids (+/-)
GRIEF/PANIC/ separation	Anterior cingulate BNST and preoptic area Dorsomedial thalamus Dorsal PAG	Opioids (-), oxytocincin (-), prolactin (-), CRF (+), glutamate (+)
PLAY/joy	Dorsomedial diencephalon Parafascicular area Ventral PAG	Opioids (+/-), glutamate (+), ACh (+), any agent that promotes negative emotions reduces play

Serotonin, NE & higher cortical areas not shown since nonspecific to all emotions. BNST-bed nucleus of stria terminalis. CCK-cholecystokinin. CRF-corticotropin-releasing factor. DBI-diazepam-binding inhibitor. LH-RH-luteinizing hormone-releasing hormone. MSH-melanocyte-stimulating hormone. NPY-neuropeptide Y. VTA-ventral segmental area

Source: Fotopoulou, *From the Couch to the Lab: Trends in Psychodynamic Neuroscience*. p. 154

An alternative to the classical categorical model of emotion

Classical Theory

- Emotions as brute reflex, "lizard brain" vs rational, "cortical processing"
- A small number of hard-wired, pre-set feelings
- Categorical, each emotion distinct
- Built-in, instinctual
- Universal, hard-wired, built in
- External Event Triggers Internal Feeling
  - Physiological Cascade along specific, localizable channels
- Easily identifiable emotional "fingerprints"

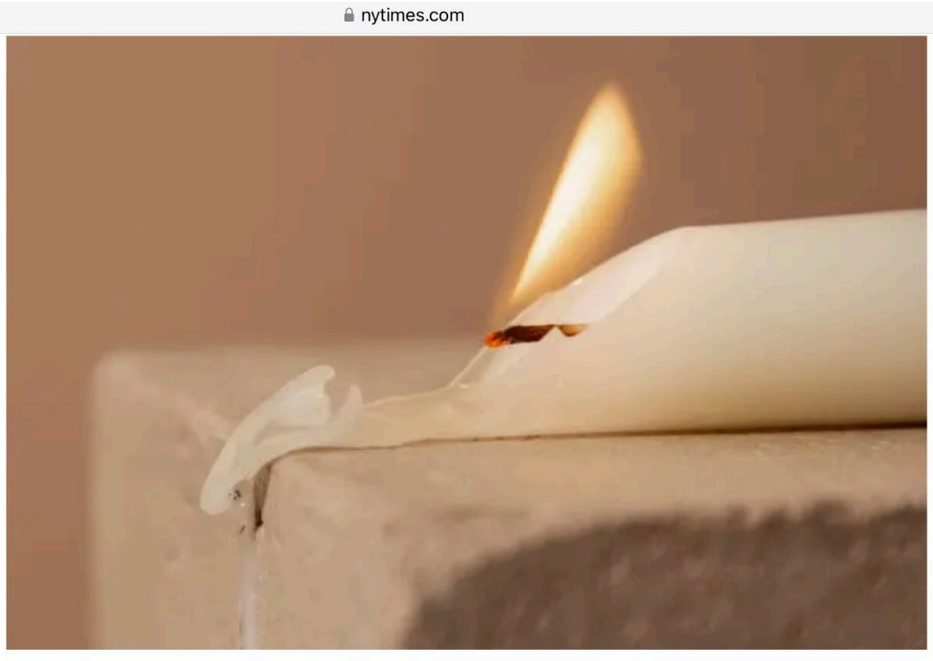
Constructivist Theory

- Emotions constructed, contextual, situationally adaptive
- Innumerable shades of feelings, idiosyncratic: constructed *each time*
- Dimensional, overlapping
- Learned
- Cultural, reinforced by social cues
- Ecosystemic interaction of internal/external - cognitive appraisals, interception, somatic states
- Emotions are often difficult to sort out, identify

Emotions are often difficult to sort out, identify

- Similar situations can evoke very different emotions
- Different situations can evoke very similar emotions
- External expressions of emotions are subject to different interpretations

nytimes.com

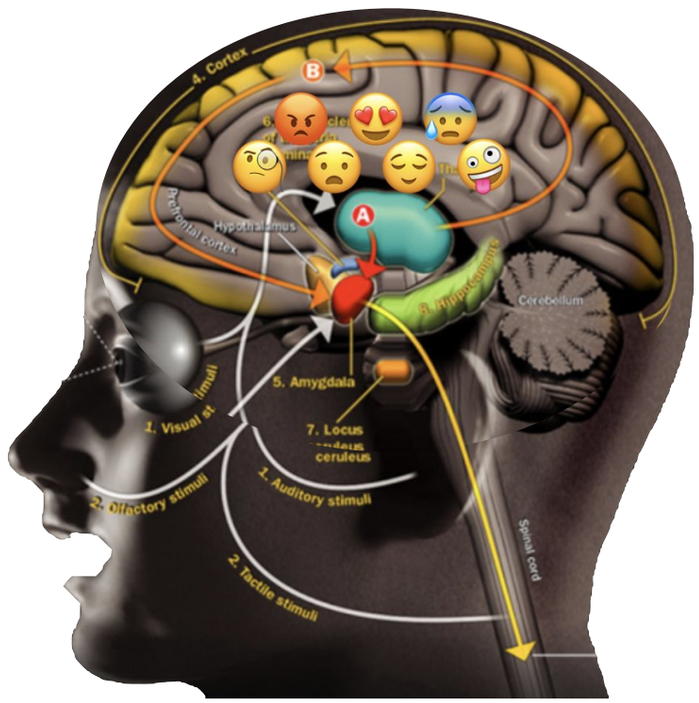


Eric Helgas for The New York Times

Am I Depressed or Burned Out?

