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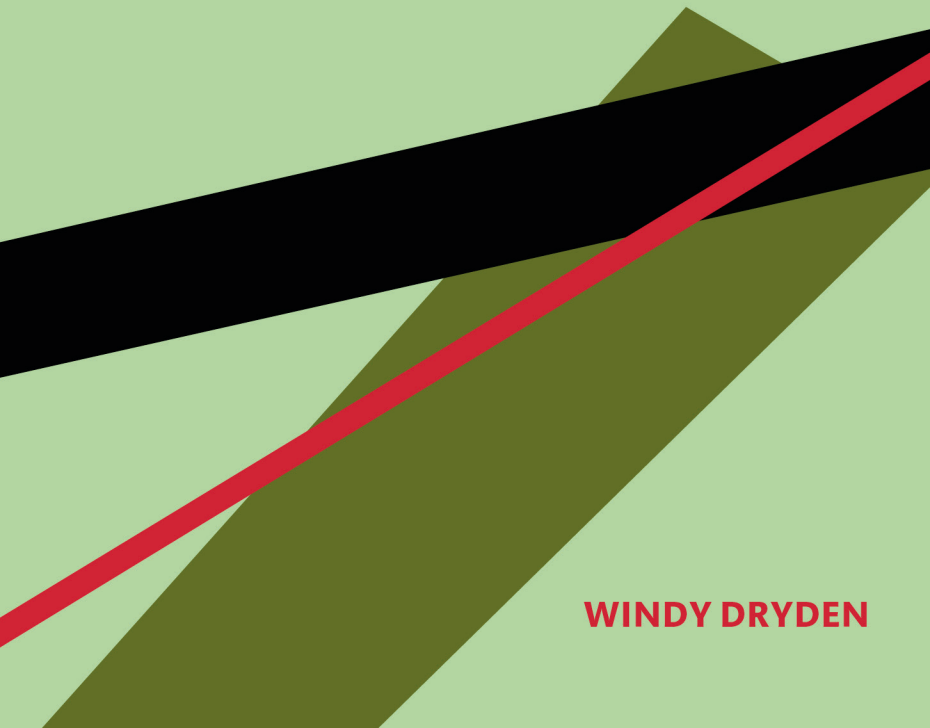
SINGLE-SESSION INTEGRATED CBT

DISTINCTIVE FEATURES

SECOND EDITION



WINDY DRYDEN

Single-Session Integrated CBT

In this book, Windy Dryden takes long-standing research on single-session integrated therapy and transfers it to the field of CBT in a timely and conceptual application.

This thoroughly updated new edition offers brand new chapters on single-session thinking. The book questions the common practice of predicating therapist training on the notion that therapy is an ongoing process. Based on his extensive work demonstrating the benefits of single-session CBT to public and professional audiences, Dryden has developed a single-session approach for work in the therapy and coaching fields. Comprising 30 key points, and divided into two parts – Theory and Practice – it concisely covers the key features of SSI-CBT.

This book offers essential guidance for students and practitioners experienced in CBT, as well as practitioners from other theoretical orientations who require an accessible guide to the distinctive theoretical and practical features of this exciting new approach.

Windy Dryden, PhD, is Emeritus Professor of Psychotherapeutic Studies at Goldsmiths, University of London. He is an international authority on Rational Emotive Behaviour Therapy and is in part-time clinical and consultative practice. He has worked in psychotherapy for more than 45 years and is the author and editor of over 250 books.

CBT Distinctive Features

Series Editor: Windy Dryden

Cognitive behaviour therapy (CBT) occupies a central position in the move towards evidence-based practice and is frequently used in the clinical environment. Yet there is no one universal approach to CBT and clinicians speak of first, second and even third wave approaches.

This series provides straightforward, accessible guides to a number of CBT methods, clarifying the distinctive features of each approach. The series editor, Windy Dryden, successfully brings together experts from each discipline to summarise the 30 main aspects of their approach, divided into theoretical and practical features.

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Introduction

In this introduction, I place single-session therapy (SST) in its recent historical context and outline why I became interested in this way of working that culminated in me developing what I call Single-Session Integrated Cognitive Behaviour Therapy (SSI-CBT).

