Single Session Psychotherapies

NPTC renton

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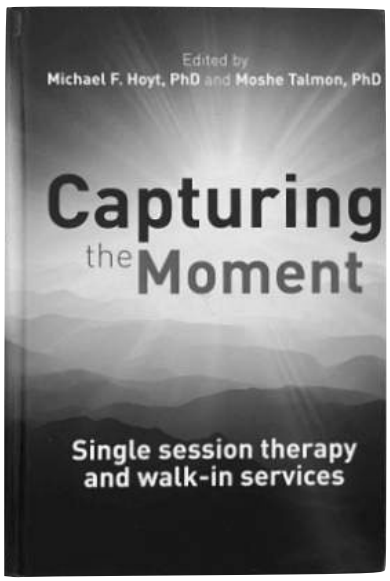
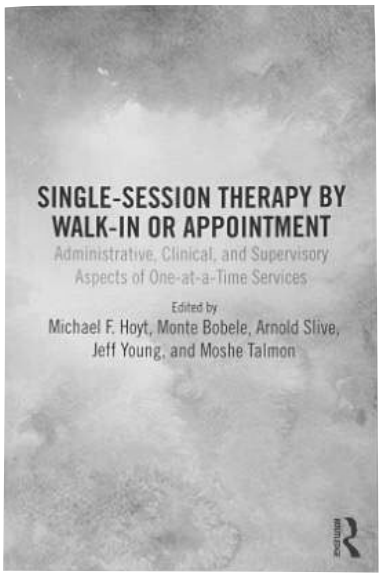
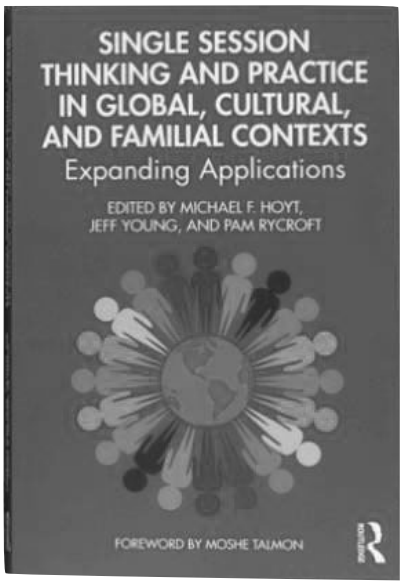
> In all beginnings dwells a magic force
> For guarding us and helping us to live.
> - Herman Hesse.

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 one-session-at-a-time therapy

Every visit is a potential single session therapy

THREE ANECDOTES

- Dissolving Anger
  - Personal example - couples tx
  - Clinical example - after CBT
- Lightening self-criticism
  - Personal example - the pencil
  - Clinical example - the chickens
- Trauma and Transformation
  - Personal example - a family tree
  - Clinical example - holocaust dreams

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

Single Session Therapy:

The Basic Attitude

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 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 didn't realize that my feelings were quite so strong ...

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.

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

- Three alterations to standard clinic procedures
  - No division between intake and therapy
  - Additional Time Allotted (but generally not used)
  - Introduction of Possibility of SST at Outset

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

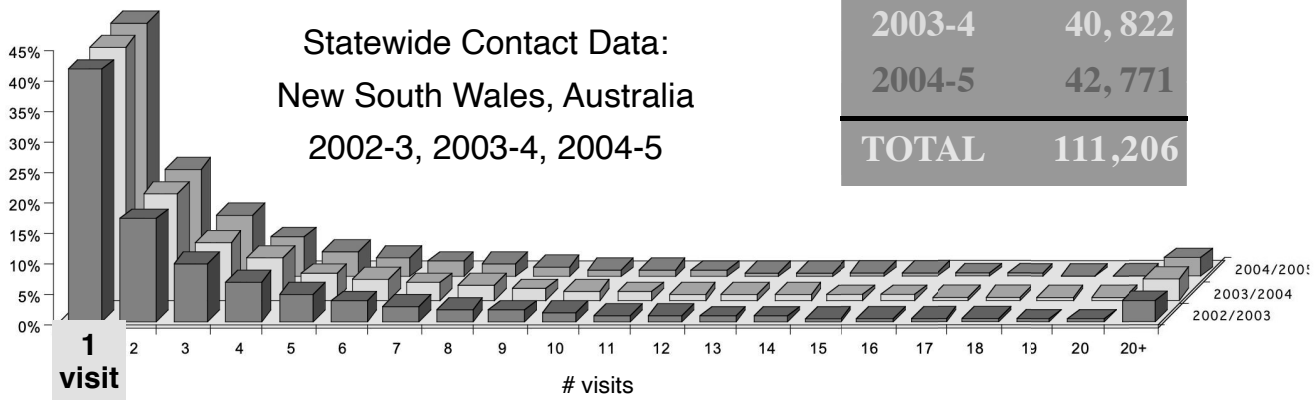
In the last 20 Years....

- 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

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

Statewide Contact Data:
New South Wales, Australia
2002-3, 2003-4, 2004-5

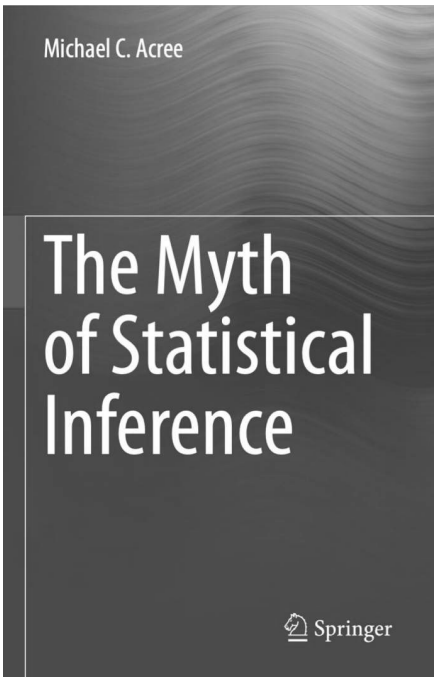
Total Contacts	
2002-3	31, 613
2003-4	40, 822
2004-5	42, 771
TOTAL	111,206



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

Research

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

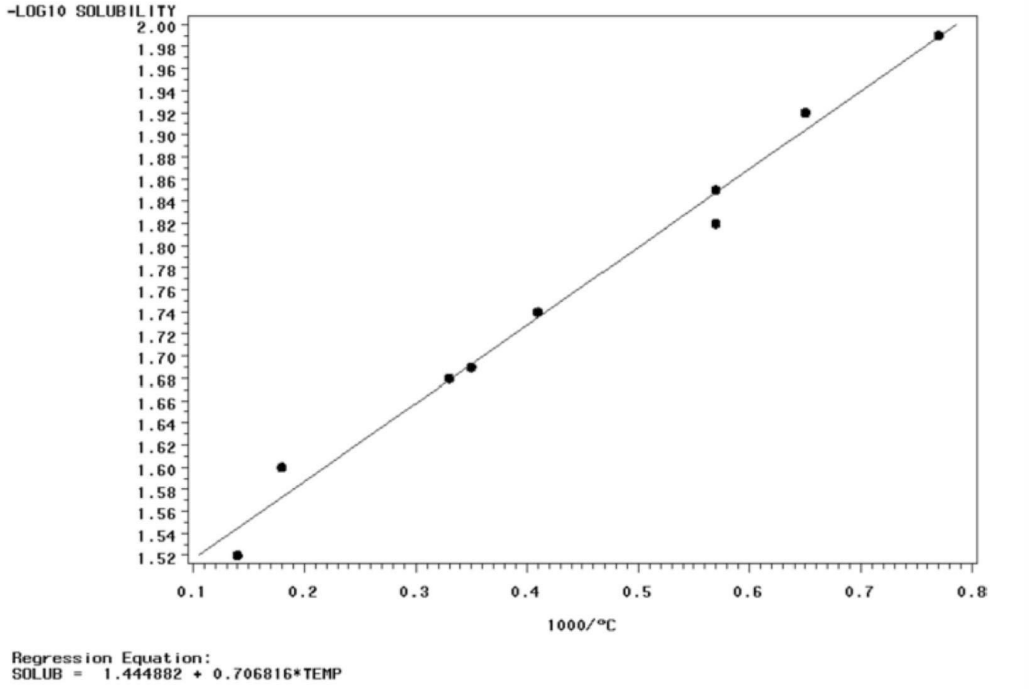
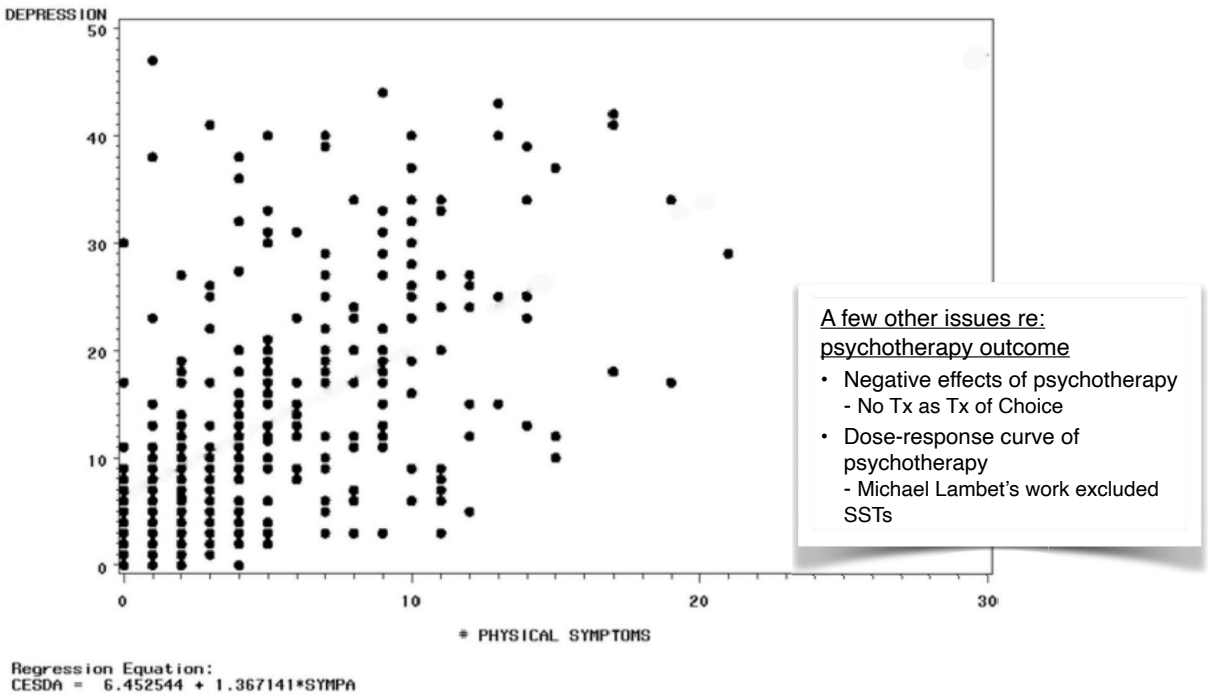


Fig. 11.1 Solubility of plutonium fluoride as a function of temperature

Research Critique



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

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

The Impact of Brief Interventions on Functioning Among those Demonstrating Anxiety, Depressive, and Adjustment Disorder Symptoms in Primary Care: The Effectiveness of the Primary Care Behavioral Health (PCBH) Model

Kevin M. Wilfong · Jeffrey L. Goodie · Justin C. Curry · Christopher L. Hunter · Phillip C. Kroke

Journal of Clinical Psychology in Medical Settings (2022) 29:318-331
https://doi.org/10.1007/s10880-021-09826-9

Caucasian, female, military dependents seen for **2 to 4** appointments (N= 5402)

A reliable change index revealed that

For individuals with a severe Behavioral Health Measure-20 score at baseline,

81.5% showed some improvement at their final appointment,

33% demonstrating reliable improvement.

Individuals with more total appointments reported worse functioning outcomes.

"Overall, the data support the effectiveness of time-limited care provided through the PCBH model."

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

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

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

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).

Key Points

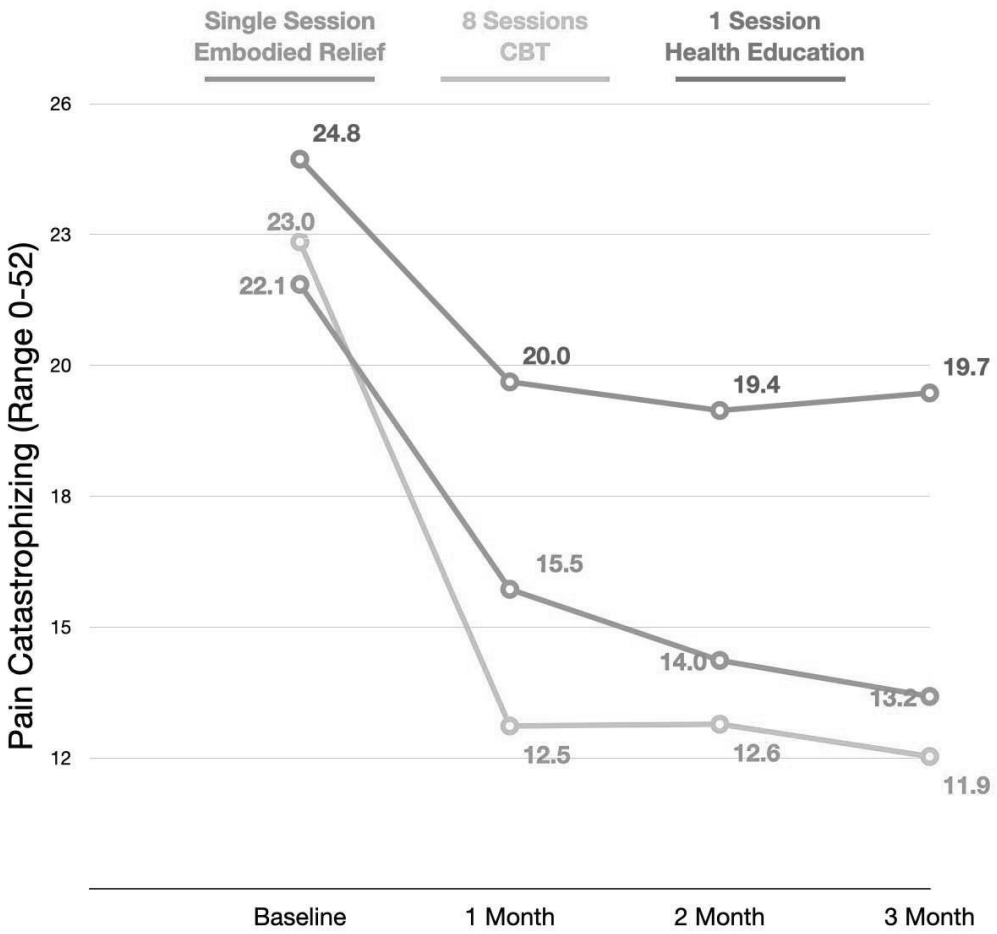
Question Is a single-session pain relief class noninferior to 8 sessions of cognitive behavioral therapy (CBT) at 3 months after treatment?