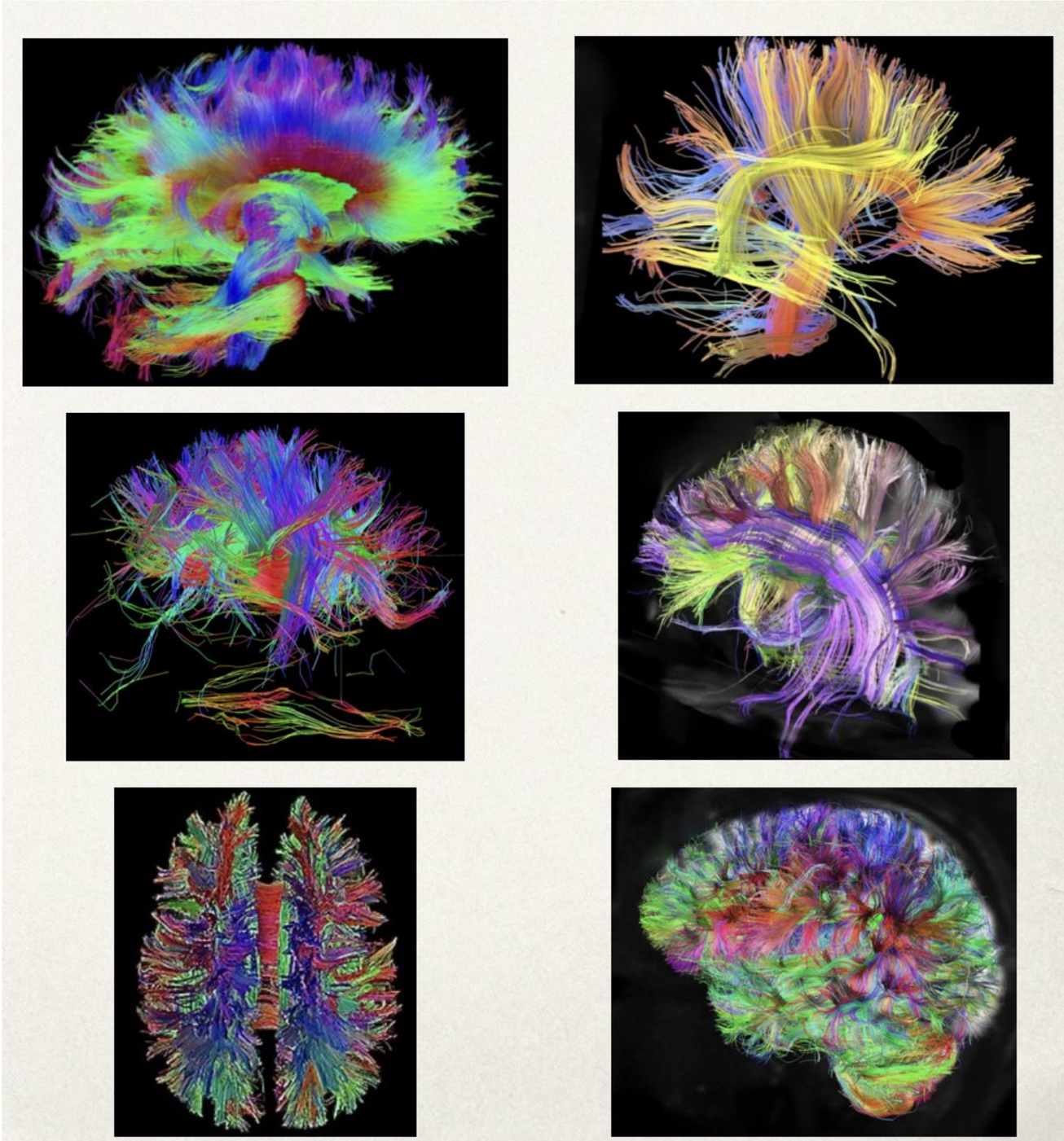
Classical Theory

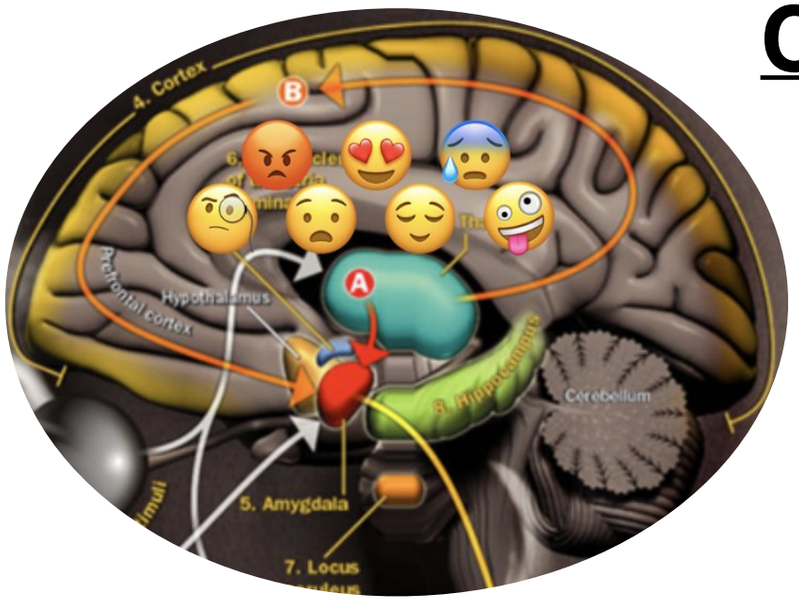
- Localized brain functions, subcortical modulated cortically
- *A small number of hard-wired, pre-set feelings*



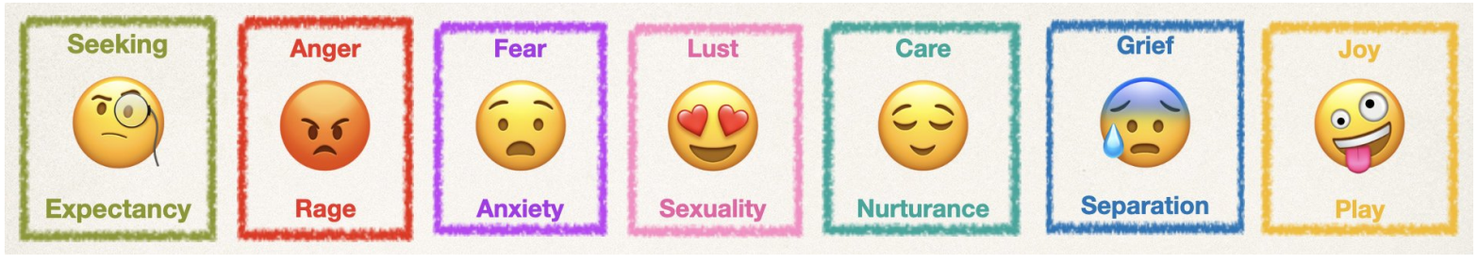
Constructivist Theory

- Whole-brain shifting, distributed and overlapping networks
- *Innumerable shades of feelings, idiosyncratic: constructed each time via dynamic networks*





Classical Theory: Categorical Emotion



External trigger → hard-wired response

• Distinguishable consistent "fingerprints" • localized "lizard" brain functions. • universal, pre-set

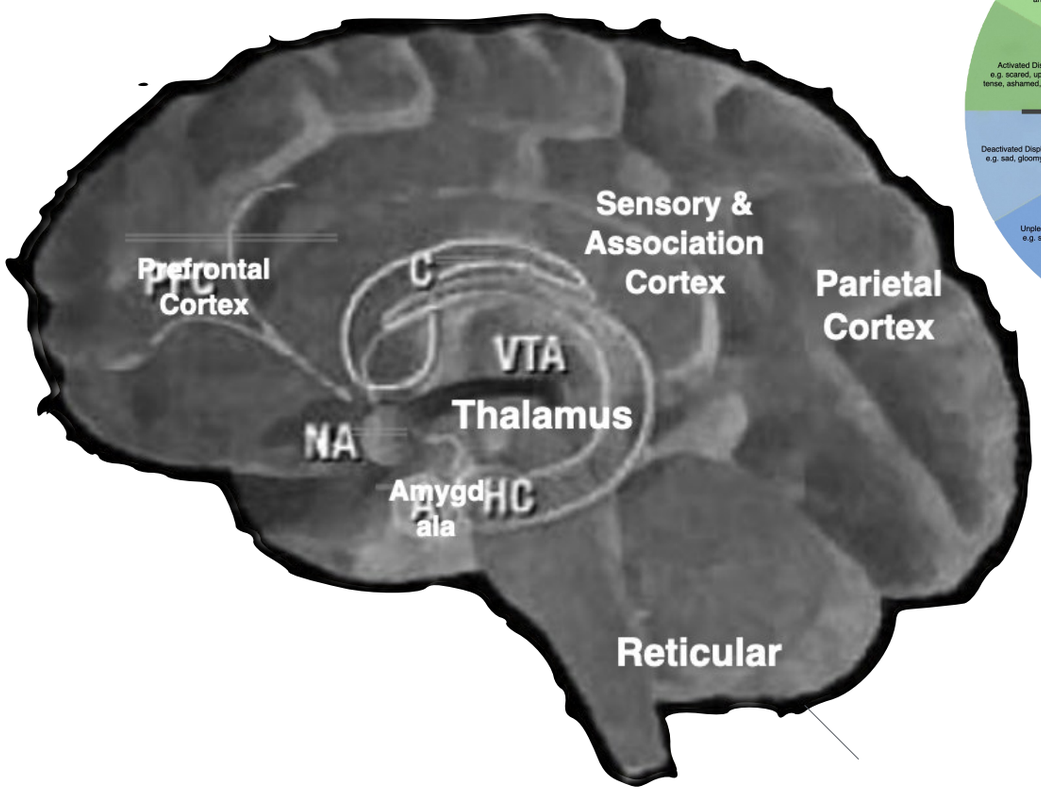
Dimensional Emotion

Constructed each time • Overlapping, variable; many-to-one, one-to-many

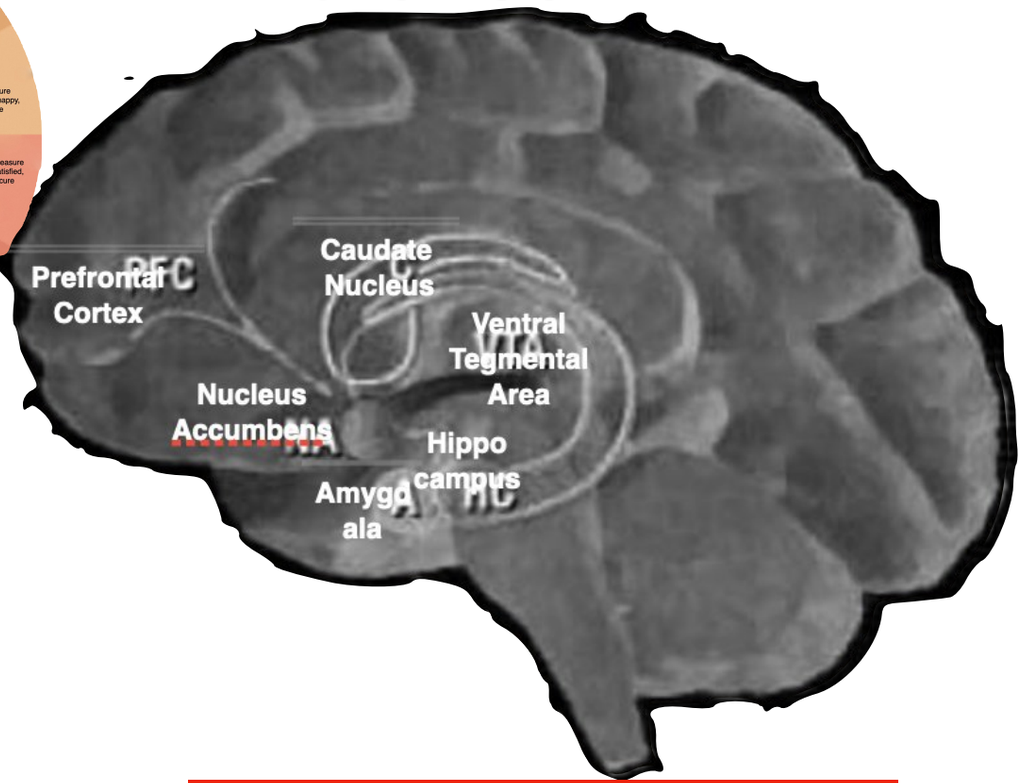
whole-brain energy budgeting, allostasis • cultural, idiosyncratic