Single-session therapy: some recent history

This book adds to the growing literature on single-session therapy (SST) that has blossomed since Moshe Talmon's (1990) seminal book on the subject. Three recent conferences on single-session work and walk-in clinics (where a lot of this work takes place) have been held, twice in Australia (2012 and 2019) and once in Canada (2015). This attests to the international interest that this way of working has attracted (see Hoyt, Bobele, Slive, Young & Talmon, 2018; Hoyt & Talmon, 2014a; Hoyt, Young & Rycroft, 2021).

Until recently, therapist training was based on the idea that therapy is an ongoing process and that clients attending for only one or two sessions were considered 'dropouts' from the process. People in the SST field have consistently questioned this notion. Talmon (1990), for example, reported on informal retrospective research that he carried out on 200 of his patients who attended only one session. He found that 78 per cent of this group said that they had got what they wanted from attending therapy, and only 10 per cent said that they did not like the therapist or the outcome of therapy. Following on from that, Hoyt, Talmon and Rosenbaum (1990) carried out a prospective study on planned single-session therapy with 60 clients, 58 of whom were reached on follow-up. Of

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that final sample of 58, 34 did not require further therapy, 88 per cent reported 'much improvement' or 'improvement', and 79 per cent thought that SST was sufficient for them. This work suggested that the idea that people only attending for a single session of therapy can be considered 'dropouts' could be challenged. I, somewhat tongue-in-cheek, offered a new definition of 'dropouts' from therapy: 'A dropout from therapy is someone leaving therapy before their therapist believes they should.' Once it was accepted that productive work could be achieved in a single session, many people began to explore the idea of designing SST, leading to different developments depending upon therapeutic setting and orientation.

Concerning therapeutic setting, much SST occurs in walk-in services (sometimes known as drop-in centres),[1] as mentioned earlier. These are used mainly by people who want to talk when they need to and don't want to be burdened by using ongoing services. Although some of these clients do return, workers in these services assume that the session will be the only one they will have with the client and design the work accordingly. In another therapeutic setting, demonstrations of therapy in front of a live or online audience, or captured on DVD, are essentially single sessions as both therapist and client know that they will not meet again. It is my view that much productive work can be done in these sessions, and the work done in such demonstrations can usefully inform more formal SST (Dryden, 2018, 2019, 2021a, 2021b).

Regarding therapeutic orientation, it is perhaps no surprise that SST would appeal to theorists and practitioners of solution-focused therapy (SFT) with its emphasis on building solutions and utilising clients' strengths rather than on problem-solving and addressing clients' deficits. However, a wide variety of other therapeutic approaches have shown an interest in SST, including CBT. From a CBT perspective, Öst developed an effective single-session approach to treating various simple phobias (see Davis III, Ollendick & Öst, 2012), which is predicated on the idea that the patient needs to stay in the phobic situation until their levels of anxiety drop markedly. This necessitated that the single session often lasted

significantly longer than the 50-minute therapeutic hour. As can be seen, this approach, while cognitive-behavioural in nature, very much relied on the patient's direct experience of the phobic object. This emphasis on experience is very much a feature of another CBT single-session treatment approach pioneered by Angela Reinecke (e.g. Reinecke, Waldenmaier, Cooper & Harmer, 2013) who modified a standard panic disorder treatment protocol (see Salkovskis, Clark, Hackmann, Wells & Gelder, 1999). After explaining the CBT model of panic disorder and the role of safety-seeking behaviour, and the importance of exposure to the feared situation without such behaviour, patients were given an immediate opportunity to practise this in a relevant situation. Very promising results have emerged from this single-session treatment. This emphasis on rehearsing the solution in the session is a hallmark of single-session work (Dryden, 2021c).

Single-session therapy: a personal journey

My interest in developing Single-Session Integrated Cognitive Behaviour Therapy (SSI-CBT) emerged from many sources. Like many counsellors trained in the 1970s, it was almost obligatory to watch the 'Gloria' films. Here, a client, Gloria, was interviewed by three therapists demonstrating their approach to therapy. What was remarkable about this series of films was that each of the therapists was the founder of the therapy approach being demonstrated: Carl Rogers (the founder of what is now known as Person Centred Therapy), Fritz Perl (the founder of Gestalt Therapy) and Albert Ellis (the founder of what is now known as Rational Emotive Behaviour Therapy).