Yes!

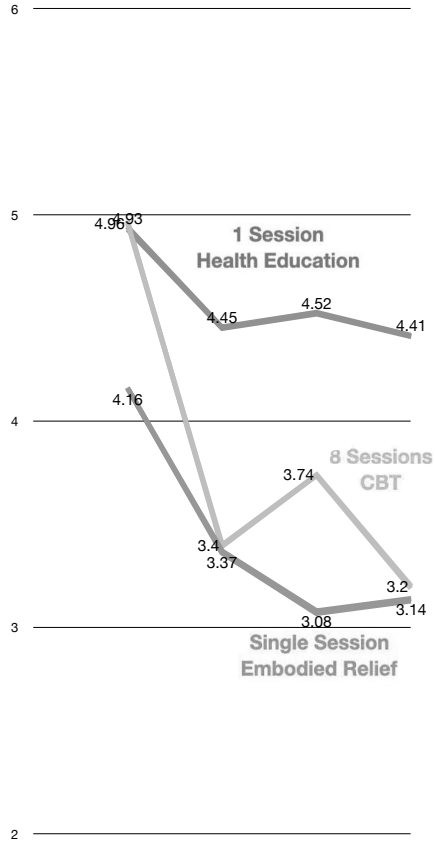
Findings

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 ow 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."



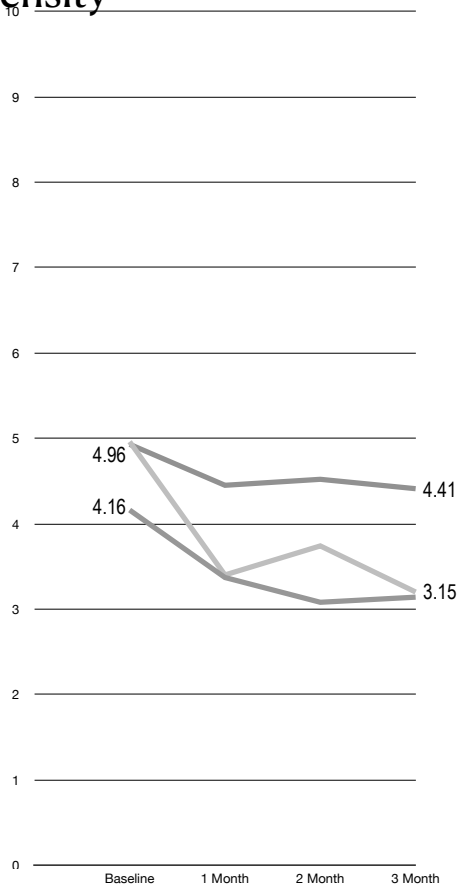
Reductions in Pain Intensity



Reductions in Pain Interference

(Scores range from 0 to 80)

	SST	CBT	HealthEd
Pre	58.33	61.61	60.83
Post	54.06	53.89	58.85



Psychological Intervention for Patients Presenting to ED with Panic Attacks

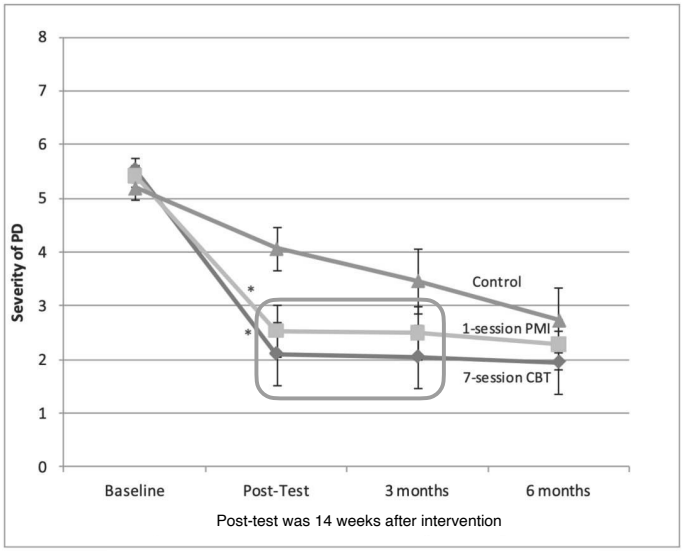
Dyckman & Rosenbaum (1999) found a single 20-30 minute intervention in the ER for patients presenting with non-cardiac chest pain diagnosed as panic attacks decreased subsequent ER us while increasing follow-up with psych services.

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

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.

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)

Conclusion
- *A single session of CBT is not useful in reducing GP visits or improving mental well-being of long-term frequent attenders.*

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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.*

No significant within-group or between-group results on SOC-13, SCL-SOM, WI

	Intervention Group. N=32				Control Group N=24				
Variable	Baseline	Followup	Change between baseline and follow-up	P within group	Baseline	Followup	Change between baseline and follow-up	P within group	P between groups (regarding change)
BDI Mean (SD)	12.4 (10.5)	10.8 (10.6)	**-2.3** (5.1)	< .05	13.7 (9.7)	12.6 (11.1)	**-1.0** (4.0)	ns	ns
GP visits Median	11.0	7.0	**-5.0**	<.001	11.0	7.5	**-4.0**	<.05	ns

Analysis *excluding* patients with psychiatric diagnosis

	Intervention Group. N=20			Control Group N=13			
Median GP visits	**-5.5**				**-3.0**		**p = .004**

Note: all study patients came in for a "baseline interview" and a 6 month follow-up interview, using the MINI and SCID

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"

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

These measures were statistically significant

Conclusion
- Both groups improved.
- Significantly stronger reduction in doctor visits and somatization severity in 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

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)

Results

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

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

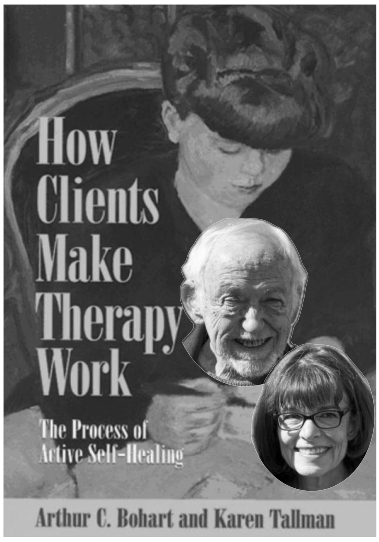
SST (and full-length therapy) showed significant beneficial effect in the small-to-medium range for treating anxiety, conduct problems but not depression

Efficacy of SST - Hard to Believe?

What's The Most important factor in therapy?

What's The Most important factor in therapy?

1. *client factors and events in the client's life* ("extratherapeutic factors")
   - These account for between **40% to 87%** of outcome.
2. the *relationship* between you and the client
   - contributes about a third (**33%** of the variance in outcome)
3. Techniques
   - Account for 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



"Remember
- therapy is not about *you*."
- Moshe Talmon

"Too often saying 'I'll try..' is something kids say to satisfy parents, but they don't really mean it.
When adults say "I'll try" it's like saying
'I'll go through the motions to get you off my back but my heart's not really in it and I don't expect anything to come of it.'"

- Michael Hoyt

I avoid *trying* to help clients

Instead, I want to join the client in an enjoyable process of discovery, and just see what emerges.

So before each session, I ask myself:

"How can I enjoy myself in this session?"

When I find a way to enjoy my client,
they seem to like it.

They collaborate more,
and we both enjoy ourselves in the process.

I remind myself of this Zen koan:

Health and sickness complete each other.

The whole world is medicine.

What is your true self?

- *Blue Cliff Record,* Case 87

What SST Is, and Is Not

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*

> 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

> 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

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

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 [making an appointment with herself, away from home]. 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.

When 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

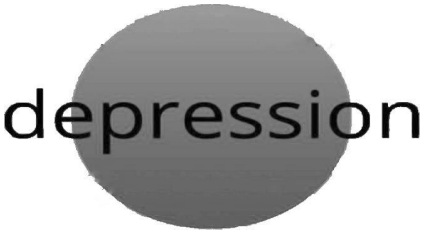
- **Enough really is enough** (more is not necessarily better)
- **No need to be brilliant -** Ordinary mind is the way
- **Expect change**
  - Change and stability are co-dependent and constant
    - All stability is maintained by change; all change relies on stability.
    - Even relatively constant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

- **Self is not a thing, but a process**
  - Constantly shifting
  - Recognizably stable
- **Self is not unitary, but the product of multiple drafts**
  - We are different at different times
  - We are different in different social situations
  - At each instant, all our selves are potentially available
- **Self resides in relationship**
  - Self is not "in" us nor "ouside" us
  - Self is a horizoning
  - All being is inter-being: We and the world arise together, linked in mutual need and love
- **Self-identity is recursive, undivided activity**
  - Embodied action
  - No separate doer and deed, rather "doing"
  - We arise touching ourselves touching and being touched
  - When I say "I'm not myself," who is speaking?
- **Self is not an accrual of experience but an ongoing, ever-changing manifestation**
  - We are not who we were, nor who we will become
  - Self is contextual - the intersection of history and immediacy presence
  - A prism, not a prison

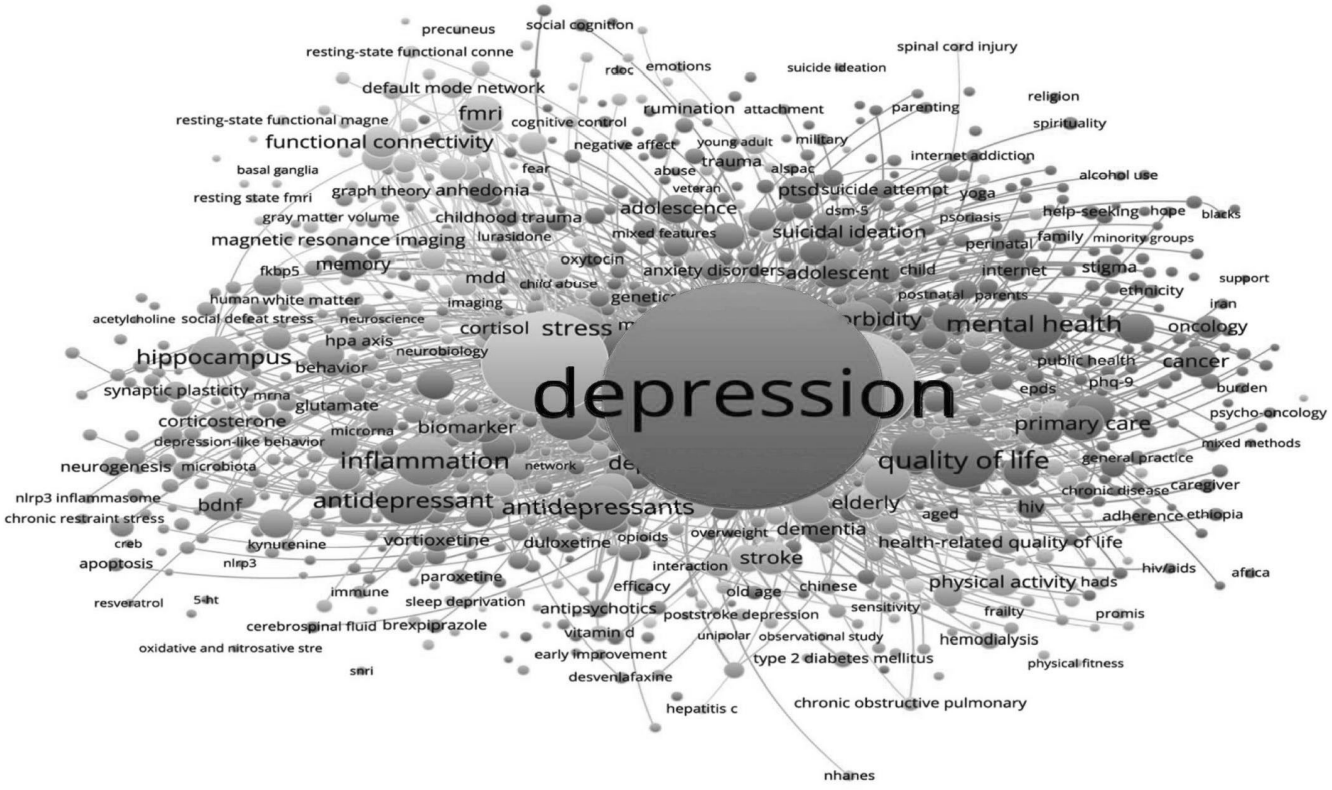
Helpful Attitudes for SST

- **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:



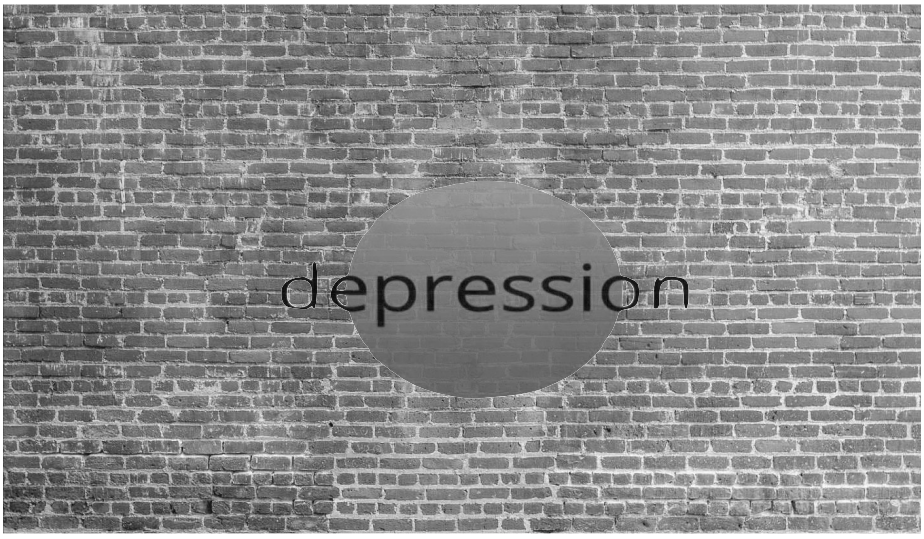
"DEPRESSION" IS COMPLEX AND MULTI-FACETED



BUT WHEN IT'S ISOLATED FROM ALL ITS COMPONENTS

"DEPRESSION" BECOMES A DORMITIVE PRINCIPLE

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 Pharmacological 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

Those who don't have any response early in treatment are less likely to have full improvement, even after several weeks.