Activated - Deactivated

Arousal



Valence



unpleasant - pleasant

unpleasant - pleasant

Activated - deactivated

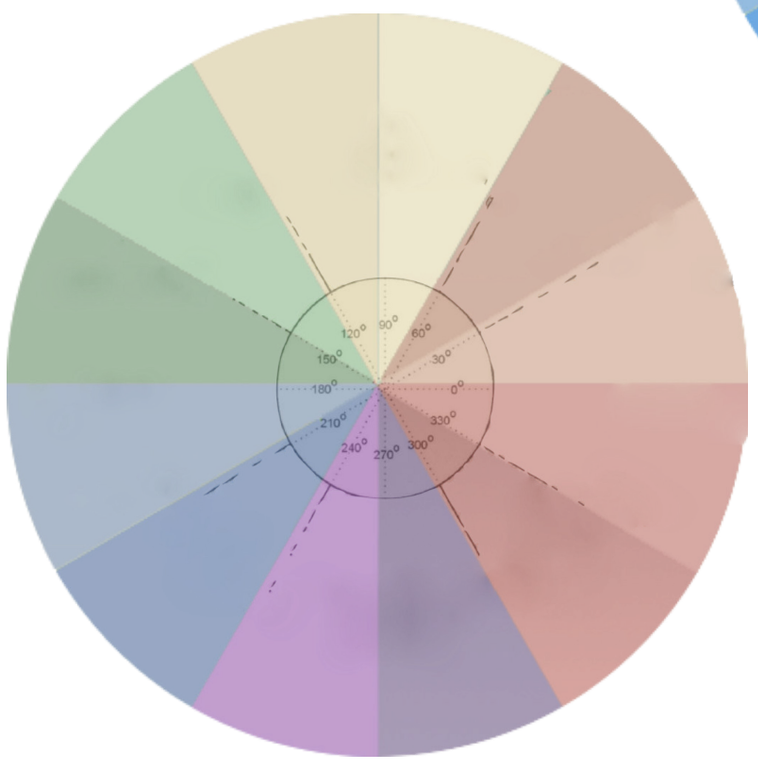
unpleasant - pleasant

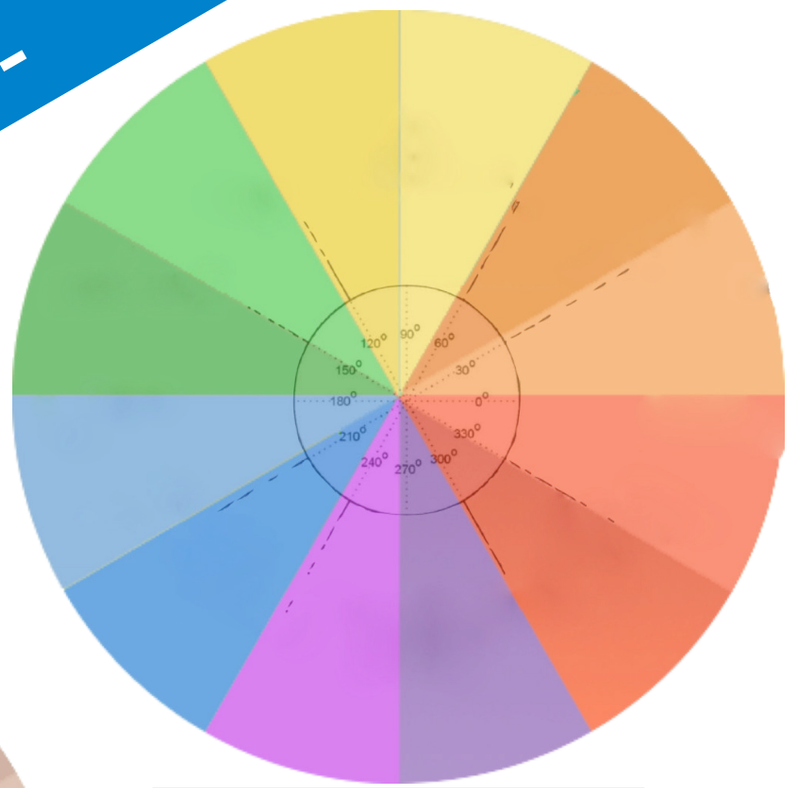
Activated - deactivated

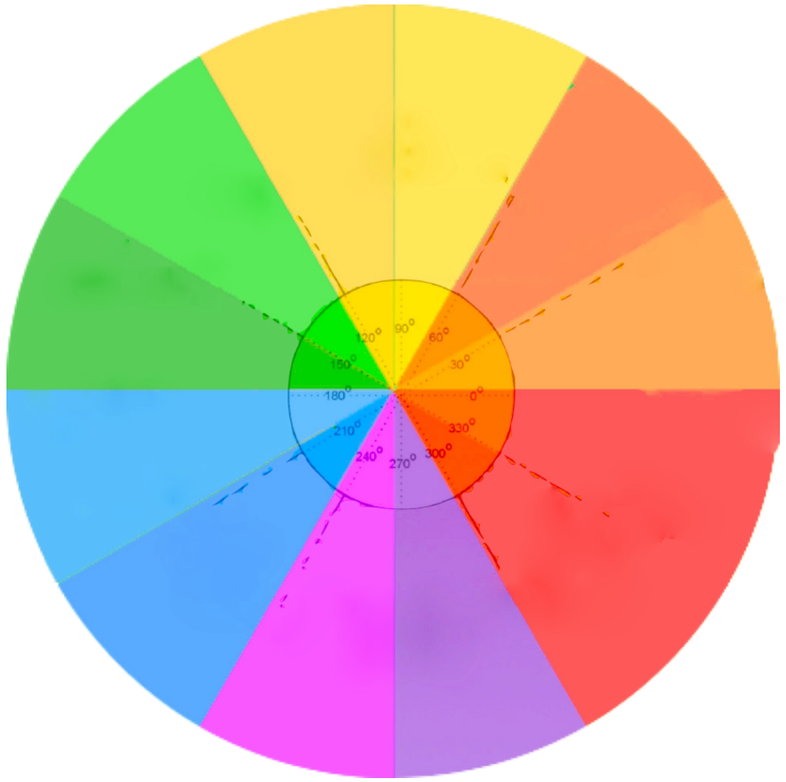
Activated - deactivated

adding intensity as a 3rd dimension

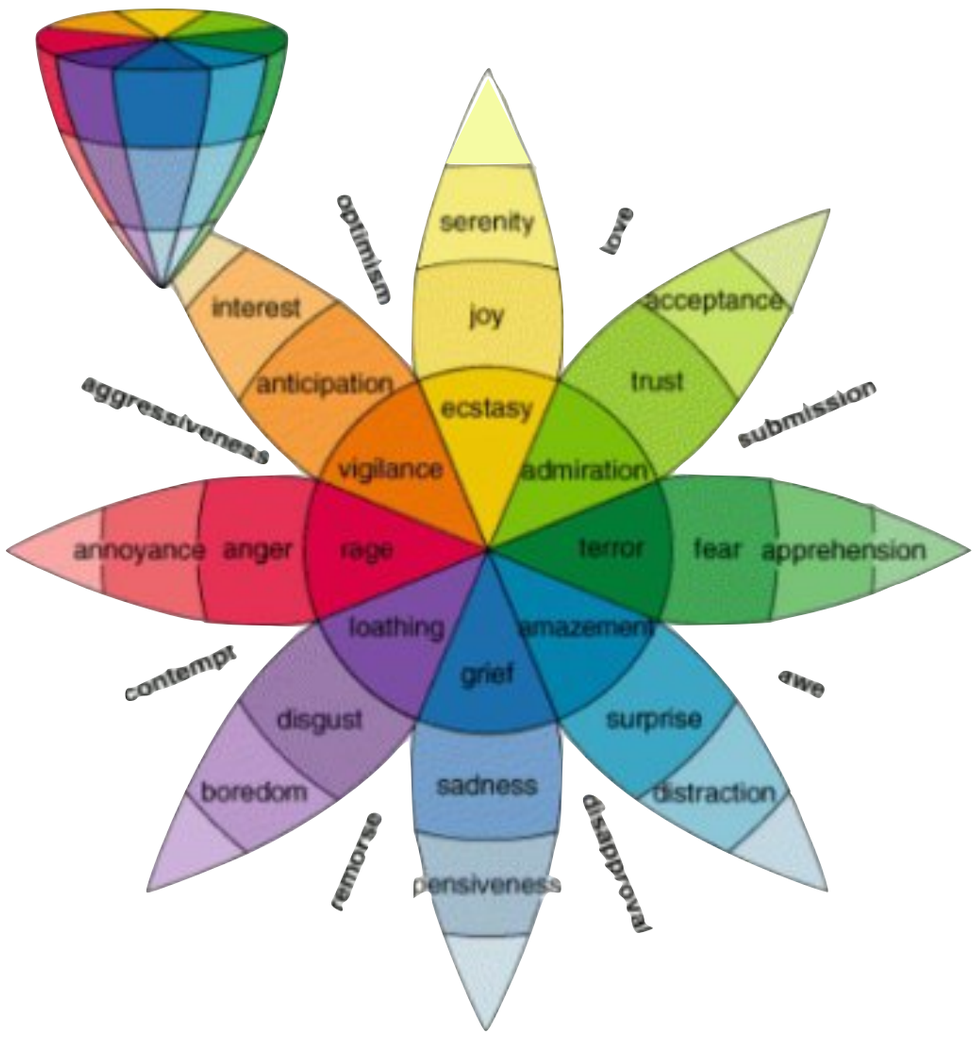
bland - intense







and emotions are always shifting, moving, modulating



unpleasant - pleasant

Practical Implications:

What's the best way of grouping these clinical situations?

