Single Session Therapy: Strengths and Strategies

Laura Wilhelm, Ph.D., Associate Professor
WVU Department of Behavioral Medicine and Psychiatry, Charleston Campus

(no disclosures to report)
Objectives

1) Overview of single session considerations for effectiveness and efficiency using strengths-based foundations

2) Invitation to learn more about single session/brief therapy as a mindset/approach

3) Exploration of ideas and interventions from brief therapy masters that you may want to pursue in more detail on your own later

4) Emphasis on the necessity of collaboration, sensitivity, training, and commitment to ethical care
Basic Assumptions for Presentation

• Understand/follow your work setting requirements.
• Risk is continually assessed/managed.
• Various mental health and life problems may be represented; people are experts on themselves.
• We don’t know how someone will respond to therapy until they are in therapy.
• Foundation of cultural sensitivity, humility, and inquiry is essential.
• Please pick/choose ideas that are helpful for YOU/YOUR WORK.
Rationale for Brief Therapy

• High levels of reported satisfaction with 1 session
• International data support effectiveness
• Limited resources/abundant barriers to care – especially with COVID
• Most common setting for possible care is primary care
• Difficult to engage clients for extended treatment
• Overall effectiveness and efficiency as a public health issue
Why? Pie: Confluence of Contributors to Emotional Disturbance

- Biological predisposition/genetics
- Temperament/personality
- Social learning history
- Medical/hormonal factors
- Environmental stressors
- Thinking
- Behaviors
Single Session Therapy

• Mindset for thinking about service delivery; not a theoretical school
• Philosophy of providing services when they are needed (rather than hyper-focus on availability and assessment)
• Modal number of session attendance = 1, then 2, then 3, etc. (0 is actually most common)
• Therapy is an open skill set; flexibility is key in trying to produce IMPACT!
• Not a Band-Aid/quick-fix; not easy; not applicable to everyone
• Let’s incorporate evidence-based trans-diagnostic strategies that address underlying mechanisms and help this person NOW.
Importance of Underlying Theory:

Theory should guide your choice of techniques/strategies. You can use single-session therapy as a mode of delivery with different models of therapy (CBT, ACT, REBT, Solution-focused Therapy, etc.)
Evidence-Based Practice

Best available research evidence

Patient preferences and values

Clinical expertise

EBP
**Competent Therapy Basics**

• Therapy time is precious – use it well.

• Teach useful, durable skills and build morale.

• Remember that patient trust and collaboration are privileges, not rights – every word matters.

• Balance validation of feelings with promoting more flexible thinking and behavioral options in service of value-based living.

• Strive to enhance effective learning and psychological flexibility – encourage “experimental” mindset.
Considerations for Brief Therapy

Helpful Factors

• Administrative support
• Shared understanding of purpose
• Realistic expectations
• Time used well to get ready for session – patient is prepared; skillful hand-off
• Flexible mindset regarding doing what works best for individual patients – openness to patient’s unique circumstances and context
• Remembering significance of “one thing at a time”/“less is more”

Potentially Interfering Factors

• Organizational deterrents
• Unclear expectations regarding therapy
• Long wait for first appointment
• Patient hasn’t thought about therapeutic agenda/concerns; rejects proposition
• Rigidity/insistence regarding format of assessment documentation, case formulation, number of sessions, etc.
• Trying to cover too many topics and interventions
Single Session Therapy

• My questions to myself:
  How can I help this person get unstuck?
  How can I help this person move forward?
  What strengths/supports can we employ?
  What do we need to “avoid avoiding?”
  What is something meaningful for this individual to take away?

• My main question to my patient:
  How can I best help you today?
# Therapist Variables: The Relationship Matters

## Predictive of Better Outcomes
- Verbal fluency
- Persuasiveness
- Emotional perception
- Affective modulation and expressiveness
- Warmth and acceptance
- Focus on the other/understanding

## Not Predictive of Better Outcomes
- Adherence to theoretical orientation
- Experience
- Age
- Personality
- Professional degree
- Self-reported social skills
- Interviews by experts

Wampold, August 2020, APA Conference
Trans-diagnostic Interventions

- Psychoeducation
- Behavioral activation
- Stimulus control
- Exposure strategies
- Response disruption
- Tolerance/acceptance
- Mindfulness training
- Cognitive restructuring
- Cognitive defusion
- 2-chair work