Tundo A, de Filippis R, Proietti L. Pharmacologic approaches to treatment resistant depression: Evidences and personal experi- ence. 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

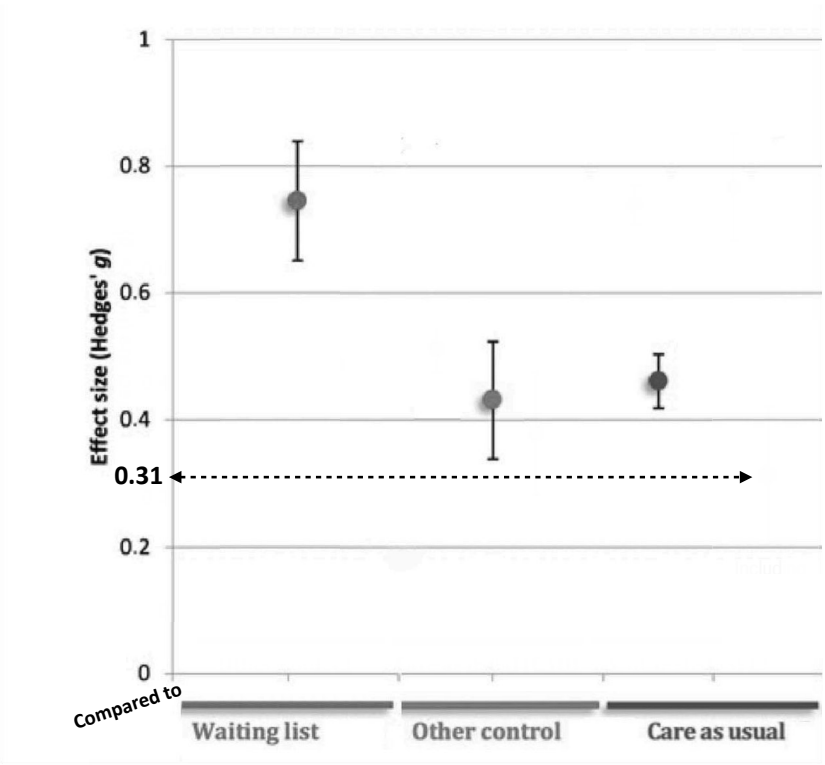
Efficacy of Psychotherapy for Depression

The overall pooled effect size for all psychotherapies was g= 0.72 (95% CI: 0.67 ~ 0.78), which corresponds with an NNT of 4.04.

But after correcting for publication bias and outliers, estimate sinks to around 0.31

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

Effect Sizes of Psychological Interventions for Depression



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

Another way of thinking about psychological treatments for depression:

Even if 75-80% of clients respond, another 20-25% don't

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

THE NEUROBIOLOGY OF "DEPRESSION" IS 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 Neurocircuity

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

Neurochemistry

- Problems with monoamine (5HT, NE, DA) hypothesis
  - Antidepressants rapidly raise monoamine levels, but symptoms don't respond for several weeks
  - Some patients with depression do not have depleted monoamine levels
  - Many patients with depression don't respond to medications which raise monoamine levels.
  - Some patients with depression respond to medications which don't target monoamines
- Accumulating evidence glutamate system is associated with depression.
  - Glutamate is main excitatory neurotransmitter in brain
    - increased levels of glutamate found in depressed patients' blood, CSF, brain
    - Stress can induce presynaptic glutamate secretion
  - Glutamate strongly binds to NMDAR and AMPAR
    - antidepressants reduce glutamate secretion and NMDARs
    - Ketamine blocks NMDAR, potentiates AMPAR - may account for ketamine's reported profound and rapid antidepressant effects
- Gabaminobutyric Acid (GABA)
  - GABA may induce antidepressant activity
  - Antidepressants targeting GABA recently approved (e.g. Zuranolone)

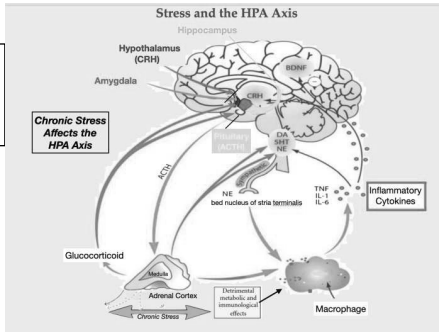
Stress-Response Syndrome
Neuroinflammation & Immune System
Decreased neurogenesis, neuroplasticity
Microbiome, Gut-Brain Axis
Glia, oxidative, mitochondria, circadian
Structural & Functional Neurocircuity

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

Stress-Response Syndrome

- Stress affects the Hypothalmus-Pituitary-Adrenal (HPA) Axis
  - Raises cortisol levels
    - Down-regulates glucocoritcoid receptors in hippocampus
    - Uncouples amygdala from hippocampus, increases connectivity with striatum (↓ adaptive learning ↑ reliance on habitual learning)
    - May impair neuroplasticity, decrease transcription of BDNF
  - Epigenetic changes in HPA axis affect gene transcription influenced by 5HT including MAO, DA
- Stress leads to overactivity of hypothalamus and amygdala
  - leads to increased sympathetic tone → release of pro-inflammatory cytokines → further metabolic and neuroendocrine disruption
  - may be experienced as fatigue, loss of appetite and libido as well as hypersensitivity to pain
  - may diminish neurotrophic support, monoamine transmission, glial damage
- Chronic Stress
  - Can reduce dendritic complexity in the medial prefrontal cortex (mPFC) - may be detrimental to the successful control of affect
  - Can cause pre-existing vulnerabilities to manifest

Note:
HPA axis dysfunction is found in *some*, not *all*, patients with depression



Neurochemistry
Decreased neurogenesis, neuroplasticity
Neuroinflammation & Immune System
Microbiome, Gut-Brain Axis
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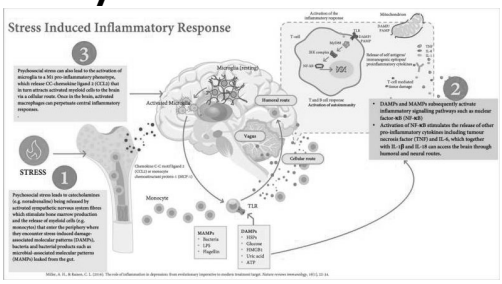
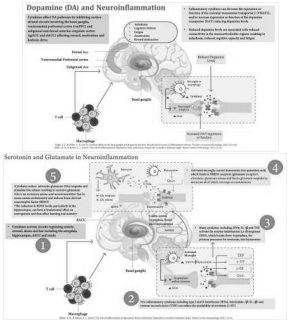
THE NEUROBIOLOGY OF "DEPRESSION" IS COMPLEX AND MULTI-FACETED

Neuroinflammation & Immune System



- Stress can stimulate inflammatory response
  - *Acute* inflammation causes adaptive 'sickness behaviors' (e.g. anhedonia, fatigue, and internal focus) in response to an infection.
  - *Chronic* inflammatory conditions can prolong 'sickness behaviors' – cardinal features of depressive symptomatology
- Some patients with depression show increased pro-inflammatory biomarkers (TNF-alpha, IL-1, IL-2, and IL-6)
  - antidepressants reduce markers of peripheral inflammatory factors
  - anti-inflammatory cytokines such as monoclonal antibodies may play an antidepressant role by blocking cytokines
  - anti-inflammatory treatments can reduce depressive symptoms in patients with MDD
    - infliximab (a monoclonal antibody directed against TNF) successfully treated patients with treatment-resistant depression that had a high baseline CRP level of >5 mg/L.
    - However, TNF-alpha antagonism does not work in patients with low levels of inflammation
- individuals without depression may display depressive symptoms after treatment with cytokines or cytokine inducers: antidepressants relieve these symptoms
- 5HT and DA are affected by neuroinflammation
- cytokines and chemokinds produced in the peripheral immune response can affect CNS
  - leak into brain through the blood brain barrier. spread through the CNS and cause a neuroimmune response
  - may act directly on neurons, change their plasticity and promote depression-like behavior



Note: Inflammation is found in *some*, not *all*, patients with depression

Neurochemistry
Stress-Response Syndrome
Decreased neurogenesis, neuroplasticity
Microbiome, Gut-Brain Axis
Glia, oxidative, mitochondria, circadian
Structural & Functional Neurocircuity

Decreased neurogenesis, neuroplasticity

- neuronal *atrophy* hypothesis
  - a deficit of neurotrophic support (e.g. glia)
  - reduction of neurogenesis, decreases in numbers of neurons, in complexity of dendrites
- *network plasticity* hypothesis
  - posits that circuits in the prefrontal cortex, amygdala and hippocampus cannot be appropriately activated and reorganized in response to the environment.
  - suggests that antidepressants' increase of monoamine levels enhances neuroplasticity in cortico-limbic brain regions.
- Suggestive findings:
  - stress reduces BDNF (brain- derived neurotrophic factor) levels in animal brain models of MDD
  - Some studies report
    - Low BDNF levels in the peripheral blood of patients with MDD
    - Low levels of BDNF in post-mortem assays
    - lower level of the pre-synaptic BDNF pro peptide - linked to long-term changes in the hippocampus
  - some indications interaction of BDNF and its receptor gene associated with treatment-resistant depression
  - Agents involved in BDNF system have been reported to have antidepressant effects
    - SSRIs may increase BDNF expression
    - rTMS and and ECT may function by increasing BDNF levels & neuroplasticity

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

Microbiome, Gut-Brain Axis

- Many studies have shown the microbiota-gut-brain axis plays an important role in regulating mood, behavior, and neuronal transmission in the brain
- Gut microbiota can interact with the brain through a variety of pathways or systems, including the HPA axis, and the neuroendocrine, autonomic, and neuroimmune systems
- Gut microbiota can affect the levels of neurotransmitters in the gut and brain, including serotonin, dopamine, noradrenalin, glutamate, and GABA
- Changes in gut microbiota can also impair the gut barrier and promote higher levels of peripheral inflammatory cytokines

Some Suggestive Findings

- comorbidity of depression and gastrointestinal diseases is common
- Some antidepressants can attenuate the symptoms of patients with irritable bowel syndrome and eating disorders
- animal studies have shown stress can lead to long-term changes in the diversity and composition of intestinal microflora, and is accompanied by depressive behavior
- some evidence that rodents exhibit depressive behavior after fecal transplants from patients with depression
- some probiotics attenuated depressive-like behavior in animal studies had antidepressant effects on patients with depression in several double-blind, placebo-controlled clinical trials

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

Glia, oxidative, mitochondria, circadian

- **Glial cells**
  - microglia contribute to neuronal plasticity and neuroimmune interactions that may be involved in the pathophysiology of depression
  - microglia can promote inflammatory factors and cytotoxins in the central nervous system, associated with development of pain and depression-like behaviors
  - microglia change polarization as two types under different inflammatory states, regulating the balance of pro- and anti-inflammatory factors. So an imbalance of M1/M2 polarization of microglia may contribute to the pathophysiology of depression
- **oxidant-antioxidant imbalance**
  - reciprocal interaction between oxidative stress and inflammation
- **mitochondrial dysfunction**
  - interaction between the HPA and mitochondrial metabolism
- **circadian rhythm-related genes**
  - Sleep & biorhythms are important!

Neurochemistry
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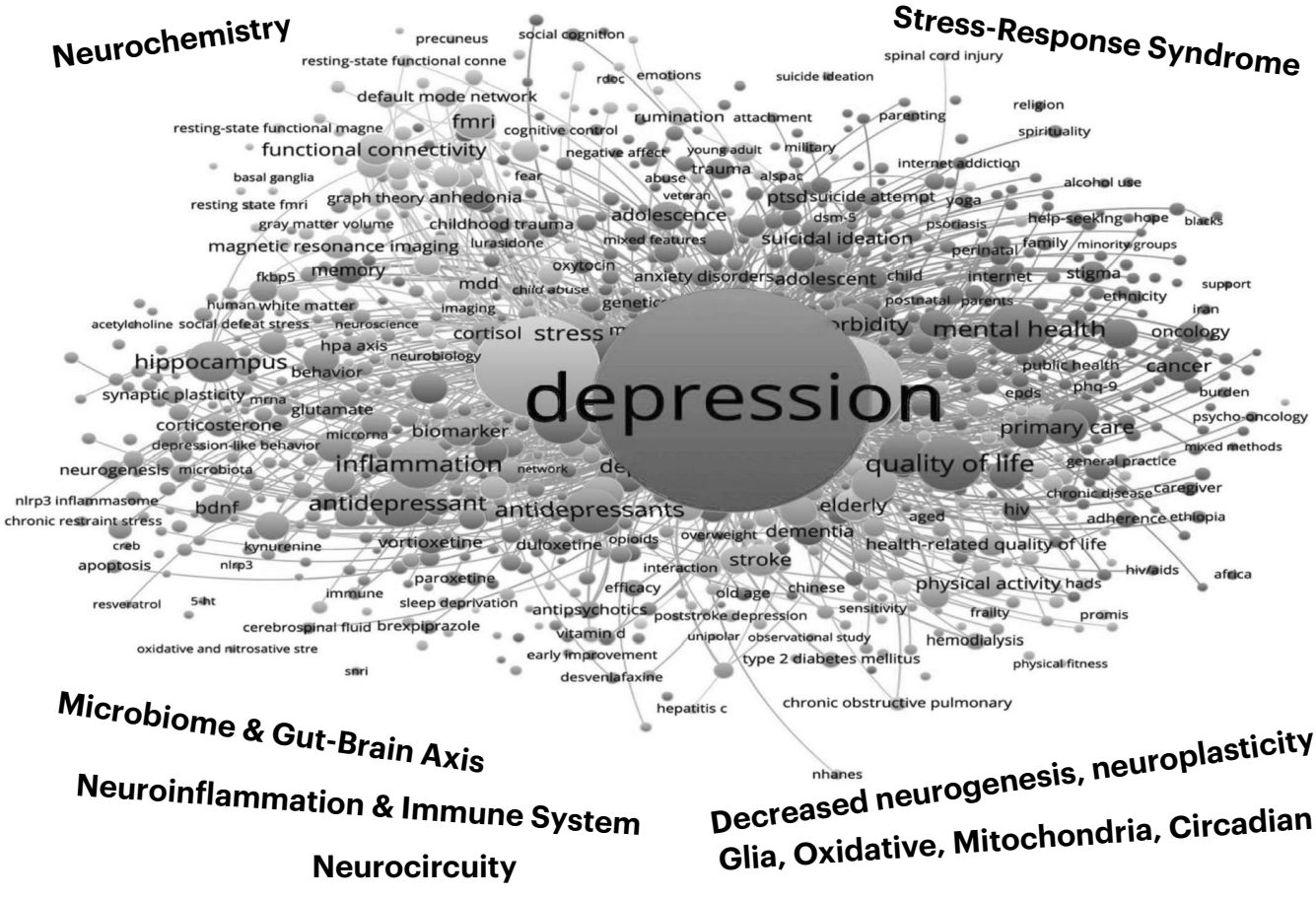