Agitated Depression
e.g. "MDD with Anxious Distress"

Avoidant Anxiety
e.g. housebound Agoraphobia

Retarded Depression
e.g. "MDD with Melancholia"

Frantic Anxiety
e.g. Panic Disorder

Practical Implications:

What's the best way of grouping these clinical situations?

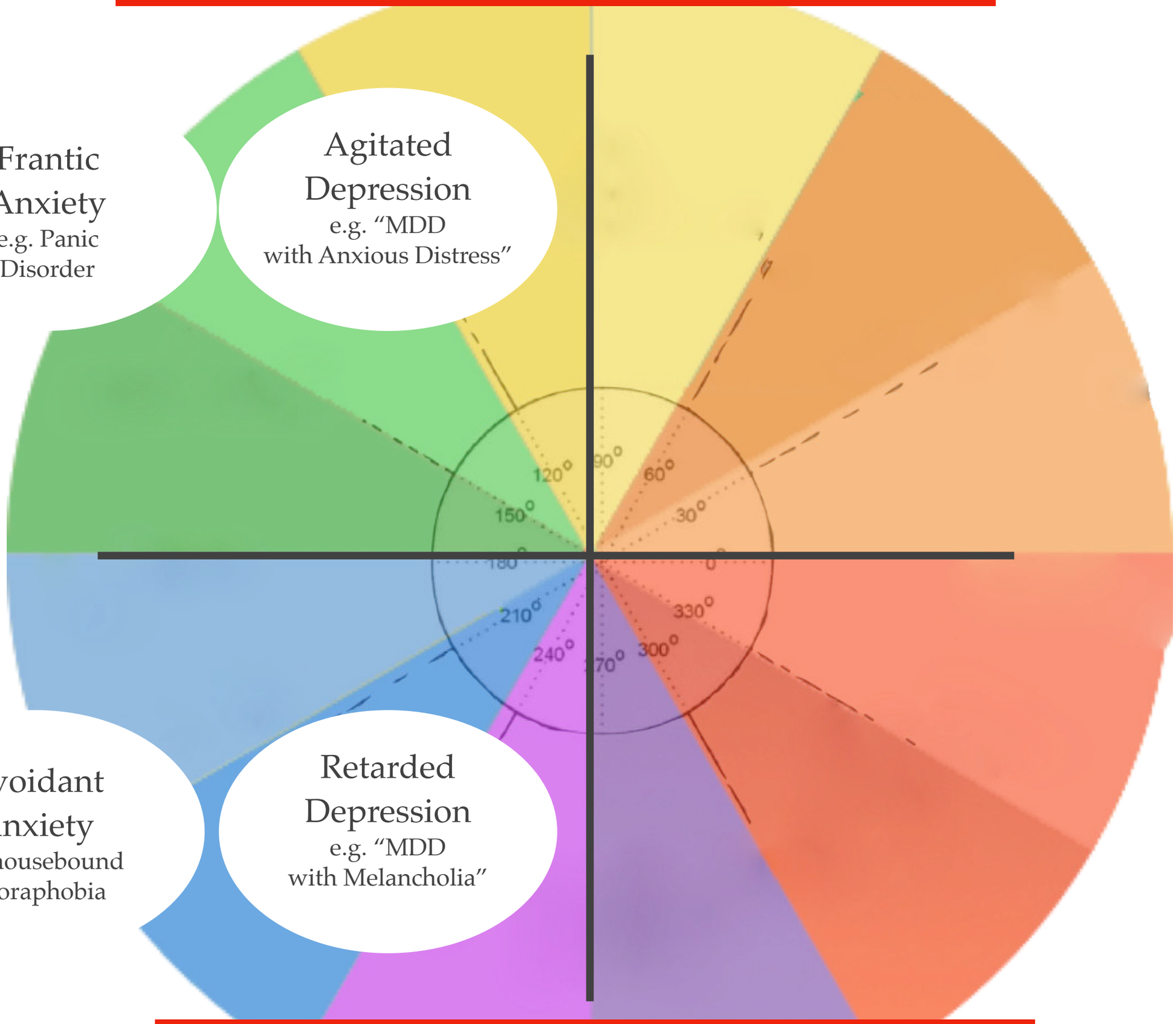
Depressive Disorder	**Anxiety Disorder**
Retarded Depression e.g. "MDD with Melancholia"	Frantic Anxiety e.g. Panic Disorder
Agitated Depression e.g. "MDD with Anxious Distress"	Avoidant Anxiety e.g. housebound Agoraphobia

unpleasant - pleasant

Activated - deactivated

Frantic Anxiety
e.g. Panic Disorder

Agitated Depression
e.g. "MDD with Anxious Distress"



Avoidant Anxiety
e.g. housebound Agoraphobia

Retarded Depression
e.g. "MDD with Melancholia"

unpleasant - pleasant

Activated - deactivated

Helpful Attitudes for SST

- **Enough really is enough** (more is not necessarily better)
- **No need to be brilliant -** Ordinary mind is the way
- **Expect change**
- **Treat the Person not the Diagnosis**
- **Emotions are Not Coercive, but Constructed**

Emotions are not reactions to the world; they are our constructions of the world

emotions arise via complex interactions of brain *networks* attempting to optimize allostasis during intimate exchanges between and within body, mind, and environment

Each instance of emotion is unique.
This is important clinically: it's easier to target (and modify) a concrete *instance* of a feeling than a superordinate emotional *category*

Dealing with Emotional Distress

	Fear Anxiety	Guilt Shame	Sadness Depression	Anger
Action Urge	Escape, Run Avoid	Hide Punish self	Withdraw Give up	Attack Punish, Criticize
Possible Negatives	Restricts life Prevents pleasure	Substitute blame for change Irrational paralysis	Helplessness Lack of pleasure	Lash out & regret it Hurt self, others
Possible Positives	Sensible caution Signal to go slow	Feedback for change Signal for right action	Empathy with others Kindness Compassion	Energy for action Break old patterns
Antidote emotions	Curiosity, Excitement Courage Calm, self-soothe	Acceptance Compassion for self Repentance Openness	Happiness, joy, laughter Competence, realism Compassion Acceptance	Patience Compassion for others Self-confidence
Antidote Actions	Approach gradually Small steps Repeated exposure *with mastery* Relaxation methods (muscles, breathing) Coaching Self-talk	remorse ≠ guilt If guilt is *appropriate*: Make amends Apologize Accept consequences Commit to change If guilt is *irrational*: Approach/don't avoid Repeat openly Clarify responsibility Acknowledge your humanity	Get active, even if you have to force yourself Exercise Do things you've enjoyed in the past, Do things that give a sense of mastery Help others Take pleasure in others' happiness Challenge irrational thoughts	If necessary, avoid action until you cool off Exercise Generate an assertive action plan Be kind to others Help others Thought record Put feelings in writing

The mountains and forests, the hills and fields fill us with overflowing delight and we are joyful.

Our joy has not ended when grief comes trailing it. We have no way to bar the arrival of grief and joy, no way to prevent them from departing.

Joy, anger, grief, delight, worry, regret, fickleness, inflexibility, modesty, willfulness, candor, insolence……

- music from empty holes, mushrooms springing up in dampness, day and night replacing each other before us, and no one knows where they sprout from.

Let it be! Let it be!

[It is enough that] morning and evening we have them,
and they are the means by which we live.