- Modeling
- Imagery
- Problem solving training
- Communication training
- Operant conditioning
- Values clarification/choice
- Self-compassion
- Forgiveness work
- Arousal reduction
- Relapse prevention
Single Session Therapy (SST), Hoyt and colleagues

• One session can help people with a variety of problems.
  • “More” may not be necessary or better
• Therapeutic encounters “capture and create moments.”
  • Highlight what’s right, not wrong; use what’s right to improve what’s wrong.
• Focus on giving people what they need when they need it.
  • Facilitates improved efficiency and utilization of resources
• Optimize “context of competence.”
  • Strengthen alliance/goals/resources.
• Activate patient “empowerment” in this venue NOW.
Basic Ingredients of Brief Therapy
Hoyt and colleagues

• Positive alliance developed quickly
• Emphasis on goals
• Clear delineation of responsibilities/activities by patient and therapist
• Highlighting strengths/capabilities/expectations for change; fostering hope
• Novelty – thinking/doing something differently
• “Here and Now” focus (this moment...and the next moment...)
• Sessions are time-sensitive and scheduled intermittently
Single Session Therapy (SST),
Windy Dryden

• Based on recognition that a brief interaction between 2 people can be helpful/therapeutic

• Brief mode of service delivery (when appropriate) can honor unique individual’s needs and reach more people struggling

• Intentionally initiated with 1 session in mind; more sessions can be added as needed

• Ingredients for change – knowledge, committed reason, taking action, and accepting costs of change

• In session, if possible, discuss: Problem – Solution – Goal

• After session: Reflect-Digest-Act-Wait-Decide
**Solution-Focused Brief Therapy**  
*de Shazer, Berg and Miller, Erickson ideas*

<table>
<thead>
<tr>
<th>Four Main Considerations</th>
<th>Three Basic Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What do you want?</td>
<td>1. If it’s not broken, don’t fix it.</td>
</tr>
<tr>
<td>2. How will you know when you have it?</td>
<td>2. Once you know what works, do more of it.</td>
</tr>
<tr>
<td>3. What are you already doing to get it?</td>
<td>3. If it doesn’t work, don’t do it again; do something different.</td>
</tr>
<tr>
<td>4. How would things look if you were a little closer to what you want?</td>
<td></td>
</tr>
</tbody>
</table>

*Questions: Miracle, Goal-building, Exceptions, Efficacy, Coping, Scaling*
Motivational Interviewing
(Miller and Rollnick)

• “A collaborative, person-centered form of guiding to elicit and strengthen motivation for change.”

• Poorer outcomes often ensue from telling patients what to do. Better outcomes result when ideas are elicited from our patients.

• Change talk predicts actual change outcomes. Providers’ interpersonal counseling style predicts change talk.

• Despite our best intentions, our eagerness for patients’ change can result in more sustain talk and discord.
Central Concepts of MI

• Collaboration vs. Confrontation
• Evocation vs. Education
• Respect/Autonomy vs. Authority
• MI focuses on acceptance, partnership, compassion, and evocation.
Central Concepts of MI

• Ambivalence is normal and to be expected.
• Change does not always equal observable behavioral action.
• Therapeutic relationship is a collaborative partnership.
• Meet the patient where he or she is.
Spirit of Motivational Interviewing

- Motivation comes from within, not externally (capitalize on intrinsic values).
- The patient, not the clinician, owns the task of identifying and resolving ambivalence.
- Beware of the “righting reflex” – the more the patient argues against change, the less likely change is.
- The clinician is active in helping the patient examine and resolve ambivalence.
- MI is curious, purposeful evoking.
- The client-centered philosophy of MI depends on an interpersonal style, not just a group of techniques.
- We want to promote change talk and commitment to better living, but we can’t force these agendas.
Change Processes are Variable

1. **Pre-contemplation**: Not considering change
2. **Contemplation**: Thinking about change
3. **Determination/Preparation**: Taking steps to start behavior change
4. **Action**: Person tries behavior change
5. **Maintenance**: Person does new behavior regularly
6. **Relapse**: Person slips up and needs to make adjustments
Fluid Motivational Interviewing Processes for Each Encounter

Engage – connect/show understanding of individual’s experience
Focus – find a useful direction, agenda setting may involve multiple choice
Evoke – draw out reasons for change, listen for/ highlight change talk
Plan – if desired, develop change plans
Recognizing and Strengthening Change Talk

• **Desire** – I want to stop smoking.
• **Ability** – I can remember to tell my son...
• **Reasons** – I don’t want to feel this tired.
• **Need** – I need to do this for my daughter.
• **Commitment** – I plan to, I will...
• **Activation**
• **Taking Steps**
Principles of Motivational Interviewing

Express empathy ("I’m being understood.")