Although not apparent at the time, these interviews were essentially examples of single-session therapy since Gloria did not have any more sessions with any of the therapists.[2] There were two further series of such films with clients known as 'Kathy' and 'Richard', which, while not having the same impact on the field

that the Gloria films had, did show me what could be achieved in a single session by representatives of different cognitive-behavioural approaches. Thus, Arnold Lazarus (the founder of Multimodal Therapy, an approach rooted in CBT), Aaron T. Beck (the founder of Cognitive Therapy) and Donald Meichenbaum (a leading proponent of Cognitive Behaviour Modification) all worked effectively in the single session that they had with their respective clients.

Another significant influence on my interest in single-session work was the live sessions carried out by Albert Ellis at his famous Friday Night Workshops.[3] At these workshops, carried out every Friday evening when Albert Ellis was in town at his Institute in New York, Ellis interviewed two people on a particular emotional problem. After each interview, Ellis and the volunteer answered questions from members of the audience, who would often make pertinent observations.[4] Research done by Ellis and Debbie Joffe, who later became Ellis's wife, indicated that volunteers often did receive substantial help from these single brief sessions with Ellis. Most of them also found the suggestions offered by members of the audience helpful (Ellis & Joffe, 2002). Ellis further claimed that audience members were also helped by watching and listening to these single sessions, although this was never studied.

My interest in the Friday Night Workshops led me to serve as the therapist at some of these workshops, both while Ellis was alive and after his death,[5] during my many visits to the Albert Ellis Institute. From this experience, I discovered that I was very much drawn to working within a single-session format. From the informal feedback that I got from clients and audience members, my work was appreciated. Following on from this, I have given demonstrations in front of face-to-face and online audiences of what is effectively single-session therapy in that the client and I only have one session. I have done so in many different settings and countries.

Thus, whenever I give a workshop on a topic, I demonstrate how I work therapeutically with one or more volunteers who have a problem in the topic area under consideration or, if I am giving a more general workshop, volunteers are invited to come forward

and discuss an issue of their choosing. The format is generally the same and derives from the Friday Night Workshop format, with an interview followed by observations and questions put to me as the therapist and to the client by audience members. In addition, I do two things. First, I digitally record the interview and offer a copy to the client.[6] Second, I have the recording transcribed and provide the transcription to the client on request. I keep a copy of both of these and consult them both as a means of self-supervision. I have incorporated both the digital voice recording (DVR) and the transcript into the Single-Session Integrated Cognitive Behaviour Therapy (SSI-CBT) approach that I have devised and which I will describe in this book.

I mentioned earlier that I was influenced by the Gloria–Kathy–Richard trilogy of films where leading therapists demonstrated CBT and non-CBT ways of working. I have subsequently made several DVD demonstrations of myself doing therapy with volunteer clients with problems such as procrastination and guilt, two areas in which I am interested. All these live and recorded demonstration single sessions have helped me over the years to refine my approach, culminating in the development of SSI-CBT.

So far I have discussed those influences on my ideas about SST that were predominantly demonstrative. In addition, my views have been shaped by what has happened in everyday practice. First, like many people in the SST field, I have been struck by the number of people over the years who have made an appointment at the end of the first session and have then cancelled it, saying that, on reflection, the first session was sufficient. While I have not canvassed these people from my caseload as comprehensively as Talmon (1990) did, those who gave reasons for not returning pointed to the first session helping them to do such things as: putting things into perspective, giving them a different way of thinking about the problem and its relevant factors, and seeing that they could deal with the issues involved better than they thought they could. As someone steeped in the cognitive-behavioural model, these reasons pointed to what could be done quickly if the conditions were right.