Helpful Attitudes for SST

- **Enough really is enough** (more is not necessarily better)
- **No need to be brilliant -** Ordinary mind is the way
- **Expect change**
- **Treat the Person, Not the Diagnosis**
- **Emotions are Not Coercive, but Constructed**
- **Time is Not a Tick**
    - You can take all the time you need, within the time you have

- **Time is Not a Tick**
  - You can take all the time you need, within the time you have

because

Single Session Therapy is Moment by Moment Therapy

The mind arises in a moment

A moment arises in the mind

This is the understanding that *the self is time*

Eihei Dogen
Uji - The Time Being

You *are* the time of your life

- so make time your friend

Time is not separate from you…
the time-being abides in each moment.

Since there is nothing but just this moment,
the time-being is all the time there is.

Because all moments are the time-being,
they are *your* time-being.

Eihei Dogen
Uji - The Time Being

Making time your friend

- View each encounter as a whole, complete in itself
- No need to rush, no need to wait
- Take all the time you need, within the time you have

What time do you practice in?

the past is gone

the future is not here yet

the present cannot be grasped

WHAT TIME DO YOU PRACTICE IN?

When you live completely in each moment,
without expecting anything,
you have no idea of time.

Shunryu Suzuki,
Not Always So

> Time is our element, and not a mistaken invader.
>
> - John Updike

Time is the substance from which I am made.

Time is a river which carries me along,

but I am the river;

it is a tiger that devours me,

but I am the tiger;

it is a fire that consumes me,

but I am the fire.

- Jorge Luis Borges

- Most of our understanding of time is a metaphorical version of our embodied experience of motion in space

  Let's put that behind us…..He's got so many experiences ahead of him…

  - We see time moving like an object past a stationary observer

    The time will come when….the time has long gone since…..

  - We see time as a path of fixed length, which we traverse

    we're halfway through September….his visit extended for a long time….

  - We conceptualize duration of time as the size of a container

    Seeing time as a container, events must occur within a container

    She ran a mile in five minutes....the ceremony took place at ten in the morning

- The problem:
  - *We forget we're using a metaphor and start thinking of time as a thing*
  - If things occur "in" time, time must be separate from us

  - we cannot observe time itself (if time even exists as a thing-in-itself)

Time can only be experienced as events

George Lakoff & Mark Johnson, *Philosophy in the Flesh*

Because time is experienced via events,

time is always embodied

time is always *lived*

moment by moment

Physical time [is an illusion which] emerges by virtue of our thinking ourselves as separate from everything else.

Craig Callender
Scientific American, 2011

Time does not pass.

We are in fact at *each instant* of our lives.

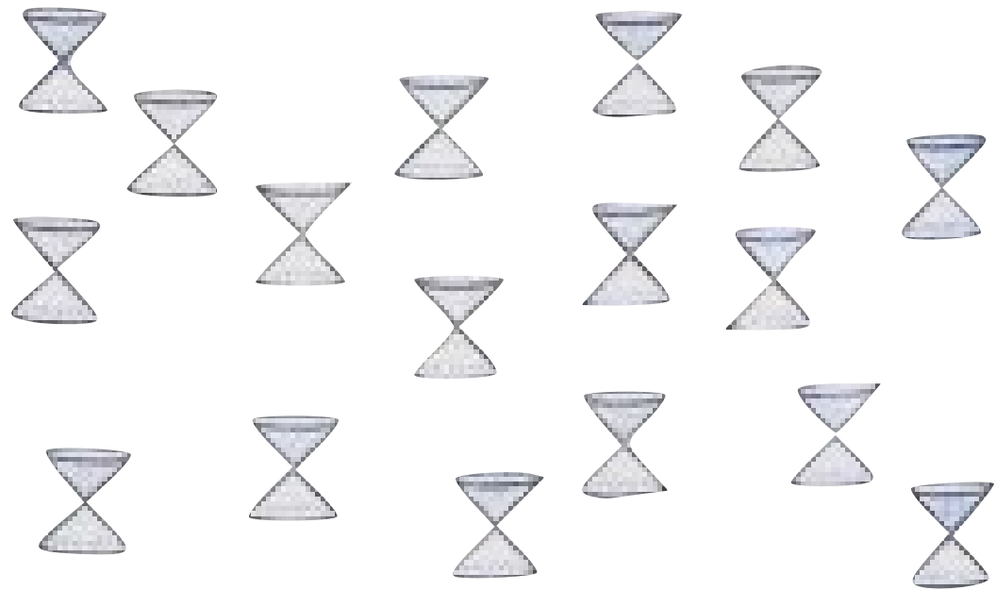
Every instant of your life exists always.

Every moment of past and future history *exists permanently* in the framework of 4-dimensional space-time.

Rudolf v.B. Rucker,
Geometry, Relativity and the Fourth Dimension

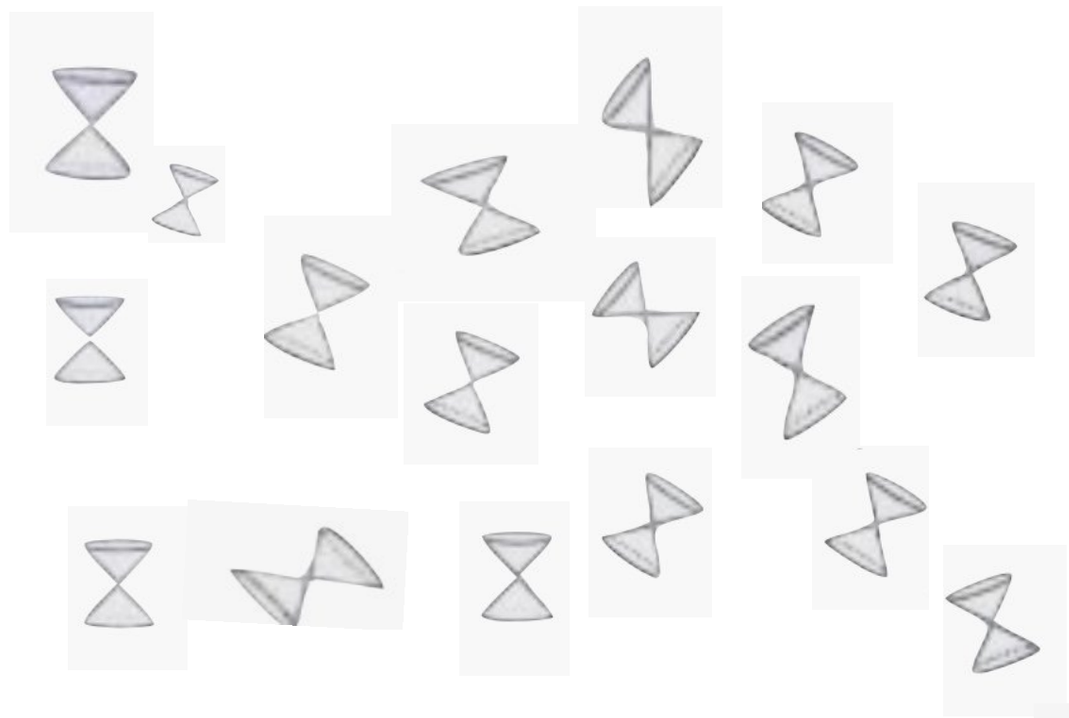
S*pecial* relativity:
Time passes slower for moving objects, so every observer experiences a differing time according to their velocities relative to each other.

There is a unique "cone" of time according to how light reaches each person before and after each moment.



G*eneral* relativity,
time flows differently from place to place:
[i.e., gravity affects the speed at which time flows].

So spacetime isn't ordered as the first diagram shows, it get distorted.