THE NEUROBIOLOGY OF "DEPRESSION" IS COMPLEX AND MULTI-FACETED

Neurocircuity

- **Structural** MRI - (sMRI) shows changes in the thickness of gray matter and brain morphology
  - damaged gray matter, decreased volume in depression-associated brain areas, including the frontal lobe, anterior cingulate gyrus, hippocampus, putamen, thalamus, and amygdala.
  - Hippocampal volumes of MDD patients lower than those of control Ss - improves with antidepressants, ECT
  - ECT increases volume of right hippocampus, amygdala, putamen in patients with treatment-resistant depression
- diffusion tensor imaging shows white matter microstructure changes in depression

- **Functional** 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*

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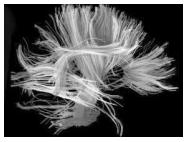
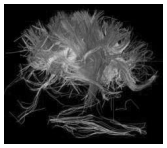
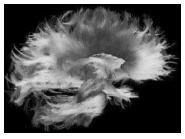
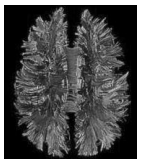
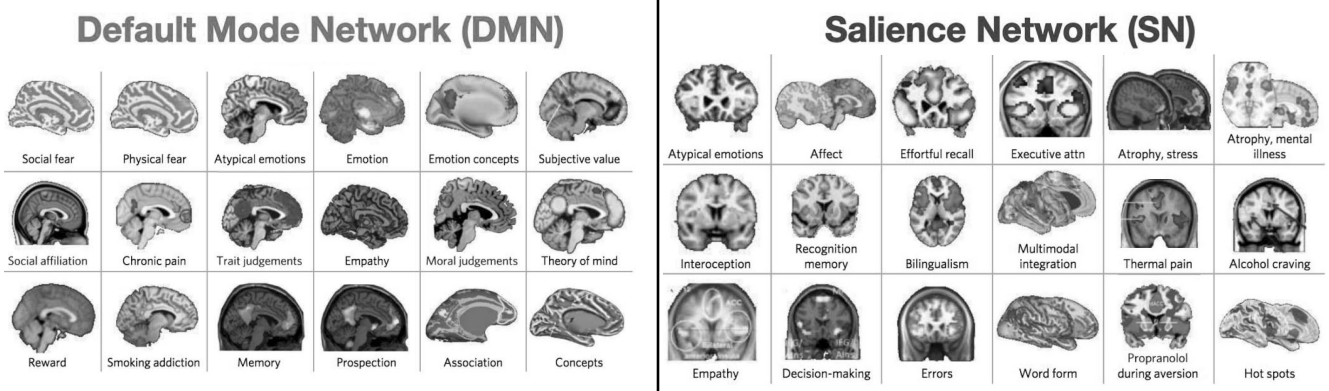


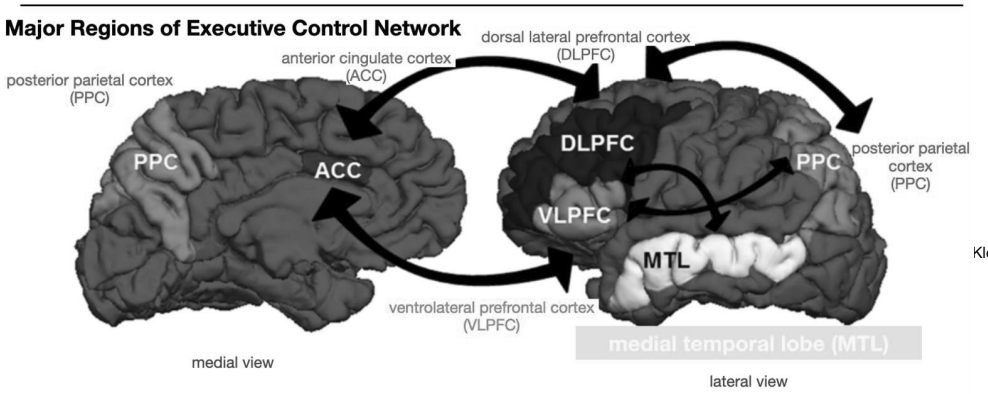




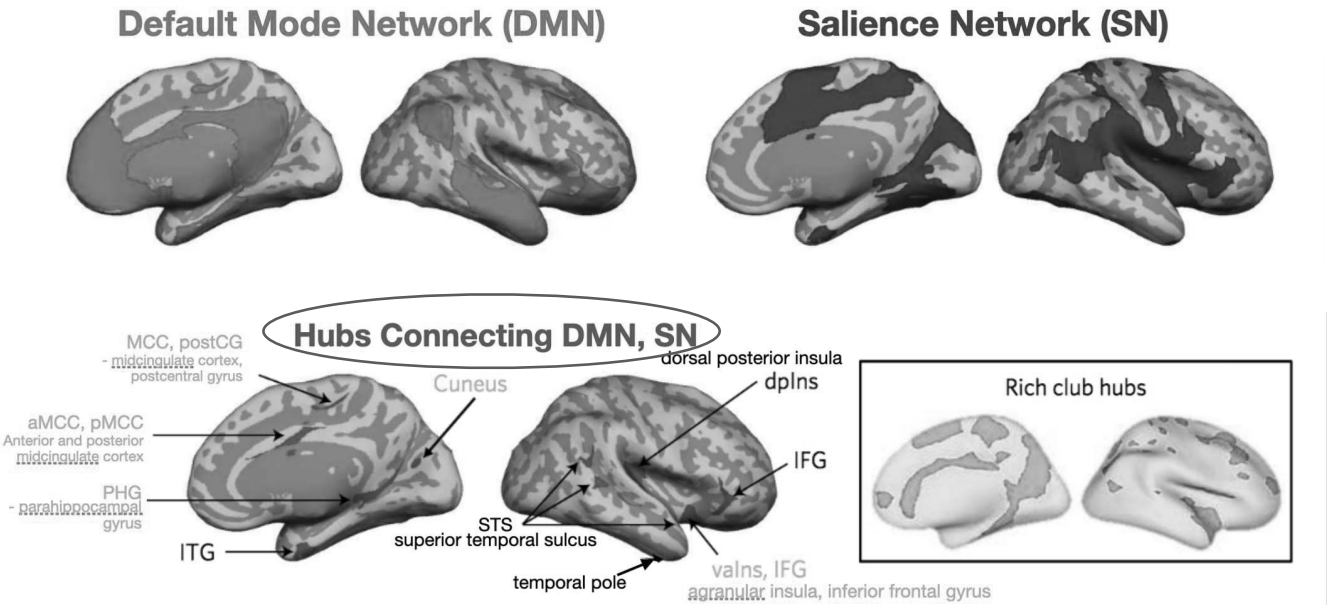


- **Dual Network: Ventral-Dorsal**
  - Ventral Network
    - Mediates vegetative and somatic symptoms and consists of hyperactive brain regions
    - Identification of the emotional significance of a stimulus
    - Production of affective states
    - Automatic regulation of emotional responses
  - Dorsal Network
    - Mediates cognitive aspects of depression and consists of hypoactive brain regions.
    - Mediates effortful regulation of affective states and behavior.
- **Triple Network Theory DMN-ECN-SN**
  - Default Mode Network (DMN)
    - Primarily active at rest
    - Involved in emotional regulation, social cognition, future-oriented thinking, autobiographical memory
    - Dysfunction in this network can give rise to alterations in cognitive processing of external information and relating it to self. (self-referential processing)
  - Salience Network (SN)
    - Mid cingulo-insular; nodes in the amygdala, hypothalamus, ventral striatum, thalamus, specific brainstem nuclei
    - Detection of salient internal and external stimuli to direct behavior
    - Response to homeostatic demands
    - Dysfunction can give rise to alterations in arousal, emotional hyper-reactivity, hypo-reactivities
    - "Fast" and "slow" aspects
    - Sometimes called the "Affective Network"
  - Executive Control Network (ECN)
    - Executive control: modulation, sustaining, shifting, coordinating
    - Impairment leads to cognitive dysfunction, emotional disinhibition

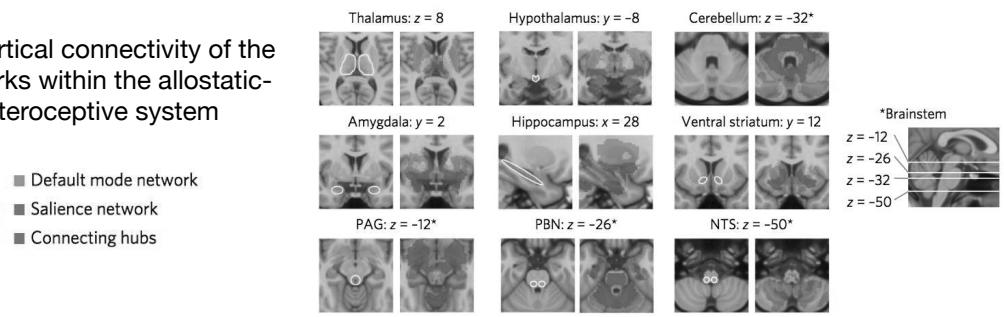




Kleckner, IR, et. al. (2017). Evidence for a large-scale brain system supporting allostasis and interoception in humans. *Nature Human Behavior, 1* article number 0069, 1-14.



Subcortical connectivity of the networks within the allostatic-interoceptive system



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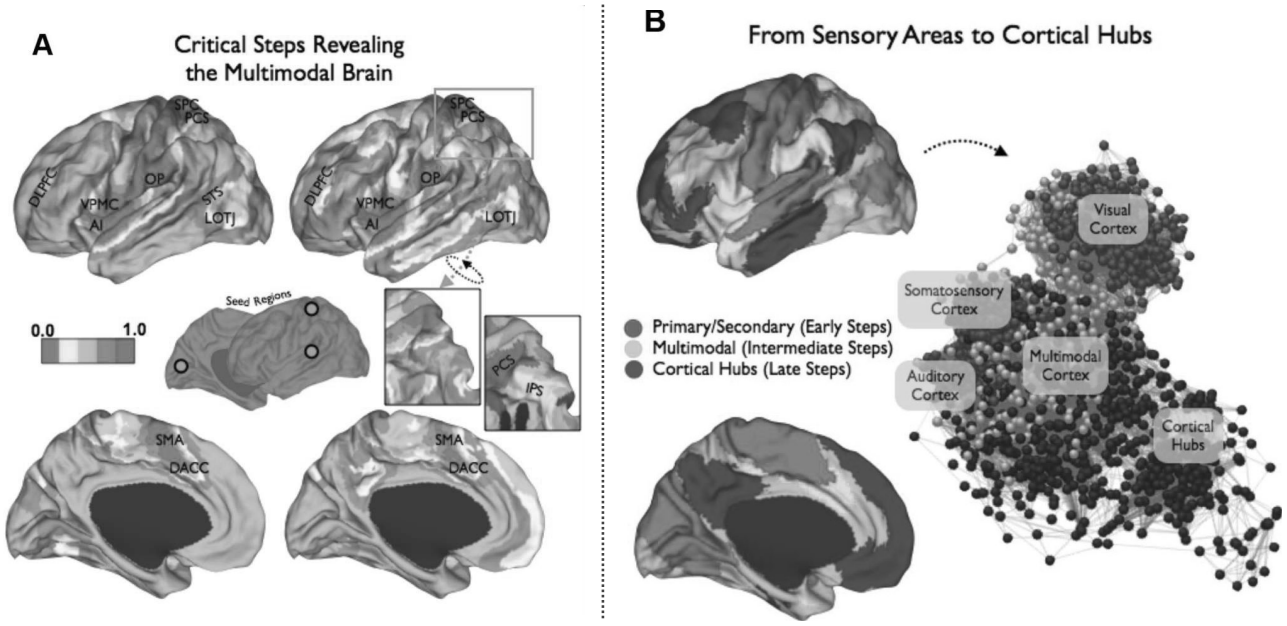
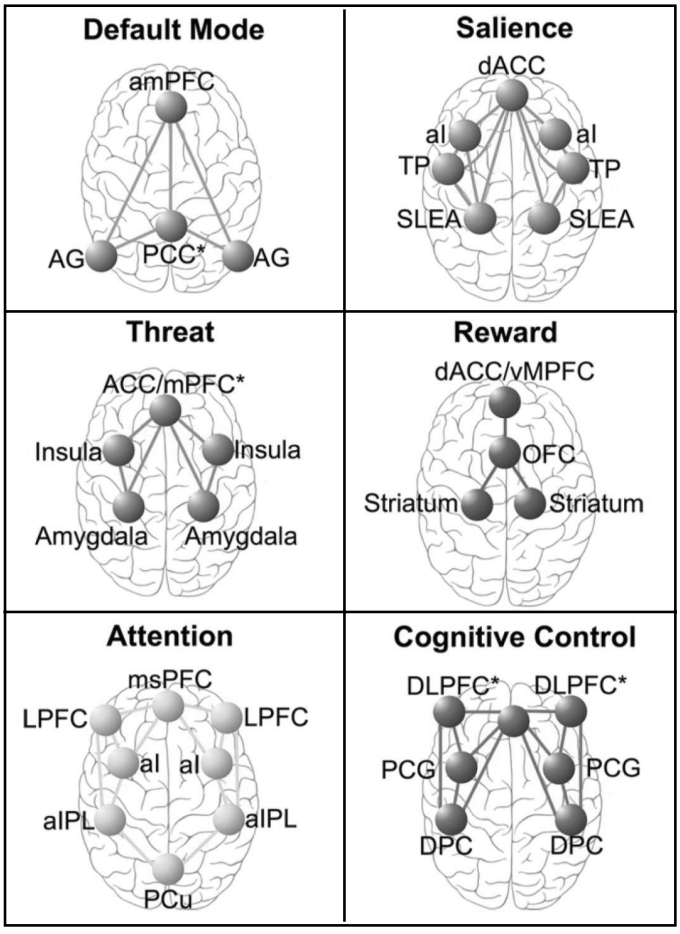
Multimodal Integration Network



Sepulcre, J; Sabuncu, MR: Yeo, TB; Liu, H; and Johnson, KA. (2012). Stepwise Connectivity of the Modal Cortex Reveals the Multimodal Organization of the Human Brain. *Journal of Neuroscience, 32*(31):10649–10661.