Second, I noticed over the years that some people use therapy very briefly but do so at various points over a long period. Thus, I have seen many clients come for one or two sessions and then stop, returning a long time later to discuss other issues and do so again very briefly. These people seem to benefit from a very brief intervention at different points of the life cycle. I have had to modify my practice to accommodate these people's therapeutic needs. I have been open to doing this rather than getting them to fit into an ongoing therapy Procrustean bed.

Finally, I encountered various situations with people that meant that I would only see them for one session if I took them on. Thus, several people have wanted to see me for one session because they did not want to commit themselves to further sessions. Also, some people in therapy wanted a second opinion on their situation, or their therapists recommended that I see them for such an opinion. Additionally, people who had heard about CBT wished to have a taste of it before committing themselves to a longer course of treatment (and not necessarily with me) and thus would only commit themselves to one 'taster' session. Because I have been happy to accommodate all of these requests, I have had to modify my practice accordingly.

In this introduction, I have provided a brief historical context of SST and discussed what has influenced my interest in this field, culminating in developing an approach that I have called Single-Session Integrated Cognitive Behaviour Therapy (SSI-CBT). Let me begin by describing its theoretical framework in the first part of this book before considering its practice in the second part.

Notes

1 In the UK, drop-in centres tend to be places where a person can come into a setting associated with the promotion of mental well-being, be greeted, invited to look around, peruse some reading material and if they want to talk to someone, that person may 'signpost' the person to

services that they may find helpful. Therapy tends not to take place in such 'drop-in' services. By contrast, in Australia, Canada and the USA, walk-in centres are places where a person can get therapy immediately for their stated concern.

2 Gloria did, however, correspond with Carl Rogers after her session with him (Burry, 2008).

3 These were initially billed under the heading 'Problems of Living' to convey the idea that help was being provided for everyday problems rather than for clinical problems.

4 And sometimes not so pertinent observations!

5 Since Ellis died, the tradition of carrying out single sessions of REBT in front of a public audience has continued under the new heading of 'Friday Night Live'. A number of trained and experienced REBT practitioners serve as the therapist at these events on a rotational basis. This has continued during the Covid-19 pandemic.

6 To get the digital voice recording (DVR) of the session, the person has to email me to request the copy, which I send via a Cloud service that provides the client with a download link. Such recordings are too large to send by email attachment.

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Part I

THEORY

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Single-Session Integrated CBT (SSI-CBT): What it is and some basic assumptions

When I developed a cognitive-behavioural approach to single-session therapy, I mainly crystallised my way of working that I had developed from the experiences I outlined in the Introduction. However, I also wanted to outline a framework that other CBT therapists could use who wanted to do single-session therapy in their way. In this book, I will discuss the general framework while illustrating the points with my particular approach. When I discuss the general framework, I will refer to it as SSI-CBT, and when I discuss my specific approach, I will refer to it as SSI-CBT (WD). My main goal is to focus on SSI-CBT, but many of the examples are taken from SSI-CBT (WD).

While CBT therapists who wish to use a single-session approach will no doubt develop their own format, at the moment my format is as follows:

- A person contacts me and requests explicitly single-session therapy, or a person contacts me and, after I have explained the services that I offer, they opt for SST
- Having agreed on a date to meet for the single session, I send the person a pre-session preparation form to complete and return before the session. This is designed to help the person get the most from the session. I used to do this by telephone, but no longer do so because it is not time efficient and adds to the cost of the process
- The session takes place, and
- A follow-up takes place at a time agreed between the client and me

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While SST can be one session and one session only (see Introduction), more usually it is seen as:

> An intentional endeavour between the therapist and the client where the former helps the latter to take away what they have come for from the session, but where further help is available if needed.

As such, at any point it may become clear that the person may need more therapy, in which case you[1] may offer this. If you offer another single session or series of single sessions, this may be viewed as 'One-At-A-Time' Therapy (OAATT) (Hoyt, 2011), which some in the SST field see as synonymous with SST. However, when you and the client agree that they will have a block of therapy sessions or ongoing therapy, at that point the work is no longer considered single-session therapy.

What is SSI-CBT?