Develop discrepancy ("I see where I am now versus where I want to be.")

Roll with resistance ("My ambivalence is normal.")

Support self-efficacy ("I can change.")
Implementing Principles of MI: Strategies to Develop Discrepancy ("I’m … now, but I want to be...")

• Review a typical day
• Look back and look forward for growth
• Decisional balance/cost-benefit analysis
• Explore goals and values
• Use importance and confidence rulers
  • On a scale of 0-10, how important is it that...?
  • What makes you at a 3 instead of a 0?
Implementing Principles of MI: Rolling with “Resistance”

• “Resistance” was considered an interaction, not a patient characteristic (newer ideas remove “resistance” word)
• Possible signs of “resistance:” arguing, interrupting, denying, ignoring, blaming
• “Resistance” might indicate:
  • The patient’s feeling unheard/misunderstood
  • Discussion is moving too fast
  • Unresolved ambivalence
  • Doubts about self-efficacy
• Ways to roll (dancing rather than wrestling) – emphasize personal choice!
“Resistance” Reconsidered

• Sustain talk - adherence to status quo
  • “I don’t want to quit drinking.”
  • “I can’t stop smoking.”
  • “It’s too hard to remember to take my medicine.”

• Discord – strain/difficulty in the relationship with provider
  • “You don’t understand what I’m going through.”
  • “You’re not listening to me.”
  • “You can’t make me stop.”

• Both respond to counseling style – use reflective listening
Implementing Principles of MI: Strategies to Support Self-Efficacy (“I can change”)

• Review past accomplishments/successes
• Highlight personal strengths
• Reframe “failures”
• Give information/advice - with permission
• Discuss outcomes of hypothetical change
• Reflect confident change talk
• Confidence ruler
  • On a scale of 0-10, how confident are you that you could change...?
Core Interactional Skills of Motivational Interviewing (OARS)

* Open-ended questions

* Affirmations

* Reflective Listening

* Summaries
Core Skill: Open-Ended Questions

* Help create momentum to move the patient forward
  * What makes you believe it might be time for a change?
  * What are your concerns?
  * What do you like about smoking?
  * What are some of the things you would not miss?

* Allow us to hear the patient’s genuine concerns and wishes; they open up the conversation

* Limit the chances that we fall into the “expert” role
Core Skill: Affirmations

* Lessen demoralization
* Highlight strengths and assets
* Enhance rapport
* Show respect for the patient
* Examples:
  • It took a lot of courage for you to come in today.
  • You’ve given a lot of thought to how this is affecting your family.
  • That’s an important point.
Core Skill: Reflective Listening

* Helps the patient feel understood

* Opens new possibilities/directions

* Promotes the development of change talk

* Useful when feeling “stuck” (a helpful default intervention)

* Levels of reflection – reflecting content, reflecting feeling, action reflections, etc. (we want 2 reflections for each question)
Core Skill: Summaries

* Show interest
* Enhance rapport
* Shift direction or attention as needed
* Highlight important features discussed
* Allow the patient to contemplate what’s been said and to make any needed corrections
Navigating the Course Flexibly

Follow – elicit concerns, listen for pros/cons, set agenda

Guide – determine importance of/confidence in changing, elaborate pros/cons, connect change to values, develop ideas for change strategies

Direct – build change ideas menu, determine next steps/how to monitor
MI Highlights

• Importance Ruler
• Confidence Ruler
• Decision Matrix (pros/cons analyses)
• Ask permission before providing information/education (elicit-provide-elicit; ask-tell-ask)
• Consider using MI app – Change Talk by Kognito
Acceptance and Commitment Therapy (ACT) and The “Language Trap”

• Notice reaction to seeing word “SNAKE”

• Without language, we could not recall a negative past or anticipate a negative future the way we do.

• Unfortunately, our minds often lead us to deal with pain in ways that make things worse.

• People tend to live by an implicit rule that suffering is bad and a lack of suffering is good.

• Further, this rule holds: If something is bad, you should try to get rid of it by acting on it directly.
The “Language Trap” continued

• Whereas this verbal rule can work well with things in the external world, it does not seem to be a consistently helpful method when applied to painful thoughts and feelings.

• Painful thoughts and feelings do not usually disappear with efforts to avoid or mask them.