An Alternative Map of Brain Networks



"Intrinsic" and "Task-Evoked" Circuits

ACC, anterior cingulate cortex; AG, angular gyrus; aI, anterior insula, aIPL, anterior inferior parietal lobule; amPFC, anterior medial prefrontal cortex; dACC, dorsal anterior cingulate cortex; DLPFC*, dorsolateral prefrontal cortex + anterior prefrontal cortex + inferior frontal cortex; DPC, dorsal parietal cortex; Hipp, hippocampus; LPFC, lateral prefrontal cortex; mPFC, medial prefrontal cortex; msPFC, medial superior prefrontal cortex; OFC, orbitofrontal cortex; PCC, posterior cingulate cortex; PCG, precentral gyrus; PCu, precuneus; SLEA, sublenticular extended amygdala; vMPFC, ventromedial prefrontal cortex.

Brain Imaging - Structural & Functional Abnormalities

- structural MRI - (sMRI) shows changes in the thickness of gray matter and brain morphology
  - damaged gray matter, decreased volume in depression-associated brain areas, including the frontal lobe, anterior cingulate gyrus, hippocampus, putamen, thalamus, and amygdala.
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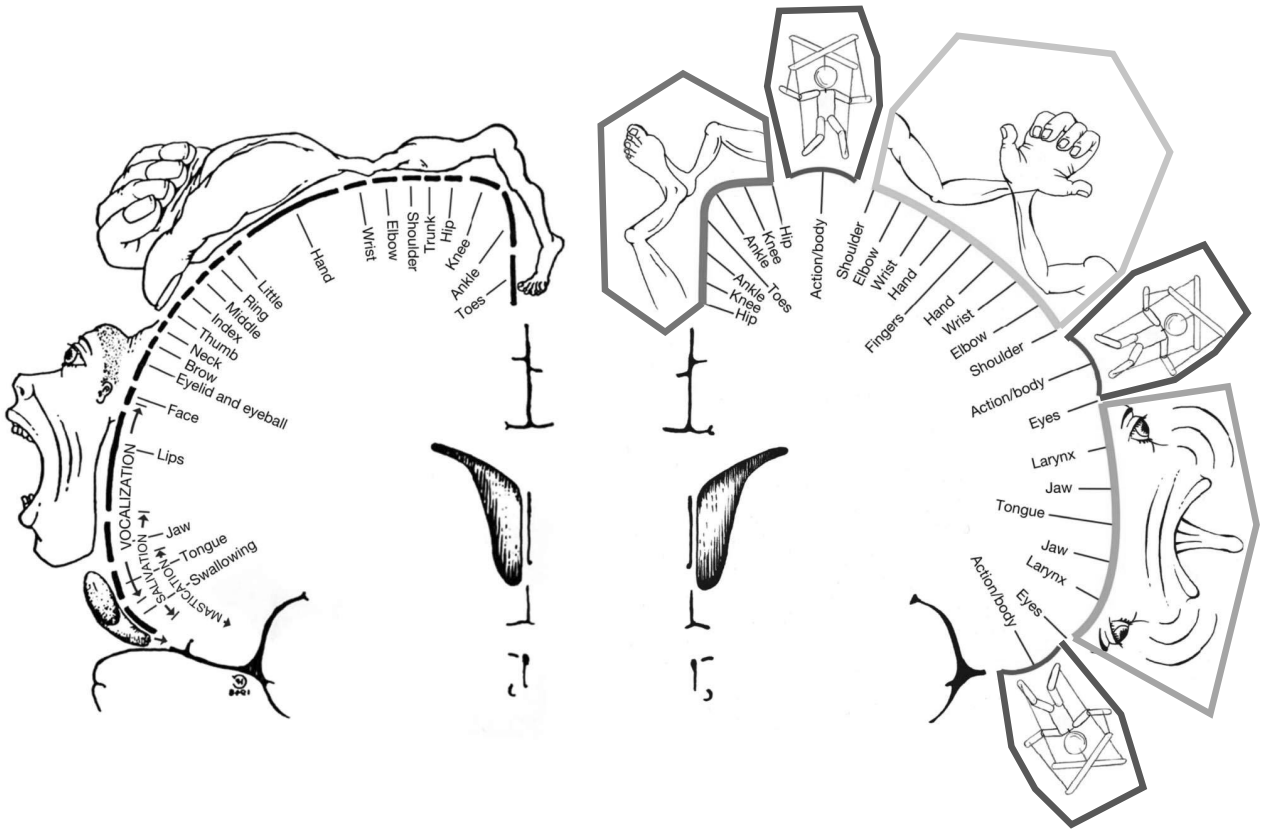
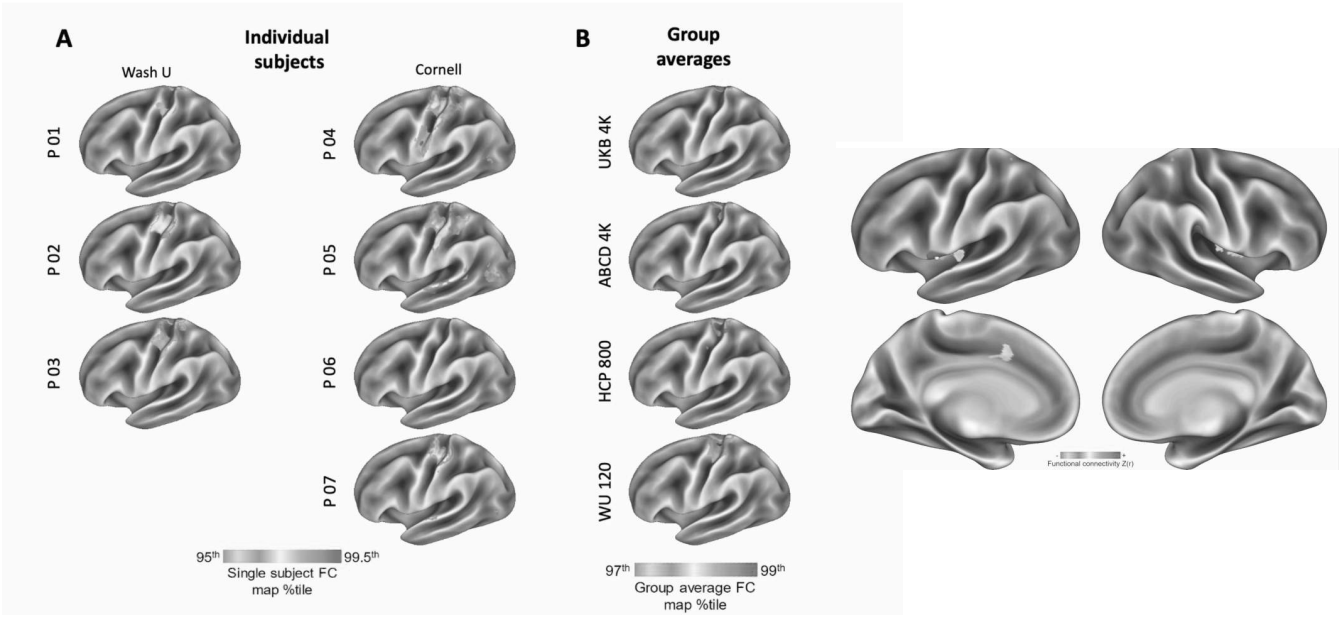
A Somato-Cognitive-Action network



Gordon, E.M., Chauvin, R.J., Van, A.N. *et al.* A somato-cognitive action network alternates with effector regions in motor cortex. *Nature* (2023). https://doi.org/10.1038/s41586-023-05964-2 DOI: https://doi.org/10.1038/s41586-023-05964-2

A Somato-Cognitive-Action network



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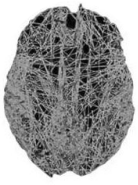
Given the multiplicity of biological pathways to depression,

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*

Somato-Cognitive-Action 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 <u>on a case by case basis</u> 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 (independent) expressions of some latent disease entities. Instead, clinicians would apply a functional analytic approach to understand the relationship between these problems that form a complex network.

The elements of this network would not be confined to any arbitrary DSM criteria, but can include any aspects that are relevant for the patient, including the patient's trauma history, cultural factors, and biological variables.

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
  - Not the "why" but the weather
    - "No bad weather, only inappropriate clothing" (HVAC)
    - Complex, chaotic, but (somewhat) predictable based on local conditions, seasonal climate, global ecology
  - 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

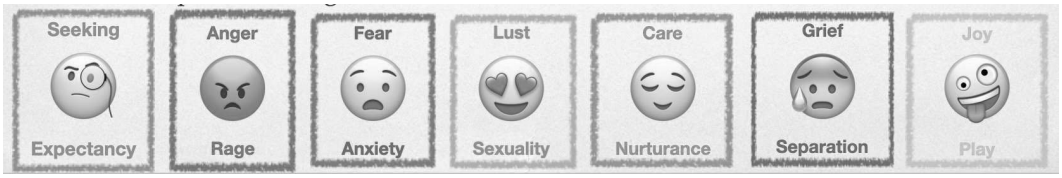
Classical Theory

- ✤ 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



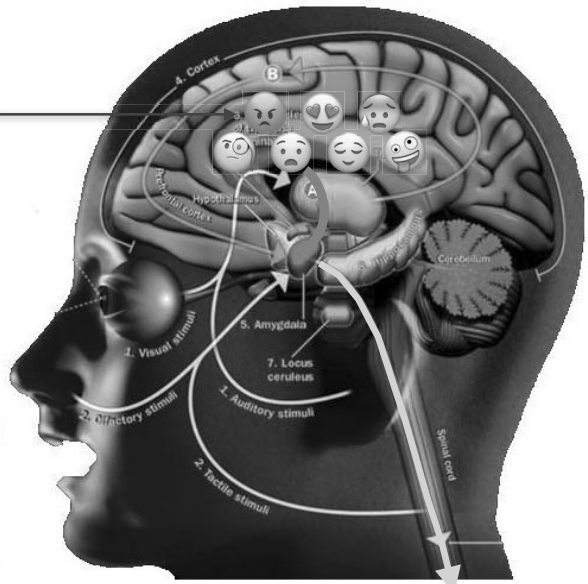
Most people use a categorical "one at a time," "either/or" model of emotion

Classical Theory

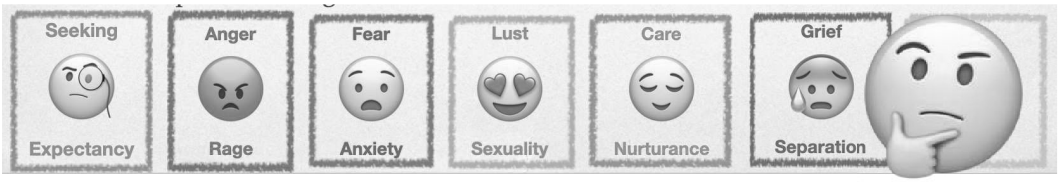
- Emotions as brute reflex, "lizard brain" vs rational, "cortical processing"
- A small number of hard-wired, pre-set feelings
- Categorical, each emotion distinct
- Built-in, instinctual
- Universal, hard-wired, built in
- Distinguishable emotional "fingerprints"
  - External expression identifies specific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

External Event → Triggers Internal Feeling

Physiological Cascade along specific, localizable channels

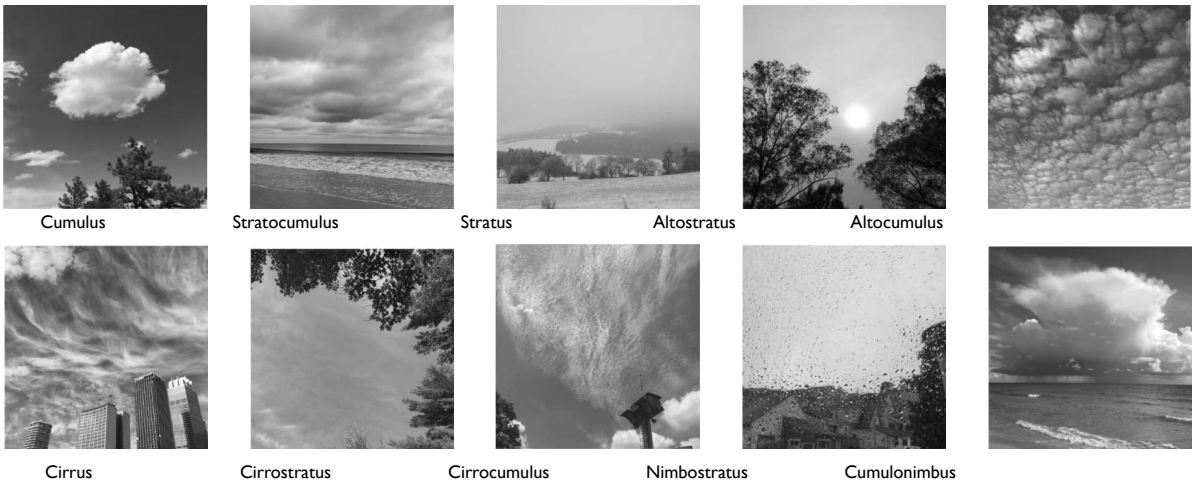


The reason we do things is because emotions "make us"



- Emotions are Not the "Why" but the Weather
  - Complex, chaotic, changeable atmospheric conditions
  - Somewhat predictable based on local topography, seasonal climate, global ecology

Emotions, like clouds - can be categorized, but each instance is unique



Often the day's weather contains a mixture of different cloud types at the same time

Have you ever known a person who reported intermittent clouds of anxiety *and* depression

and who also seemed basically emotionally open and psychologically clear?