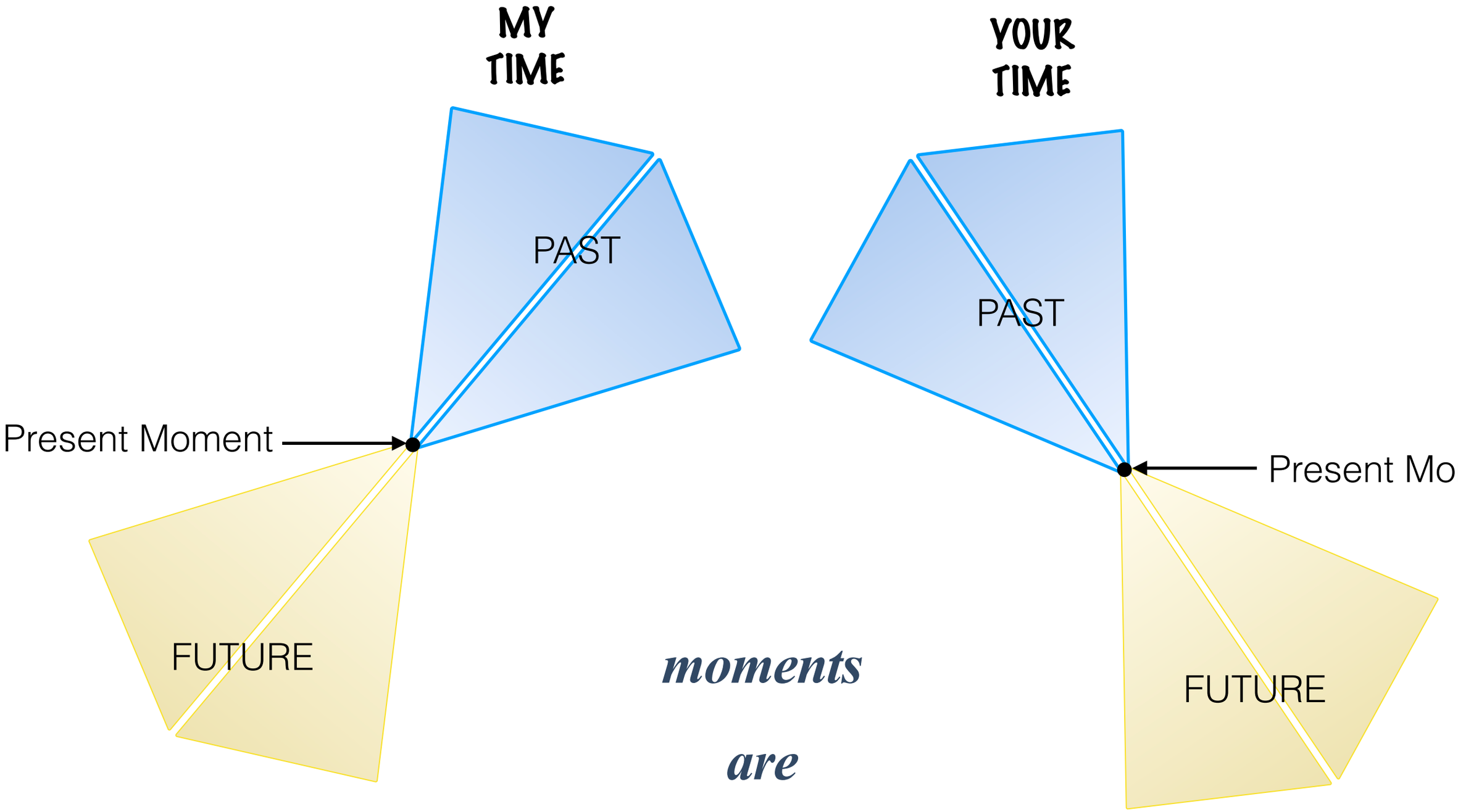
How long was that hour?

How long was that moment?

moments

are

meetings



moments

are

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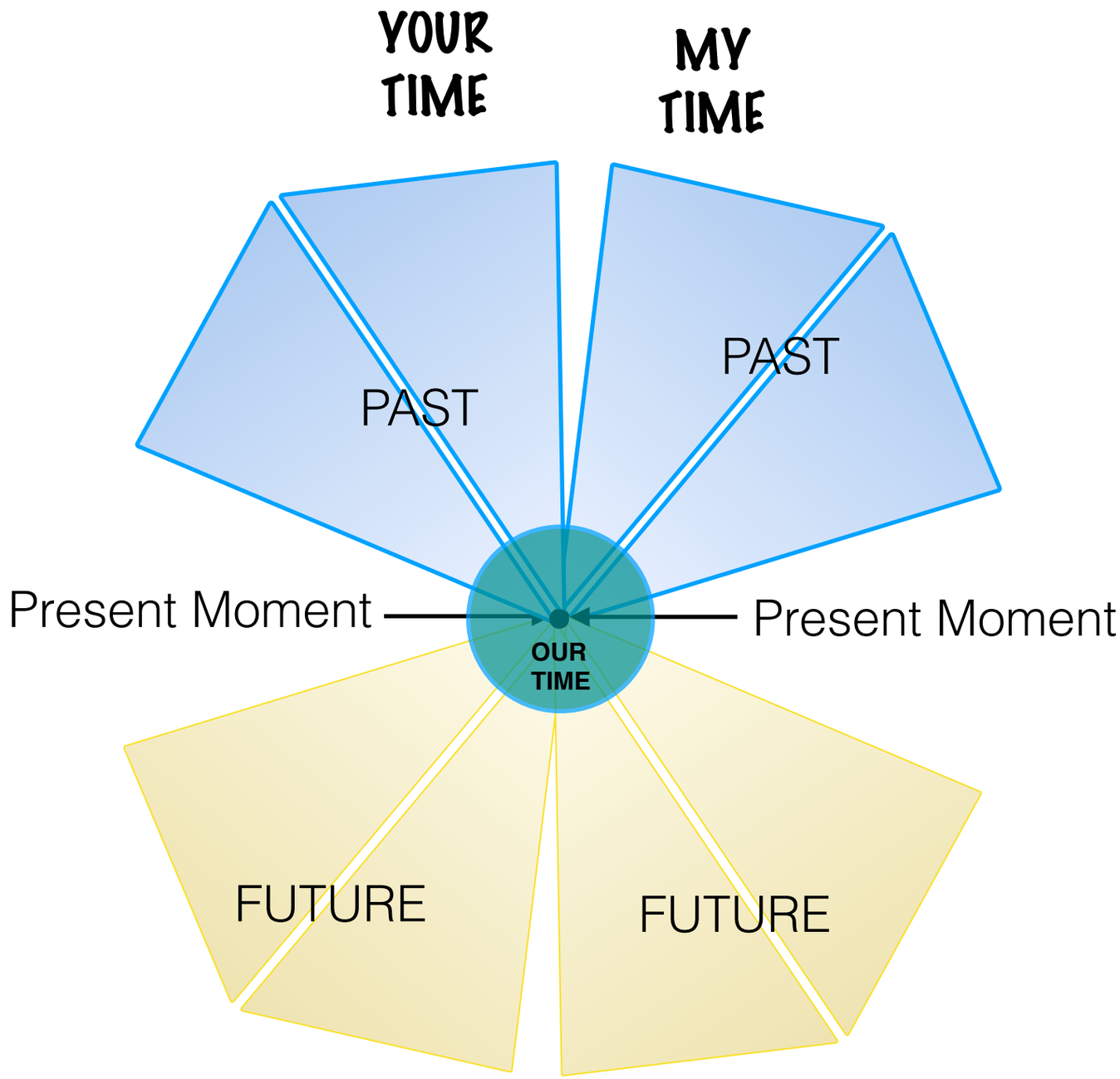
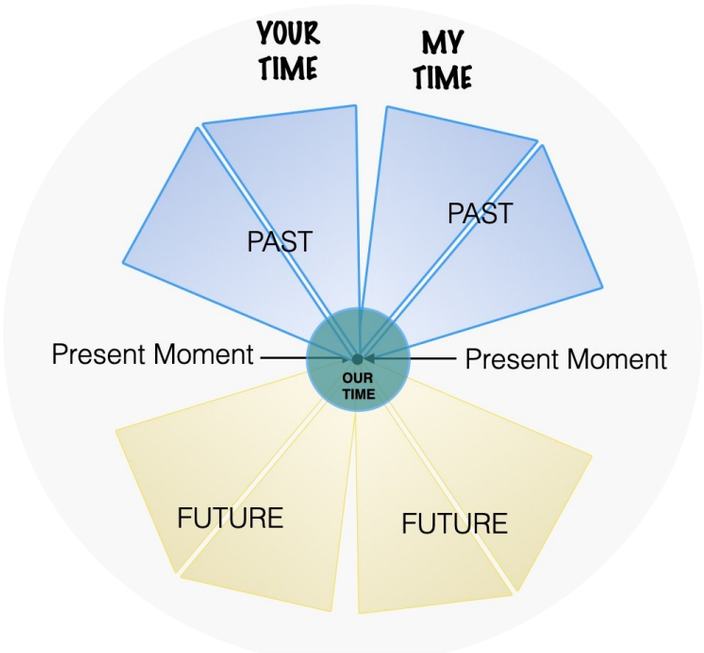

YOUR TIME
MY TIME
PAST
PAST
Present Moment
Present Moment
OUR TIME
FUTURE
FUTURE



Single-Session Therapy is simply our time-space together: moment-by-moment therapy

Time is not separate from you…

the time-being abides in each moment.

Since there is nothing but just this moment,

the time-being is all the time there is.

Eihei Dogen
Uji - The Time Being

Ash does not turn into firewood

Firewood does not turn into ash

Each is an expression complete this moment

Firewood is a complete expression of firewood:

ash is a complete expression of ash

It is like winter and spring.

You do not call winter the beginning of spring,
nor summer the end of spring.

Ash does not turn into firewood

Firewood does not turn into ash

Each is an expression complete this moment

Firewood is a complete expression of firewood:

ash is a complete expression of ash

The evening becomes night.

Yet the night is not a conclusion drawn from the evening, as
death is not a conclusion drawn from a life.

Neither is the night the fruition of the evening, as death is
not the fruition of life.

There is evening, and there is night -

each of them eternal in its own right and mode.

The Embers and the Stars: A philosophical inquiry into the moral sense of nature by Erazim Kohák

Each is an expression complete this moment

So people do not change *from* one state of being *to* another

A little girl is not a half-grown woman

An elderly woman is not a decayed adult

Cases: dancer mother, woman sexually abused as a child

Eihei Dogen:

The reason you do not clearly understand the time-being is that you think of time only as passing.