• Distraction, alcohol, staying in bed, reassurance-seeking, etc. may provide temporary relief, but the feelings/thoughts tend to return.

• The rule: “I must avoid my painful feelings” does not work, and life gets smaller.
Assessment of Values and Barriers

(Dahl & Wilson, 2003)
Observer-Self

Thoughts: I can’t stand this anxiety anymore. I’ve got to make it stop.

Sensations/Feelings: Throbbing heart, chest pressure, sweating, terror, despair.

Actions: Try to force self to calm down, “gulp” air to get a deep breath, take a pill, watch TV.
Defusion Activity: Wise Mind

Observer Self (Wise Mind)

Thoughts
I can’t stand this anxiety anymore. I’ve got to make it stop.

Sensations/Feelings
Throbbing heart, chest pressure, sweating, terror, despair.

Actions
Try to force self to calm down, gulp air, take a pill, watch TV.
Increasing Willingness to Feel

Feel BETTER or **FEEL better** – Feeling Experiences Enrich Living!
ACT Key Principles

• Diagnosis doesn’t always help treatment. Understandable trans-diagnostic concepts can explain a wide range of difficulties.

• Symptom reduction isn’t the measure of full living.

• Human suffering often stems from unworkable rules to avoid pain, but pain is part of full living and tells us about values. Efforts to control/erase pain are the problem, not the solution.

• People can transcend their suffering, despite level of chronicity.

• Living by values – with full range of feelings – works better than avoidance.
Focused Acceptance and Commitment Therapy (FACT), Robinson and Strosahl

- **F**ocus on unworkable results of rule-following and emotional/behavioral avoidance

- **A**ccept that distressing, unwanted private experiences regularly show up

- **C**hoose a life path guided by personal values instead of pain avoidance

- **T**ake actions on the values-guided path
ACT / FACT Therapist Approach

• People are not broken and do not need fixed—look at behavior in context.
• Show curiosity, openness, authenticity, equality, and non-judgmental stance.
• Demonstrate awareness, acceptance, and humility, especially in “stuck” moments.
• Ask questions to improve understanding of contextual issues and to facilitate patient’s awareness of unworkable/workable options.
• Help patient recognize counter-productive effects of avoidance focus.
  • Short-term gain leads to long-term pain.
• Embrace experimental mindset that acknowledges the best teacher is life itself.
• Allow what actually works to shine (not what “should” work).
• Highlight the power to choose (“the choice point” is a key concept).
• First visit may be the last; powerful interventions can be used brief encounters.
FACT Interview - CARE (Strosahl and Robinson)

- Contextualize the problem
- Assess and attack avoidance
- Reformulate/reframe rule-governed behaviors
- Expand behavioral variability with experimental mindset

First 2 minutes are most important/set stage for rapid change in 30-minute (often same-day) primary health care visits.
## Contextual Interview (Love, Work, Play, Health)

<table>
<thead>
<tr>
<th>Love</th>
<th>Work</th>
<th>Play</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where do you live? With whom?</td>
<td>Do you work/study? If yes, what is your work?</td>
<td>What do you do for fun?</td>
<td>Do you use tobacco products, alcohol, illegal drugs?</td>
</tr>
<tr>
<td>How long have you been there?</td>
<td>Do you enjoy it? If no, are you looking for work?</td>
<td>For relaxation?</td>
<td>Do you exercise on a regular basis for your health?</td>
</tr>
<tr>
<td>Are things okay at your home?</td>
<td>If no, how do your support yourself?</td>
<td>For connecting with people in your neighborhood or community?</td>
<td>Do you eat well? Sleep well? How much social media?</td>
</tr>
<tr>
<td>Do you have loving relationships with your family or friends?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Verbatim CI questions from Robinson and Strosahl
### For Identified Problem: The Three Ts Functional Analysis

<table>
<thead>
<tr>
<th>Time</th>
<th>Trigger</th>
<th>Trajectory</th>
</tr>
</thead>
<tbody>
<tr>
<td>When did this start?</td>
<td>Is there anything--a situation or a person--that seems to set it off?</td>
<td>What’s this problem been like over time?</td>
</tr>
<tr>
<td>How often does it happen?</td>
<td>Is there anything that seems to make it better?</td>
<td>Does it seem to be getting worse, getting better, or staying about the same?</td>
</tr>
<tr>
<td>How does it end?</td>
<td>Have any new triggers showed up recently?</td>
<td>Have there been times when it was less of a concern?</td>
</tr>
<tr>
<td>What happens immediately before and after the problem?</td>
<td></td>
<td>Have there been times when it was more of a concern?</td>
</tr>
<tr>
<td>Why do you think it is a problem now?</td>
<td></td>
<td>Do you see any other pattern with the problem?</td>
</tr>
</tbody>
</table>

On a scale of 1 – 10, how big of a problem is this for you?