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

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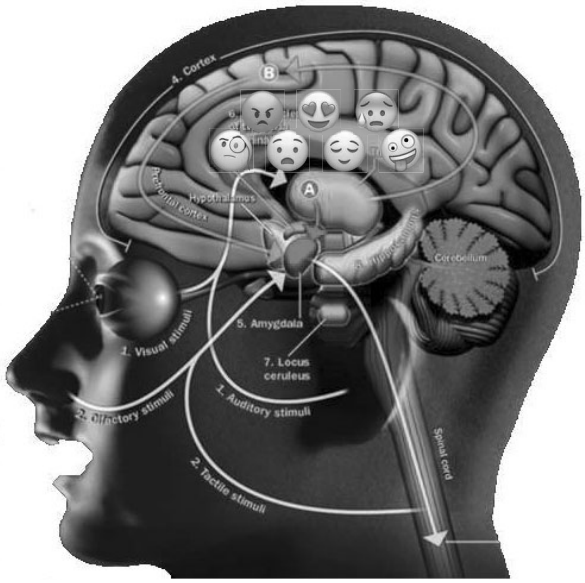

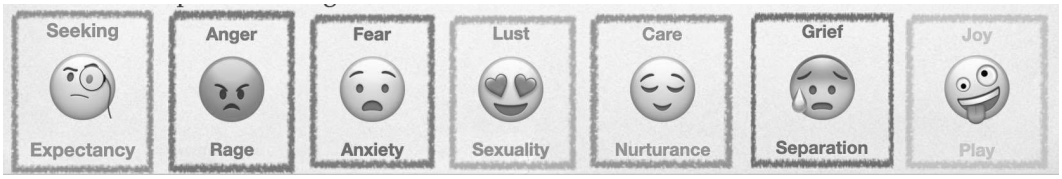

Categorical Emotions' *Overlapping* Neuroanatomy and Neurochemistry

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"
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- 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
  - Widely distributed cognitive appraisals, interception, somatic states
- Emotions often difficult to sort out, identify

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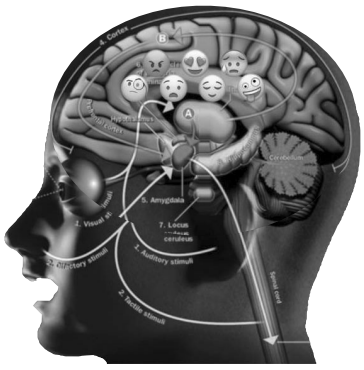
- ✤ Ecosystemic interaction of internal/external
  - ✤ Widely distributed cognitive appraisals, interception, somatic states
- ✤ Emotions often difficult to sort out, identify
  - ✤ External expression subject to different interpretations
  - ✤ Many-to-one and one-to-many relation of conditions & emotions
- ✤ Whole-brain shifting, distributed and overlapping **networks**

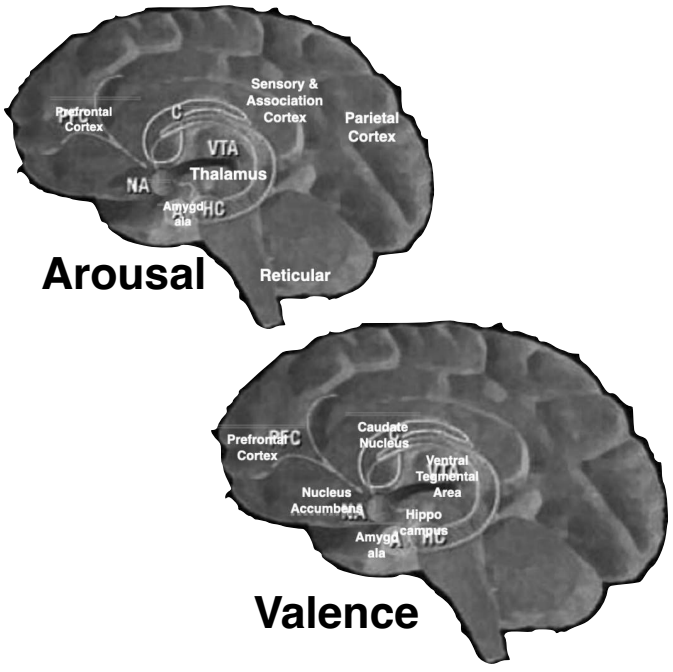
Classical Theory

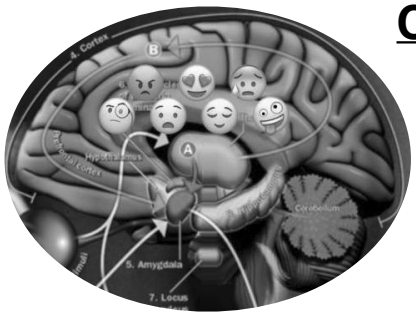
- ✤ Localized brain functions, subcortical modulated cortically
- ✤ *A small number of hard-wired, pre-set feelings*



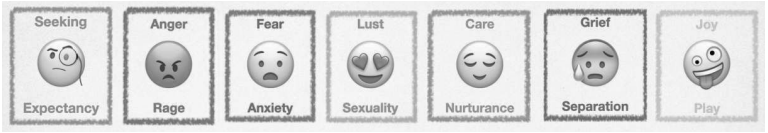
Constructivist Theory

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





Classical Theory: Categorical Emotion



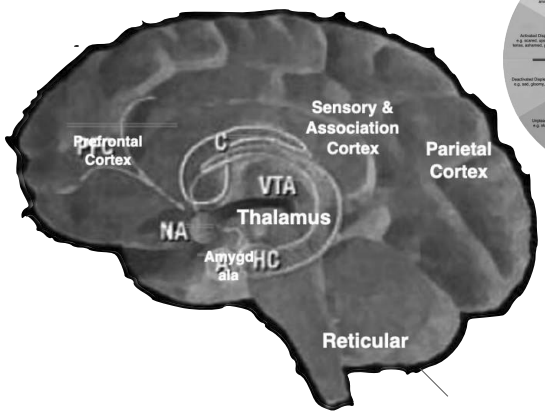
External trigger → hard-wired response
• Distinguishable consistent "fingerprints" • localized "lizard" brain functions. • universal, pre-set

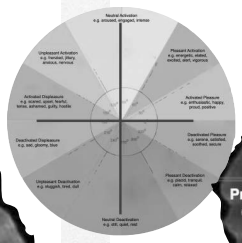
Dimensional Emotion

Constructed each time • Overlapping, variable; many-to-one, one-to-many
whole-brain energy budgeting, allostasis • cultural, idiosyncratic

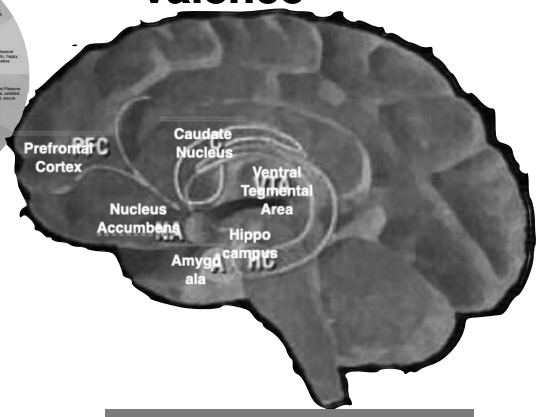
Activated - Deactivated

Arousal



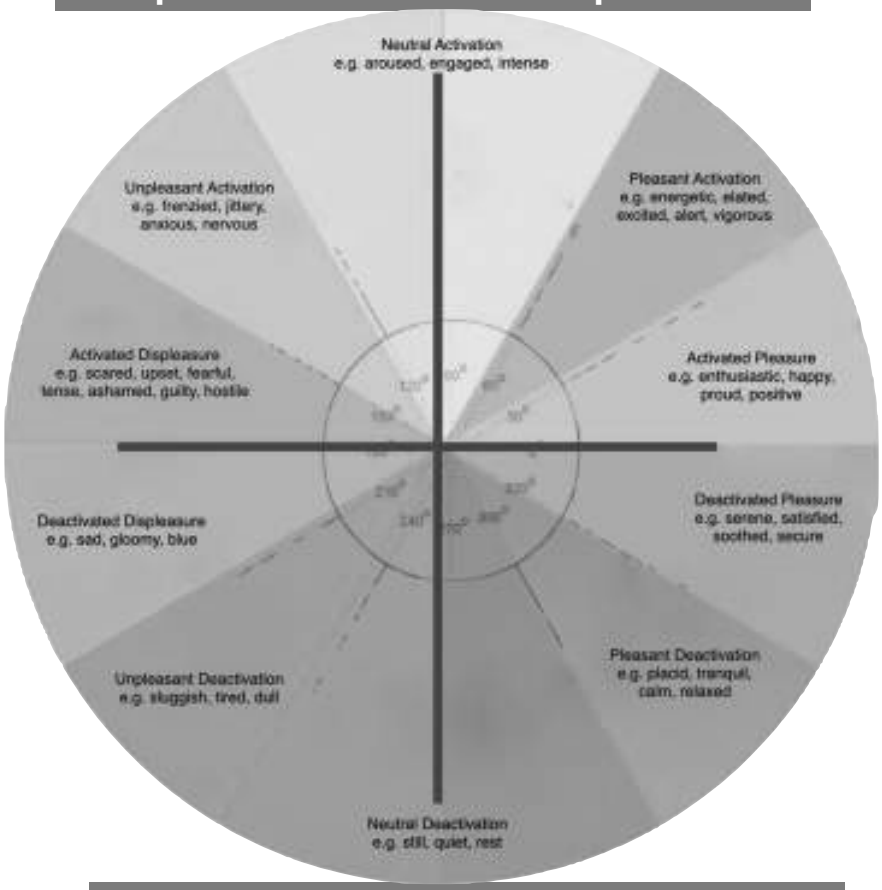


Valence



unpleasant - pleasant

unpleasant - pleasant



Activated - deactivated

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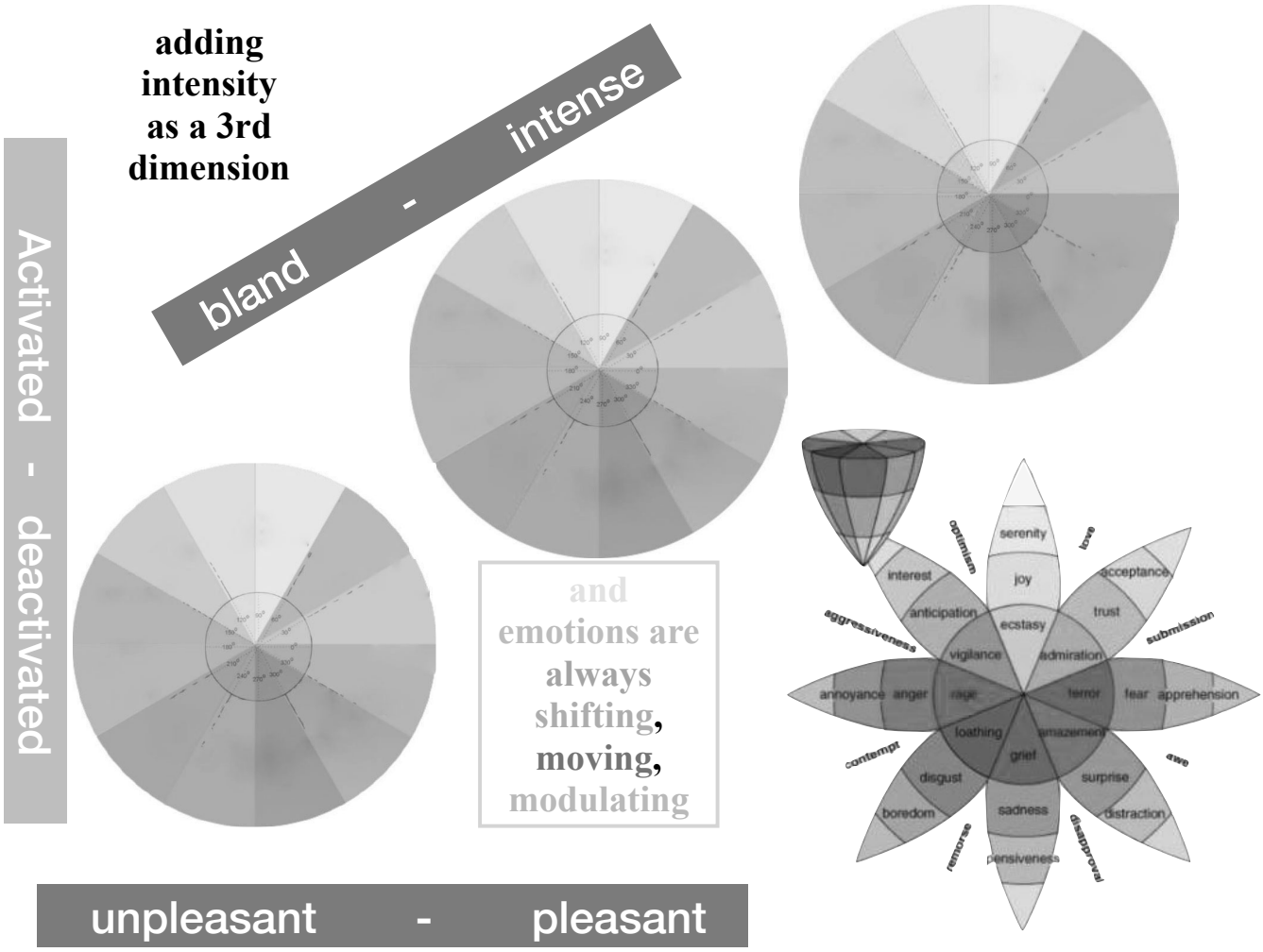
unpleasant - pleasant



Practical Implications:

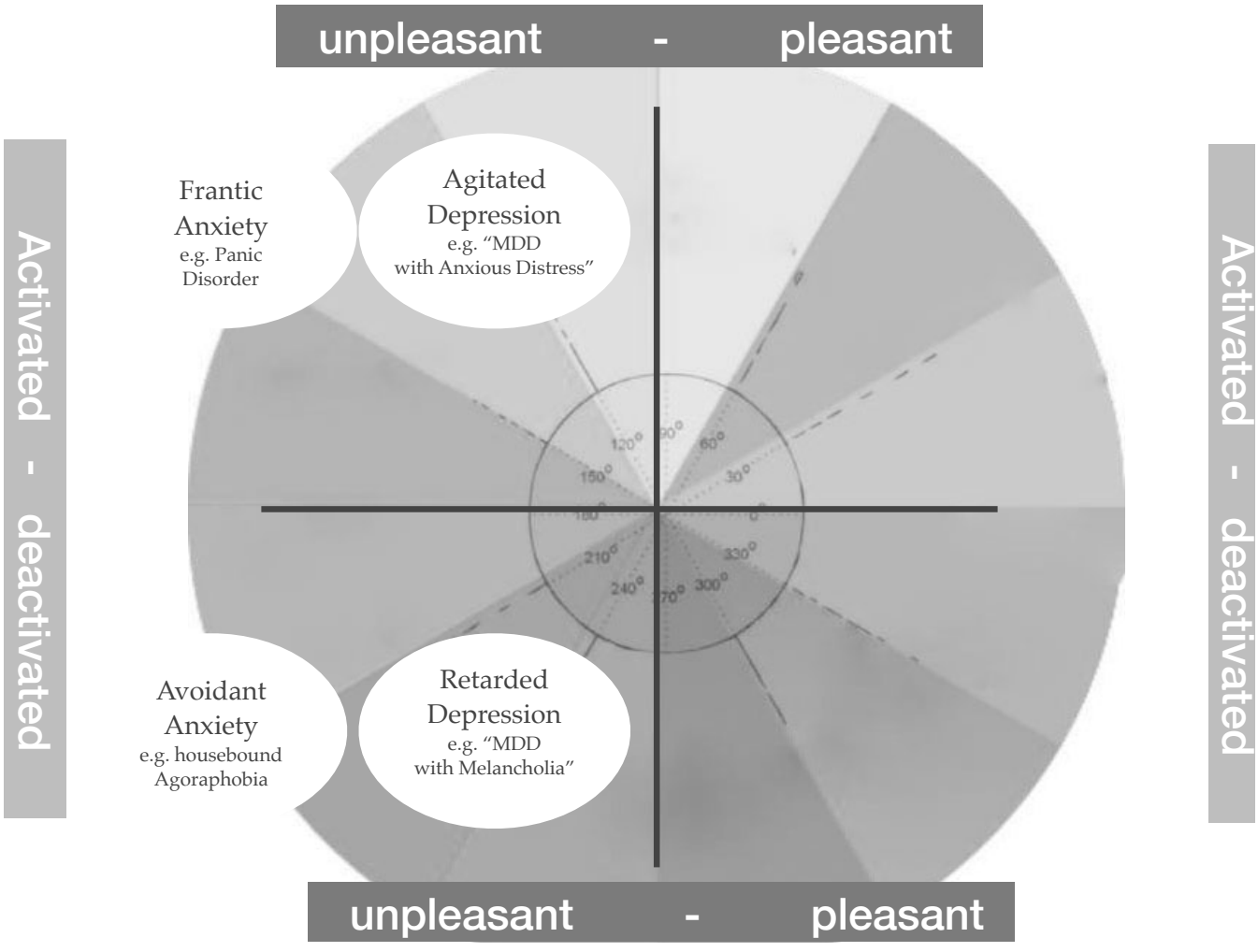
What's the best way of grouping these clinical situations?