You may suppose that time is only passing away and not understand that *time never arrives*.

You may suppose that time is only passing away and not understand that *time never arrives*.

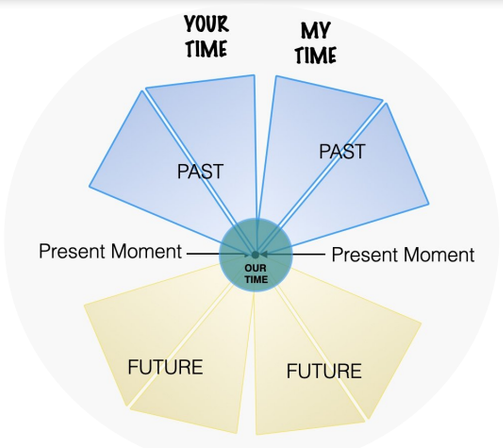
We don't know what will happen.

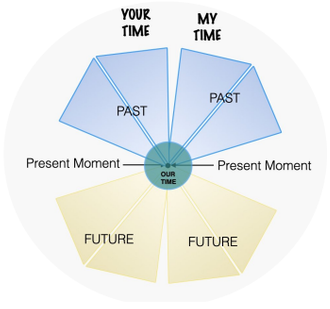
If you fail to express yourself fully on each moment, you may regret it later.

Because you expect some future time, you miss your opportunity.....

Do not wait to express yourself fully.

Shunryu Suzuki,
Not Always So





Practical Tips for Making Time Your Friend

★ Setting the Time

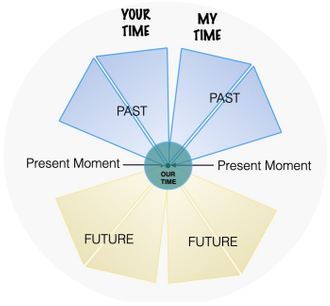
BEGIN BEFORE THE BEGINNING

- <u>"Whenever possible -</u>
  - set aside enough time so you are not rushed
  - To allow time for last minute issues, set a "pre"ending time with a 10' buffer

- <u>"Make an end" to whatever you were doing before the session</u>
  - Close computer windows, turn off phone
  - Attend to body needs; breathing, mindfulness
  - relax face, hands, feet
  - Qigong: cleanse hands, wash face; acupressure; open/close

- <u>Punctuate a beginning</u>
  - Pause before leaving office
  - Ask yourself the most important question

- <u>When time is at a premium:</u>
  - Acknowledge the time situation
  - *Slow down!*
  - Adjust Expectations



Practical Tips for Making Time Your Friend

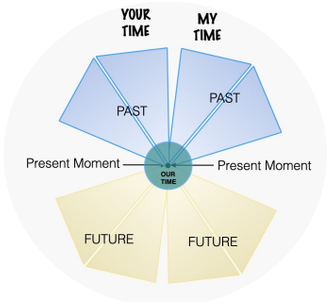
★ Living the Time

DEMONSTRATE AND EMBODY TIME

- Take extra moments
  - Walking from office to waiting room
  - *Meet* - not just greet - the client
  - Walking with client (to office, exam room)

- Model: *Show* there is enough time
  - take time to seat yourself
  - Check client is comfortable
    - “Have a cup of tea”

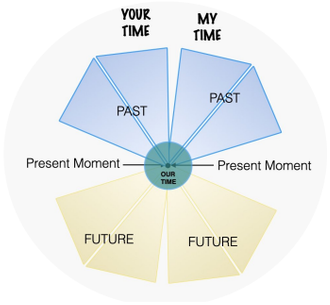
- Take a pause or a break when helpful
  - Client-Centered
    - If client seems overwhelmed: “would you like to take a break for a few minutes?”
    - If client seems fuzzy or distracted: “is there something you’d like to do to help you get on track here?"
  - Therapist-Centered
    - “There’s a lot to what you’ve told me. Would it be OK with you if I close my eyes for a minute and think about what you’ve said?”
    - I have a few ideas, but I’d like to consult with a colleague who’s particularly good at these kinds of things. Is it OK with you if I go out and talk with them for a few minutes, then come back?



Practical Tips for Making Time Your Friend

★ Framing the Time

- Let’s take all the time we need, within the time we have
- We only have X minutes so what do we most need to talk about?
- We've only got about X minutes, so can I ask you a sensitive but important question ?
- We don't have much time, so can I be really upfront with you?
- Let me explain how I’d like to use the time we have...
- We’ll stop when that clock on the wall shows….
- What do you want to have accomplished by the time the hands on that clock reach X…..

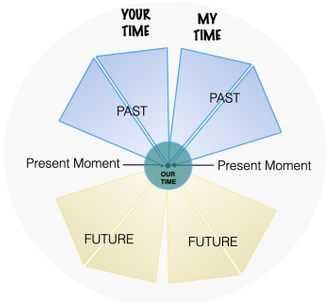


Practical Tips for Making Time Your Friend

★ Languaging the Time

Past-Present-Future

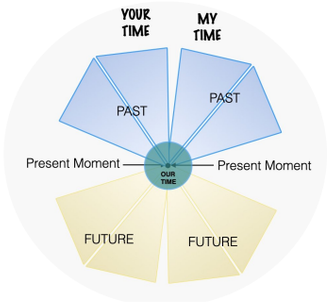
- How { have you known / do you know / will you know } when you're on the right track?
- What work, hobbies, or interests { have you / do you / will you } most enjoy(ed)
  - Have you ever solved a problem by working at it back to front?
  - It's sometimes not obvious when things are changing. How do you go about noticing change?
  - What made you decide to come in now, rather than last week or next week?
  - When you've experienced difficulties before, how did you get past them?
  - How do you take care of yourself currently?
  - What skills do you want to learn to help you cope with difficulties in the future?



Practical Tips for Making Time Your Friend

★ Punctuating the Time

- <u>Attend to rhythm, pace</u>
  - Let's go slow here…. Hold on a moment…
  - Let's pause for a moment so you can absorb that
  - Let's zip through a few of the basics…
  - Use silence to incubate or to emphasize
- <u>Use repetition</u>
  - "Can you please repeat what you just said?"
  - "I want to underline what you yourself have said:…"
  - "This seems important to me - does it seems important to you?"
  - "Let's rehearse this, and go over this several times"
  - Broken record technique
- <u>When something good happens</u>: *stop the session at that point*



Practical Tips for Making Time Your Friend

★ Most Importantly

Never rush, never wait:
go moment by moment

The SST Mind-Set in Supervision

- Facilitate a conversation with a clear beginning, middle, end.
- Plan the meeting - develop a clear agenda for here and now
- Hear the “story” of the work. Listen for what’s likely to be most helpful
- Stay on track: interrupt respectfully if needed
- Move between content and process
    - Check in with the supervisee - is this what we need to be talking about?
    - Respond to challenges: anticipate “yes, but….”
    - Offer thoughts in ways that can be heard and integrated usefully.
      Where helpful, be transparent about one’s own thinking
    - Optimize empowerment - make choices overt by inviting reflection,
      asking supervisee to be transparent about and reflect on their own thinking
- Finish well, in a way that leaves the door open

Rycroft, P. (2018). Capturing the Moment in Supervision. In *Single-Session Therapy by Walk-in or Appointment.* M. Hoyt, M. Bobele, S. Slive, J. Young and M. Talmon (Eds). New York: Routledge, 334-346.

SST Mindset - Therapy

Context setting
Engagement
What we already know
Questionnaire
Any updates since intake

Finding a focus
Developing working themes: Clarifying
From your questionnaire, there are a number of issues you're dealing with right now...

Establishing the client's priorities
of all the issues you've raised, given that we could spend at least one session on any one of them, which is the most important for us to focus on today?

Staying on track
Checking in
- *Are we talking about what we need to be focusing on, or are we getting off track?*
- *Can I just check with you that this is where we need to be heading? Is this helpful? Can you let me know if there is anything I'm missing?*

Investigating attempted solutions
Listening for clients' resources
- *Of everything you have tried, what do you believe came closest to working?*
- *What do you think got in the way when things didn't work?*
- *What do you know about yourself / this family that tells me that you are ready to try something different?*

Break
(Either actual break or a punctuation in the session)
- *Before we take a break, is there anything also that you feel I need to know in order to be helpful to you today?*

Reflecting
(Either by yourself or with a co-therapist)
Sharing therapist thoughts, clear feedback and direct, tentative, advice
Reflection can provide a rationale for advice or may be the advice itself
- *I'm beginning to get some ideas: I'll share them and see what you think?*
- *Maybe I can share my thoughts with you and see what you think?*
- *Tell me if I'm I've got it totally wrong, but I wonder if. ...*

Hearing feedback from clients
Listening carefully to clients' response to our reflections and suggestions

Allowing for last-minute issues
What hasn't been covered that needs to be brought up?
Any questions / concerns?