Verbatim CI questions from Robinson and Strosahl
Workability Questions

• What does “better” mean to this individual? (looking for more.../less...)
• What have you tried so far to achieve that result? (listen for avoidance focus)
• How have your strategies worked in terms of what matters to you?
• What have been the costs of using these strategies?
• Are you ready or willing to try something different?
• What kind of life would you choose if you could choose?

Through today’s conversation: How can I help this person be more ready/willing/able to take a values-consistent committed action?

At end of session, ask how confident patient is that they will follow through on action plan. Also ask how helpful session was (0-10).

Robinson and Strosahl
FACT Three Pillars of Psychological Flexibility

OPEN: open up

AWARE: be present

ENGAGED: do what matters

Robinson and Strosahl
## FACT Four Square

### Workability

<table>
<thead>
<tr>
<th></th>
<th><strong>UNWORKABLE</strong>-control/avoid</th>
<th><strong>MORE WORKABLE</strong>-approach</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACTIONS</strong> (observable)</td>
<td>Staying in bed, not going to work, bingeing on food/tv, drinking alcohol too much, etc.</td>
<td>What are you willing to try that’s different than what you’ve been doing (experiment)?</td>
</tr>
<tr>
<td><strong>THOUGHTS</strong></td>
<td>Your mind told you…to withdraw, avoid, hide, numb out, etc.</td>
<td>What are your values telling you? What matters? Who matters?</td>
</tr>
<tr>
<td><strong>EMOTIONS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ACTION TENDENCIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MEMORIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SENSATIONS</strong> (private)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Robinson and Strosahl
# FACT Pillars of Psychological Flexibility

<table>
<thead>
<tr>
<th>OPEN</th>
<th>AWARE</th>
<th>ENGAGED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accepting of distressing stimuli; use</td>
<td>Experiencing present moment; active perspective-taking</td>
<td>Connected with values; doing what’s important</td>
</tr>
<tr>
<td>behavioral results more than rules</td>
<td></td>
<td>Taking committed actions in service of values</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>IN THIS MOMENT</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Who do I want to be?</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>What do I stand for?</strong></td>
</tr>
</tbody>
</table>

Robinson and Strosahl
Life Path Activity – What Direction Am I Heading?

Control Focus
What do you want to control, avoid, or get rid of and how are you trying to do that?

Meaning Focus
What type of life would you choose if you could choose?
<table>
<thead>
<tr>
<th>Values Domain</th>
<th>Action Plan/Committed Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intimate Relationship</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td></td>
</tr>
<tr>
<td>Parenting</td>
<td></td>
</tr>
<tr>
<td>Friends/Social Connections</td>
<td></td>
</tr>
<tr>
<td>Job/Vocation/Career</td>
<td></td>
</tr>
<tr>
<td>Education/Learning</td>
<td></td>
</tr>
<tr>
<td>Community/Civic Pursuits</td>
<td></td>
</tr>
<tr>
<td>Religion/Spirituality</td>
<td></td>
</tr>
<tr>
<td>Physical Health/Well-Being</td>
<td></td>
</tr>
<tr>
<td>Recreation/Leisure</td>
<td></td>
</tr>
</tbody>
</table>
Life is a Series of Moments

Past (If only...)

Present (WHAT IS)

Future (What if...?)
Examples of Single Session Interventions:
Increasing Values-Consistent “Response-Ability”
Target Trans-diagnostic Mechanisms and Effective Skill Development

• Chip away at:
  – Emotional, cognitive, and behavioral avoidance
  – Emotion-driven behavior
  – Cognitive misappraisals and over-importance of thoughts

• Focus on functionality - set the stage for more internal locus of control and healthier skill development:
  – Emphasis on acceptance of internal experiences & promotion of value-based living (including psychoeducation and mindfulness)
  – Motivational enhancement
  – Cognitive reappraisal (including restructuring and defusion)
  – Increased willingness to do value-driven behavioral activation and exposure (opposite action, mood-independent behavior)
Cognitive Restructuring and Cognitive Defusion

• Cognitive restructuring traditionally has focused on replacing an unhelpful thought with a more balanced, realistic, accurate, adaptive self-statement.
  – “I’m a failure” is replaced with “I’m a human being with strengths and weaknesses--I’m learning from my mistakes.”
  – “This anxiety is ruining my life” is replaced with “Anxiety keeps me alive—I can be anxious and still function.”