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



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.

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

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because

Single Session Therapy is Moment by Moment Therapy

Eihei Dogen
Uji - The Time Being

The mind arises in a moment

A moment arises in the mind

This is the understanding that *the self is time*

You *are* the time of your life

Enjoy your lunch time

Zen teacher Dongshan was unwell.

A student said to him,

"You've been sick, teacher. Is there anyone who doesn't get ill?"

Dongshan replied:

"There is."

The student was surprised, and asked:

Does the one who doesn't get ill take care of you?

Dongshan replied:

"I have the opportunity to take care of him (her)."

The student was confused, He said,

"I don't understand! You're sick, and you're taking care of the one who doesn't get sick? What happens then?"

Dongshan replied:

"Then I don't see any illness."

Health and sickness complete each other.

The whole world is medicine.

What is your true self?

- *Blue Cliff Record*, Case 87

Single Session Psychotherapies

Afternoon: Time, Methods

NPTC renton
October 6, 2023

Robert Rosenbaum, Ph.D.
brosenbaum1@mac.com

> Buddhists with time on their hands
> divide each thought into ninety moments
> and each moment into nine hundred cycles
> - Red Pine

How to welcome, offer help, say farewell

A MAP FOR THE FIRST SESSION / MEETING
OPTIMIZING THE TIME YOU HAVE TOGETHER

CONNECT, SET CONTEXT, CONTRACT
- Engagement.
- What we already know.
- Orient to possibility of single session,
- Clarify what's to be achieved in THIS session.
- Making time your friend

AVOIDING THERAPEUTIC DRIFT
- Maintain alliance while staying on track
- Talk about what's most important
- Cut to the chase
- How is the problem a problem?
- Ensuring nothing important has been missed

FINDING A FOCUS
ESTABLISHING PRIORITIES
- Discover the client's priorities.
- Be clear about your priorities.
- Make space for both your & the clients' priorities.

INTERVENING
- Before offering your suggestions
- Punctuate (pause or break)
- Summarize
- Share your thoughts
- Ask for clients' response
- Fine-tune, adjust

GATHER INFORMATION, AVOID DEAD ENDS,
RAISE UNEXPLORED POSSIBILITIES
- Enter client's world
- Explore the problem(s) and possible approaches
- Ask about attempted solutions - what has/hasn't worked
- Listen for clients' resources, strengths

ENDING WELL
- Prepare - check in with client
- End while leaving the door open
- Clarify follow-up options
- Leave it to the client to determine follow-up
- Listen to client voices - solicit feedback for yourself & the clinic
- Clear a space before the next session

A MAP FOR THE FIRST SESSION / MEETING
OPTIMIZING THE TIME YOU HAVE TOGETHER

CONNECT, SET CONTEXT, CONTRACT

- Engagement.
- What we already know.
- Orient to possibility of single session,
- Clarify what's to be achieved in THIS session.
- Making time your friend

"If our meeting were as helpful as possible to you,
given the time that we have today,
what would you want to leave here with?"

• 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

Single Session Therapy
is
Moment by Moment Therapy

Moments are not short amounts of time
Time is Not a Tick

The mind arises in a moment

A moment arises in the mind

This is the understanding that *the self is time*

You *are* the time of your life

Eihei Dogen
Uji - The Time Being

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

the past is gone

the future is not here yet

the present cannot be grasped

What time do you practice in?

What time do you practice in?

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

When you are involved in an idea of time
-- today, tomorrow, or next year --
selfish practice begins.

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

- <u>The problem</u>
  - 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 <u>experienced</u> as <u>events</u>

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

The mind arises in a moment
A moment arises in the mind

The apparent flow of time is a product of our surreptitiously putting into the river a witness of its course; we then forget to put ourselves and our connections to the world into the picture.

In this picture, 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

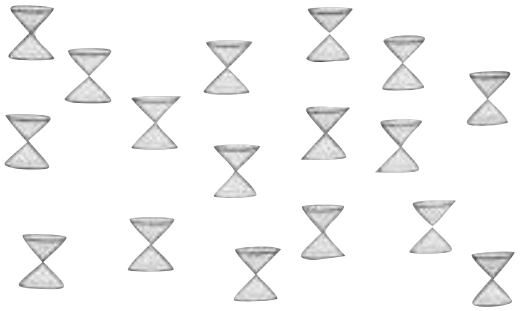
moments

are

meetings

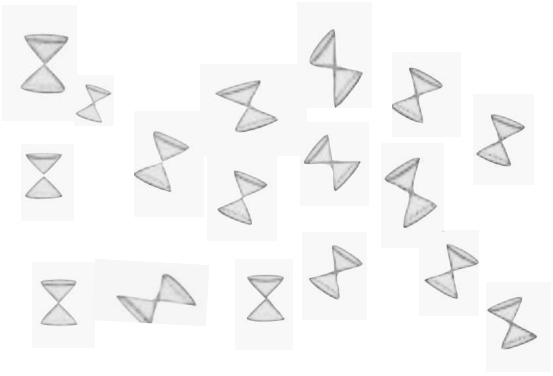
This is the structure of spacetime Einstein
understood via *special* relativity.
Time passes slower for moving objects, so every
observer experiences a differing time according
to their velocities relative to each other.

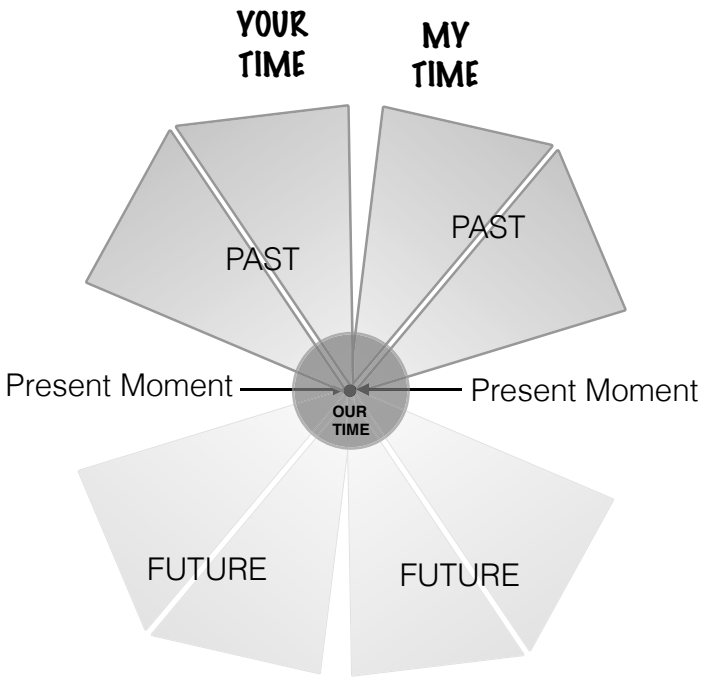
There is a unique "cone" of time according
to how light reaches each person
before and after each moment.

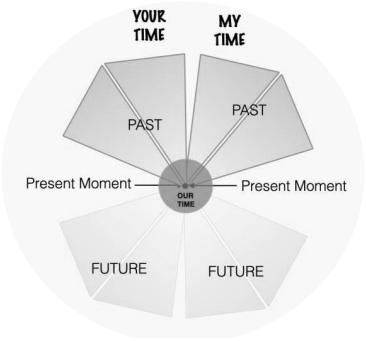


In *general* relativity, Einstein understood time
flows differently from place to place:
[i.e., gravity affects the speed at which time flows].

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







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.

Each moment is all being,
is the entire world.

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

Each moment is all being,
is the entire world.

It is like winter and spring.

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

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

Because each moment is complete in itself,
psychotherapy need not be a project of self-improvement

- it can be an enjoyable voyage of self-*exploration*

[Conventional] culture is based on ideas of self-improvement
[but] improvement is based on comparative value,
which is also the basis of our society and our economy

As long as you are trying to improve yourself,
you have a core idea of self,
which is wrong:

You are perfect as you are…
AND you could use a little improvement

- Shunryu Suzuki

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

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*.

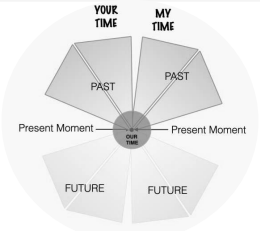
We don't know what will happen.

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

- "Whenever possible -
  - 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
- When time is at a premium:
  - Acknowledge the time situation
  - *Slow down!*
  - Adjust Expectations

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

- Punctuate a beginning
  - Pause before leaving office
  - Ask yourself the most important question

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

- Attend to rhythm, pace
  - 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

- Use repetition
  - "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

- When something good happens: *stop the session at that point*

Practical Tips for Making Time Your Friend
★ Most Importantly

Never rush, never wait:
go moment by moment

A MAP FOR THE FIRST SESSION / MEETING

OPTIMIZING THE TIME YOU HAVE TOGETHER

A MAP FOR THE FIRST SESSION / MEETING
OPTIMIZING THE TIME YOU HAVE TOGETHER

CONNECT, SET CONTEXT, CONTRACT

- Engagement.
- What we already know.
- Orient to possibility of single session,
- Clarify what's to be achieved in THIS session.
- Making time your friend

AVOIDING THERAPEUTIC DRIFT

- Maintain alliance while staying on track
- Talk about what's most important
- Cut to the chase
- How is the problem a problem?
- Ensuring nothing important has been missed

FINDING A FOCUS
ESTABLISHING PRIORITIES

- Discover the client's priorities.
- Be clear about your priorities.
- Make space for both your & the clients' priorities.

INTERVENING

- Before offering your suggestions
- Punctuate (pause or break)
- Summarize
- Share your thoughts
- Ask for clients' response
- Fine-tune, adjust

GATHER INFORMATION, AVOID DEAD ENDS,
RAISE UNEXPLORED POSSIBILITIES

- Enter client's world
- Explore the problem(s) and possible approaches
- Ask about attempted solutions - what has/hasn't worked
- Listen for clients' resources, strengths

ENDING WELL

- Prepare - check in with client
- End while leaving the door open
- Clarify follow-up options
- Leave it to the client to determine follow-up
- Listen to client voices - solicit feedback for yourself & the clinic
- Clear a space before the next session

Three Steps for a Good Party

Invite

Meet & Greet - *let's do this!*

Validate - *empathize by acknowledging and accepting the client's perceptions*

Collaborate - *hear the music, partner in the dance.*

Entertain (Mingle)

Explore - *prepare to be surprised*

Cut to the chase - *how is the problem a problem?*

Expand - *your life is bigger than your problem*

Pivot - *you are perfect the way you are…and you could use a little improvement*

Adieu

Integrate - *client meanings, values, identity*

Coda - *back to before*

Invite

The "start of the session" is not the start of the session

Before the Party

- Your preparations
  - Clean
  - Cook
  - Set everything out
  - Relax
- Client preparations
  - Making arrangements (getting off work, arranging childcare, etc.)
  - Who did you talk to about coming here? What did they say? What did you think of that?
  - What changes have you noticed since making the appointment?
  - What were your thoughts as you were waiting just now?

Invite

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- **Be aware of common client fears**
  - You'll think they're crazy
  - You'll judge them (or their parents & families)
  - You'll be either too "touchy-feely" (psychobabble) or too "medical" (prescriptive)
  - You "won't understand" how *serious* it is - or treat it as *too* serious

- ***Enact* your interest in hearing patient's experience**
  - "I want to hear your perspective" is NOT sufficient
  - If patient feels like a "case," little new will emerge
  - Treat client as a collaborator, your consultant and your guest - you'll be able to work less!
    - Client is the expert on their experience
    - Client is a resource for improving your services

Invite

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- ***Let client know where you're coming from***
  - The context of your situation
    - I work on team X, doing Y
    - Any mandated priorities
      - I have ## minutes to be with you
      - I will/won't be able to follow up with you / refer you
      - I need to ask you about abc, which will take maybe X minutes, but that leaves Y minutes for us to focus on what you'd like to walk away with from today's meeting
  - The information you have
    - "The doctor told me….."
    - I read your file / questionnaire
    - I didn't have a chance to read your file questionnaire but I can/will…..

- ***I know the information I have is not the whole story***
  - You are more than what's in your chart / what others say about you
  - You are bigger than your presenting problem

Invite

Meet & Greet - let's do this!

CONNECT, SET CONTEXT, CONTRACT

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Special Cases

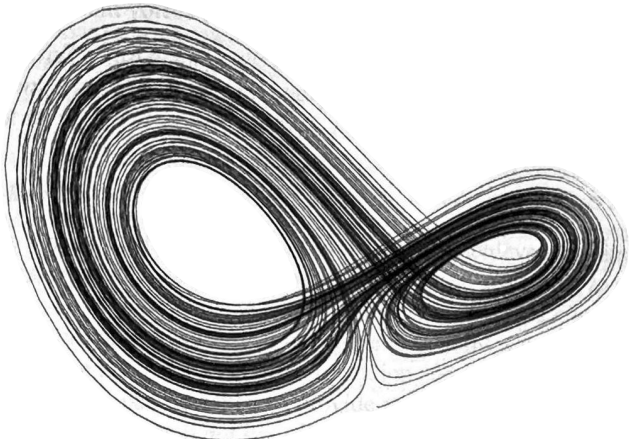
- **For those who may be very skeptical about psychological & behavioral interventions**
  - Lots of people are skeptical about psychotherapy - what are your concerns?
  - What would I have to do to really mess this up with you - to put you off counseling completely?