Closure
Making an appointment for a follow-up phone call

SST Mindset
- Supervision

Seven Eyes Model of Supervision

1. System context
2. Client's issues
3. Relationship between client & supervisee
4. Supervisee's issues
5. Supervisor's issues
6. Supervisor-supervisee issues
7. Parallel processes in supervisor-supervisee / supervisee-client

SST Mindset - Supervision

Context setting

- Connecting, contracting
- Understanding the supervisee's context, values
- Negotiating a good outcome

"If this could be as helpful as possible…"

Finding a focus

- Hearing "the story" about the work
- Establishing the particular aspect of the work to focus on (what are the clinical issues?)
- Negotiating how to proceed. enumerating any choices

What kind of supervisor would you like me to be today?

Would you like me to make suggestions, or be quietly supportive?

Staying on track

Checking in

Are we talking about what we need to be focusing on, or are we getting off track?

Can I just check with you that this is where we need to be heading? Is this helpful?

Can you let me know if there is anything I'm missing?

Investigating attempted interventions

- Keeping the focus on the appropriate "eye"
- Listening for supervises' resources

Of everything you have tried, what has gone well, and what not so well?

On reflection, is there anything you would do differently? Or that you wouldn't change?

What do you know about yourself / your client that tells me that you are ready to try something different?

Reviewing/Transition

"Before I tell you what I'm thinking, is there is anything further I need to know, do you think, to be helpful to you?"

"Have I understood the issues so far, do you think?"

"Is there anything I haven't asked you, but should have?"

Reflecting

- Offering one's thinking as openly as possible while keeping in mind the hoped-for outcome
- Balancing both support and challenge

I'm impressed by…concerned about…

I wonder if…….

Hearing supervisee's feedback

"Is there anything in what I've said that is not sitting well with you?

Tell me how this strikes you"

Allowing for last-minute issues

What hasn't been covered that needs to be brought up?
Any questions / concerns?

Checking in & closure

"How far have we come in meeting what you had hoped for?"

"Any last questions / concerns?"

"What are you going to be taking away?"

Seven Eyes Model of Supervision

1. System context
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SST Mindset
- Supervision

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Tell me how this strikes you”

What hasn't been covered that needs to be brought up?

Any questions / concerns?

"How far have we come in meeting what you had hoped for?"

"Any last questions / concerns?"

"What are you going to be taking away?"

The SST Mind-Set in Supervision

- Foster a comfortable, safe environment for both yourself and the supervisee
  - Cultivate curiosity
  - Instill hope - or letting go of hope, as appropriate
  - Don't get *too* comfortable! No waves ➔ stagnant ponds
- Address issues both in the moment and from the perspective of ongoing developmental learning
- Prepare to be surprised
  - Be alert to learning "edges"
  - Look for "pivot chords" for the supervisee
  - Be multi-lingual - explore non-clinical "languages"
    - use supervisees' and clients' interests
    - Films, books, TV, art, music, dance, sports, hobbies, vacations, fantasies….
- When in doubt
  - Go wider - A Bigger Container
  - Go narrower - small changes can make big differences
  - Don't overlook the obvious
  - Stop holding to fixed views
  - Encourage the process of practice

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Some Questions for Supervisors to Ask Supervisees

Just as couples can get into stuck patterns in their relationship to each other, so can supervisors and supervisees.
Opening a relationally reflexive space for supervisees helps them feel empowered to co-construct a relationship with with the supervisor.
To increase learning potentials a supervisor can pose questions - and questions about questions - such as:

Questions to foster a session-by-session mind-set

- What kind of supervisor would you like me to be today?
- Are we talking about the issues that are important to you, in ways that are useful, at a pace that is OK?
- If this supervision were to stop now, what important issues would have been resolved already, and what issues would you feel we could have worked on further?
- I'm wondering- have I been challenging enough in today's supervision?

Questions to alter an ongoing supervisory relationship

- I've been thinking about how we might change how we do our supervision sessions. Do you have any ideas on this?
- Over our sessions so far, which aspect of your experience do you think has been explored/changed most, and which do you hope to work on from now on?
- Usually I wait until you've finished what you have had to say before I say anything. I wonder what it would be like if I interrupted earlier and asked some questions to make sure I'm understanding you in the way that you want me to?"
- How could our supervision be organized so that you don't feel that you're having a negative experience? If it started to go that way would you be able to speak out?"
- If I want to say something positive or appreciative about your work, how could I do it in ways that you could use to improve your image of yourself as a therapist?

Questions about supervisees' sessions with clients

- "How long did that hour last?
- When clients ask you questions, which questions are most useful to you, the easy ones or the difficult ones?"
- When clients ask you questions that are really too difficult for you to answer, for whatever reason, are you be able to tell them?"

Burnham, J. (2019). Relational reflexivity: a tool for socially constructing therapeutic relationships. In *The Space Between Systemic Thinking and Practice* (2019). Carmel Flaskas, Barry Mason, Amaryll Perlesz (Eds.) Taylor & Francis Group, 0367328860, 9780367328863 Pp 1-17 John Burnham

Exercise

- Form pairs
- Decide who will be supervisor/consultant, who will be supervisee/client
- Supervisee/client: Either
  - Choose a case to present you are seeing, or role play one of your supervisees presenting a recent case
  - OR Select a supervisee you are having troubles with, you'd like your colleague's help with
- Supervisor
  - At the outset, frame the meeting as an SST
  - Employ one of the time-management methods and/or questions to expand the time's "space"
  - Use one of the other questions from the next slide during the consultation

If this could be as helpful as possible…

What kind of supervisor would you like me to be today?

Which do you find more supportive, for me to ask questions & make suggestions, as we go along, or to listen quietly until you've finished?

Are we talking about what we need to be focusing on, or are we getting off track?

Can I just check with you that this is where we need to be heading? Is this helpful?

Can you let me know if there is anything I'm missing?

Of everything you've tried, what's gone well, what not so well?

On reflection, is there anything you would do differently?

On reflection, is there anything you wouldn't change?

What do you know about yourself that tells you you're ready to try something different?

When clients ask you questions, which questions are most useful to you, the easy ones or the difficult ones?"

When clients ask you questions that are too difficult for you to answer, for whatever reason, are you be able to tell them?"

Before I tell you what I'm thinking, is there is anything further I need to know to be helpful to you?"

Have I understood the issues so far, do you think?

Is there anything I haven't asked you, but should have?

I'm impressed by…concerned about…I wonder if…….

Tell me how this strikes you

Is there anything in what I've said that'snot sitting well with you?

What hasn't been covered that needs to be brought up?

How far have we come in meeting what you'd hoped for?"

What are you going to be taking away?

<u>Demonstrate, Embody Time</u>

Take extra moments

Meet - not just greet - the supervisee

Model: Show there is enough time

Take time to seat yourself, relax, breathe

Check supervisee is comfortable

<u>Frame the Time</u>

Let's take all the time we need, within the time we have

We only have X minutes so what do we most need to talk about?

We've only got about X minutes, so can I ask you a sensitive but important question ?

We don't have much time, so can I be upfront with you?

What do you want to have accomplished by the time the hands on that clock reach X….

<u>Attend to rhythm, pace</u>

Let's go slow here…. Hold on a moment…

Let's pause for a moment so you can absorb that

Let's zip through a few of the basics…

Use silence to incubate or to emphasize

<u>Use repetition</u>

Can you please repeat what you just said?"

I want to underline what you have said:…

This seems important to me - does it seems important to you?

Let's rehearse this

Let's go over this several times

Supervision is artistry and science, a way of being and a way of doing.

It's about techniques and strategies, and relationships.

It involves both development and evaluation, supporting *and* challenging,
fact *and* imagination, about truth *and* opinion….

It's a relationship, a learning partnership. It supports learning *and* unlearning.

It meditates on the past in the present to prepare the future.

It makes meaning and new meaning using reflection, curiosity and imagination.

It involves dialogue and conversations about conversations.

It deals with the work and with the person doing the work…

It banishes fear and shame and anything that threatens the fragile flower of learning.

It takes stands and can be dogmatic. It opens up and is flexible.

It’s an oasis, a valet service, a large mirror and a retreat.

Now, tell me you can’t get passionate about that?

- Michael Carroll (2011). Supervision: A journey of life-long learning. In R. Shohei (Ed.), *Supervision as Transformation: A passion for learning.* London: Jessica Kingsley Publishers, p,. 27

Like the moon reflected on the water.
The moon does not get wet, nor is the water broken.

Although its light is wide and great,
the moon is reflected even in a puddle an inch wide.

The whole moon and the entire sky are reflected in dewdrops on the grass, or even in one drop of water.

The depth of the drop is the height of the moon.
Each reflection, however long or short its duration,
manifests the vastness of the dewdrop,
and realizes the limitlessness of the moonlight in the sky.

- Eihei Dogen