• Cognitive defusion doesn’t address the thought content or try to answer it back. Emphasis is on choosing valued behaviors, not controlling thoughts.
  – “Thank you, mind, for that thought. It’s time for me to get on with my day.”
  – “I notice I’m having the thought ‘I’ve blown it’. There goes my mind again...”
Thought/Feeling/Behavior Interrelations
## ABCs of Emotions

<table>
<thead>
<tr>
<th>Activating Event</th>
<th>Beliefs</th>
<th>Consequences (Feelings/Behaviors)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long skinny thing on the ground in the woods</td>
<td>It’s a snake! Or It’s a stick.</td>
<td>Scared/Run Neutral/Keep Walking</td>
</tr>
</tbody>
</table>
Single Session Sample Strategies

- Feeling Words Activity
- Reasons for Hope/Life is Worth Living, Even with Pain
- Depression Recipe/Antidote
- Wellness Way vs. Relapse Road
- Advantages/Disadvantages of ?
- DBT Skills: Mindfulness, Distress Tolerance, Emotion Regulation, Interpersonal Effectiveness applications
Movement for Meaning

- Walking into corner vs. turning around
- Opposite action (doing the opposite of what I say – standing up while saying “I can’t stand up”)
- Standing on chair to show power we give others/thoughts over us
- Arranging chairs to represent less workable vs. more workable thoughts
- Using emotion and willingness “thermometers”
- Shooting baskets to promote tolerance of uncertainty (to help question hopelessness and excessive worrying)
Thought/Feeling/Behavior Interrelations

I’m no good. It’s hopeless. Nobody cares.

Stay in bed. Cry. Isolate.
Depressed
I can talk to some people. They care more than I thought.

Get out of bed. Call friend.

Less depressed

Thought/Feeling/Behavior Interrelations
Metaphors

Intended to promote living more mindfully by values rather than a focus on escaping from painful thoughts and feelings.

Useful for teaching acceptance (acknowledgement) and conveying role of choices

Stimulate different ways of thinking that may “stick” more

- Emotion/urge wave
- Clouds and sky
- Waterfall of unwanted thoughts
- Commercials & Internet pop-ups
- Windshield vs. rearview mirror
- Emotional bully
- Crowded bus
- Checker or chess board
- Junk mail
- Movies
Metaphors for Meaning

• Post-it notes – we are not our thoughts
• Bubbles – we can notice thoughts and feelings without acting on them
• Old tapes/new tapes – we can identify thoughts that keep us stuck and begin practicing more workable messages
• Dollar bill – our worth doesn’t change; we benefit from evaluating behaviors, not personhood
• Fortune cookie – we can’t predict the future; we do influence how we talk to ourselves/behave now
Maximizing Meaning

• Rubber band and Chinese finger traps
  – Illustrate value of relinquishing control agenda in anxiety and relationships

• Soda bottle
  – Generate discussion about ways to ease pressure; challenge all-or-nothing responses

• Coping cards
  – Use written note cards for remembering important ideas
Role-Plays:

Capitalize on Opportunities for In-Session Rehearsal

• Learning/practicing I statements
• Setting limits (saying no, broken record technique)
• Giving others feedback
• Accepting compliments
• Modeling ways to respond to criticism
• Enhancing appreciation of non-verbal communication cues
Take-Home Messages

• Let’s optimize THIS ENCOUNTER with THIS PATIENT in THIS MOMENT.
• Increase psychological flexibility; decrease experiential avoidance—for enhanced valued living!
• Single session therapy offers many opportunities for developing a different relationship with internal experiences and pursuing more values-based behaviors.
• Treatment is multi-modal and geared towards unique patient and context.
• Creative, visual, experiential techniques may promote more effective, “impactful” learning.
• Be willing to learn from patients.
• Practice, repetition, and rehearsal are essential for learning. Practice makes automatic/routine.
• Ultimately, we are giving our patients choices; we can’t force them to follow our agendas.

• We don’t have a clear answer to important question: “What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances, and how does it come about?” (Paul, 1969, p. 44), but we can be sensitive to its implications NOW.