- **For those who are overly keen on having many therapy sessions**
  - If you start to feel better sooner than you expected, would that feel OK or would you worry we're missing something?
  - I appreciate your desire to get all you can out of therapy - how will we know when it's enough?

Balance Warmth & Care with Honesty & Directness

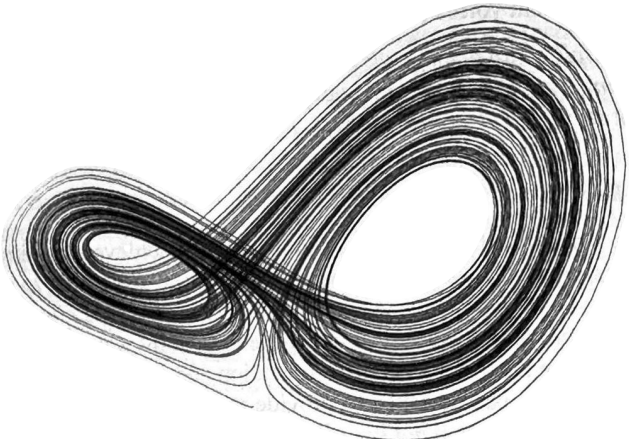
Balance Warmth & Care with Honesty & Directness

Therapy-Averse Clients



Honesty Directness **Warmth Care**

Therapy-Keen Clients



Warmth Care **Honesty Directness**

Invite

Meet & Greet - let's do this!

Given we might have only have one session,
what would you like to walk away with today?

CONNECT, SET CONTEXT, CONTRACT

- Engagement.
- What we already know.
- Orient to possibility of single session,
- Clarify what's to be achieved in THIS session.
- Making time your friend

We've found a lot of people - not everyone, but around a third of the people we see - tell us that a single visit, like we're having now, was enough for them to get a handle on their problem.

Of course, if you need more therapy, we will provide it. And part of what I want to do today is figure out whether there are any additional resources you might find helpful.

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?

Invite

Meet & Greet - let's do this!

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- Orient to possibility of single session,
- Clarify what's to be achieved in THIS session.
- Making time your friend

Referral

- What's your understanding of why your doctor referred you?
- How do you feel about your doctor referring you to me?
- Do you believe what people think and feel affects their body?
- Do you feel a person's physical problems can influence their emotions and thinking?

Seeding positive expectations

- What might come out of a good conversation today?
- What will be helpful today, to achieve in this meeting?
- At the end of the session today, how will we know that our talking together has been useful?

Invite

Meet & Greet - let's do this!

"If our meeting were as helpful as possible to you, given the time that we have today, what would you want to leave here with?"

CONNECT, SET CONTEXT, CONTRACT

- Engagement.
- What we already know.
- Orient to possibility of single session,
- Clarify what's to be achieved in THIS session.
- Making time your friend

Additional Questions to Help Establish an Agenda:

- What is the issue you are struggling with most at the moment?
- If there was one thing that, more than anything else, you wanted to change, what would that be?
- What is most urgent/important/likely to work for you right now?

  What will be *easiest* part to change? What will be the *most important* part to change?
- Do you prefer to make changes little by little, or all at once?
- Do you prefer to work on the hardest problem first, or choose an easier one where you're more likely to make some progress sooner?
- What will be the first sign of change?
- How soon do you expect the change to take place?
- If you couldn't change it immediately, but you could take a step in the direction that's right for you, what might that step look like?

Invite

Meet & Greet - let's do this!

Validate - *empathize by acknowledging and accepting the client's perceptions*

Collaborate - *hear the music, partner in the dance.*

- **Meet client at his/her view of the world - ask about "uncovered" territories**
  - What do you think the doctors (friends, family members) are missing?
  - When wakeful in the middle of the night with the problem, what are you most worried about?
  - How do you bear it?
  - Coping style, Learning Style
    - Do you prefer to make changes little by little, or all at once? (The beach question)
    - Do you find it easier to learn new things by listening, seeing, or doing?
    - Do you solve problems by thinking through them, or feeling your way into them?
  - Hobbies, interests
  - Faith, spirituality (or lack of it), values

- **Look for pivot chords**
  - Where experience can be in "two keys at once"
  - Problems can serve as vehicles for healing
  - Examples: pain, anxiety, insomnia, obesity

Invite

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Validate - empathize by acknowledging and accepting the client's perceptions
Collaborate - hear the music, partner in the dance.

Entertain (Mingle)

Explore - prepare to be surprised

Cut to the chase - how is the problem a problem?

Expand - your life is bigger than your problem

Pivot - you are perfect the way you are…and you could use a little improvement

EXPLORE
- Gather information
- Avoid dead ends
- Raise possibilities
- Avoid therapeutic drift
- Intervening

Invite

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Elicit a fresh *perspective*

- Inquire about and acknowledge prior efforts but avoid a hopeless rehash
  - If the client feels the session is a "re-hash" it can reinforce a sense of hopelessness
  - Don't repeat what hasn't worked
- What do you think your doctors / other people / you. are missing?

Elicit a new *experience*

- *Any* new experience seeds change
- Mind and/or body, thought and/or sensation, insight and/or behavior
- *during the session*

Invite

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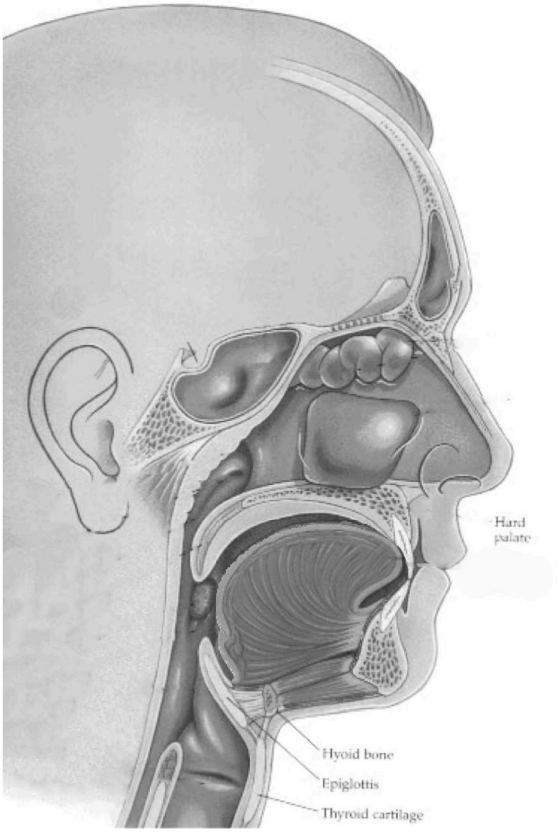
Enter client's world
- Hobbies, interests
- Learning styles
- Beliefs, values
- Daydreams
- When wakeful in the middle of the night…..
- How do you bear it?
- **How is the problem a problem?**

Look for pivot chords
- Where experience can be in "two keys at once"
- Problems as vehicles for healing/learning,
- "Paradoxical" interventions
- Working with worst case scenarios ("vertical arrow")



Small Changes Can Make a Big Difference

Invite

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Entertain

Explore - prepare to be surprised
Cut to the chase- how is the problem a problem?
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EXPLORE
- Gather information
- Avoid dead ends
- Raise possibilities
- Avoid therapeutic drift
- Intervening

Before Intervening
- Interventions and suggestions won't work if client is still concerned about uncovered issues
- Ensure nothing essential has been missed
- Avoid last-minute bombshells

Questions to ensure the bases have been covered

- Given that we are about halfway through our time, is there anything you think we haven't touched on that shouldn't be left out of the conversation?
- What haven't we touched on that's important to you?
- Is there anything that you haven't told me that I should know, to be helpful right now?
- Is there anything that you would regret not saying, if it were left unsaid?
- Do you believe I have the picture - at least enough of the picture to be helpful?
- If there was one thing that was the most important for me (or others) to understand in all this, what would that be?
- Do you think we have covered what we have needed to, or have we left something out?

Invite

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- Intervening

Optionally, Before Intervening: Consider Taking a Pause or a Break
- Opportunity for you to collect your thoughts, consult with a colleague
- Helps client take stock, process, relax
- Punctuates the intervention, makes it easier for client to remember

Questions for Taking a Pause or a Break before sharing your thoughts

- "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 take a break for a few minutes and consult with a colleague who has special expertise on these matters. Is that OK with you?
- You've told me a lot, and done some important thinking. Would you like to take a little break before we go on?

Invite

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Collaborate - hear the music, partner in the dance.

Entertain

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EXPLORE

- Gather information
- Avoid dead ends
- Raise possibilities
- Avoid therapeutic drift
- Intervening

Intervening

- **Consider what would you'd want to say to your client if you were never to see them again**
- Share thoughts honestly and respectfully
- Take the relationship into account
  - Some clients want a confident authority
  - Some clients benefit from therapist taking a tentative, one-down position

Some phrasings:

- Before I share what I'm thinking about your situation, is there anything else I should know?
- 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've got it totally wrong, but I wonder if.
- You said you wanted some advice about xyz, so let me share my thoughts with you.
- I've found that…
- Research tells us that the best course is….

Invite

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Entertain

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ENDING WELL

Elicit unasked questions, hidden agendas
Summarize, underline
End while leaving the door open
Listen to client feedback

Adieu

Integrate - client meanings, values, identity
Coda - back to before

General Guidelines

- Reach closure by the end of each contact
  - Even if the session is one of many
- Help client regroup
  - Lot of therapists know how to help a client open up. It's just as important to be able to help client close down and return to daily activities
- End spaciously
  - "In my end is my beginning"
  - Leave it to the client to determine follow-up
  - Leave an open door
- End flexibly
  - stop the session at a "learning point" for the client, *whenever it may be*
  - end "early" to allow space for last-minute issues
  - there's not one "right" way to end
- Check in with the client
  - ask client if session was helpful.
    - if so, how/what?
    - if not, what next?
  - Client is a resource for improving clinic services
  - Client is a resource for improving your own skills
- Clear a space before going on to next client
  - wash hands…and mind

Invite

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ENDING WELL

- **Elicit unasked questions, hidden agendas**
- Summarize, underline
- End while leaving the door open
- Listen to client feedback

Double-check

"Last chance…" signals- the beginning of the ending

Another signal you care about the client

Prevents regrets (yours or the client's!)

Questions to ensure nothing important has been left out

- Is there anything else you'd like to bring up or ask, before we end?
- Are there any questions you had that haven't been answered yet?
- If there were something you might regret not having said (or asked) once you leave, any thoughts about what that might be?

Invite

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ENDING WELL

- Elicit unasked questions, hidden agendas
- **Summarize, underline**
- End while leaving the door open
- Listen to client feedback

Summarize and Structure

People remember beginnings and endings

Another signal you care about the client

Prevents regrets (yours or the client's!)

Some phrasings

- So, what we did today was….
- We started off today with X, now I hear you saying Y
- What new thoughts or feelings do you have?
- What's your intention on how you might build on what happened here?
- How does this fit in with your…..(overall life goals, spiritual values, hopes for your life)

Invite

Meet & Greet - let's do this!
Validate - empathize by acknowledging and accepting the client's perceptions
Collaborate - hear the music, partner in the dance.

Entertain

Explore - prepare to be surprised
Cut to the chase- how is the problem a problem?
Expand - your life is bigger than your problem
Pivot - you are perfect the way you are…and you could use a little improvement

ENDING WELL

Elicit unasked questions, hidden agendas
Summarize, underline
End while leaving the door open
Listen to client feedback

Adieu

Integrate - client meanings, values, identity
Coda - back to before

Cooperating on the Conclusion

★ *Leave it to the client to determine follow-up*

Help client client feel that you "have their back"

Let client know you (and other resources) are available and accessible

The more the client feels secure your door is open, the less likely they'll feel a need to pound on it

An "open door" policy can lead to helpful intermittent assistance along the life cycle

Questions for concluding

- Does this feel like enough, for now?
- Would you like to set up a follow-up appointment now, or would you prefer to give yourself a little time to absorb what we've done today, and then decide about calling [me] for a follow-up?
- Do you know how to reach [me, the clinic, emergency services] when you want to contact us?

Invite

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Integrate - client meanings, values, identity
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Set Expectations for Future

Ensure if treatment is needed in the future it's not experienced as disheartening defeat

Frame future treatment possibilities as fine-tuning current efforts, or nipping future problems in the bud, or exploring interesting new life issues that arise

Obtain permission for you (or the clinic) to contact them

If client opts for another appointment, clarify what happens next

Questions and statements

- I don't always have time to follow up with a phone call, but I like to when I can….would it be OK for me to call you?
- I hope you understand you don't have to be in distress in order to come back - if you simply want to improve on progress you've made, that's fine too.
- Please feel free to contact me if you have some positive experience and want to share it with me - I always like to hear those!
- I do have one request: should you run into difficulties, please don't wait too long to call me. It's much easier to deal with problems at the start, instead of after they get big and stuck.

Invite

Meet & Greet - let's do this!
Validate - empathize by acknowledging and accepting the client's perceptions
Collaborate - hear the music, partner in the dance.

Entertain

Explore - prepare to be surprised
Cut to the chase- how is the problem a problem?
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ENDING WELL

Elicit unasked questions, hidden agendas
Summarize, underline
End while leaving the door open
Listen to client feedback

Listening to clients' voices

Solicit feedback to cultivate a client-informed service

Appreciate clients as valuable resource to improve your skills and your clinic's services

Questions for collaboration

- Has this been helpful?
- Was there anything that wasn't helpful, or you didn't like?
- Do you have any advice for us on how to improve our services?
- Was there anything in our session you wish we could have done more of?
- Was there anything you wish we'd done less of?
- Do you have any advice for me personally?
- Would you be willing …..
  - to fill our a questionnaire…
  - for one of our staff to contact you to get feedback….

for Single Sessions, remember:

- Moments are meetings, not measures
  - Enjoy your client, enjoy your self
- Health and sickness, calm and chaos, are *both* natural
  - Focus on compassion and curiosity, not cure
- Ordinary is Enough
  - Small changes can make a big difference
- When it's hard, break it down into manageable bits
  - Go step by step
- Therapy is not about *you* - no merit, no fault
  - But you are the time of your life

When the work is done, stop:
retire and rest.

When the work has its fruit, allow people to say,
"It just happened naturally."

- Tao Te Ching

And when in doubt….. Simply offer the gift of presence

The most precious gift you can give …….. is your true presence.

To have compassion for someone is above all to be there….. If you are not there, how can you be compassionate?

But being there is not an easy thing. Some training is necessary, some practice. Being there is very much an art…..bringing your true presence to the here and now;

being present to yourself, to those you care for, to life.

- Thich Nhat Hanh

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.

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