How can Single-Session Integrated Cognitive Behaviour Therapy (SSI-CBT) be summed up in a nutshell? I think the approach is characterised by the following:

- It is a perspective on SST that is broadly CBT in its foundations (from all waves). In my view, CBT is a tradition, not an approach, and SSI-CBT draws from a variety of CBT approaches
- SSI-CBT also draws upon relevant work from outside CBT. Thus, in my approach to single-session therapy that I refer to as SSI-CBT (WD), I am influenced by:
  - The work of leading single-session therapists, including Talmon (1990)
  - Solution-focused therapy (e.g. Ratner, George & Iveson, 2012)
  - Pluralistic therapy (Cooper & McLeod, 2011)

  - Transformational chairwork (Kellogg, 2015) and
  - Strengths-based approaches (e.g. Duncan, Miller & Sparks, 2004)
- It recognises the importance of behaviour and putting learning into practice
- It recognises the impact of various cognitions (e.g. inferences, attitudes/beliefs/schemas) expressed in several ways (words and images) at different levels of awareness
- It emphasises the importance of emotional impact
- It highlights the importance of the client taking away new meaning in a memorable form and which can be used in appropriate situations
- It is not a single approach to single-session work and is not protocol-driven. Instead, the therapist is encouraged to view each encounter as an unrepeatable event and respond to the client as a unique individual rather than a person with a diagnosable condition treated in a standard manner

An important note

I want to clarify that there are occasions when a person wants to use a single session of therapy *not* to solve a particular problem or deal with a specific issue. Instead, they may want to explore an issue or talk to get things off their chest. These are legitimate uses for a single session. Any SST practitioner (including an SSI-CBT therapist) needs to offer a helping stance to facilitate the client in these respects. However, they do not require the therapist to draw upon their skills as an SSI-CBT therapist, and, as such, they fall outside of the scope of this book. This does not mean that helping clients explore an issue or express their feelings is not valuable. Far from it. It is beneficial in that, by doing so, you are helping the client in the way that they want to be helped. Having made this point, this book focuses on situations where the client wants to solve a particular problem, get unstuck, make a decision, resolve a dilemma, or any other situation where there is a specific focus to the work. In such

cases, I will discuss how you can use SSI-CBT to help clients with the issues for which they are seeking help.

The basic assumptions of SSI-CBT

Both the general SSI-CBT approach and my specific SSI-CBT (WD) approach are underpinned by several theoretical assumptions that I need to clarify so that you understand the foundation of this way of working.

This may be it

A vital assumption of all forms of SST is that the time you have with a client may be 'it', and therefore both parties need to appreciate this and work determinedly to get the most out of this time.

It's all here

If SSI-CBT were a play, then you and your client are the two protagonists, and the context plays a vital role in determining the focus of the action. These three ingredients are all that is necessary to help both parties get the most out of the process. Thus, 'it's all here'.

Focus on both the 'here and now' and the future

What makes CBT an approach that is a good fit with single-session therapy are its present-centred and future-oriented foci. While as an SSI-CBT therapist you might ask questions about a client's past, this would be to discover what the person has tried that was not effective – in which case you would encourage the client to distance themself from this, going forward – and what the person has done that has been helpful – in which case you might wish to encourage the client to capitalise on this, going forward. Generally, however, you will want to find out what the current issues are that the person

wants help with and what the person will accept as a viable and realistic goal, given the single-session nature of the work.

Therapy starts before the first contact, and will continue long after the final contact

It is tempting to think that while SSI-CBT is very brief, all its therapeutic potential is realised through contact between therapist and client. This is not the case and, as an SSI-CBT therapist, it is important that you appreciate the therapeutic value of extra-therapy variables. Thus, just deciding that one wishes to address one's issues can be a powerful therapeutic force, as can contact with other people once such a decision is made.

> Leonard had experienced several losses and, for a while, had felt emotionally 'stuck'. He sought a single session from me, and, as is my custom, I sent him a pre-session questionnaire (see Table 19.1) to help him prepare for the session. The night before the session, Leonard had a Zoom conversation with some of his friends and told them how he felt after these losses. His friends all said that they had felt similar feelings after experiencing loss, which helped Leonard to 'normalise' some of his feelings and so, even before we had the session, Leonard began to feel far less stuck than hitherto.

Therapy occurs over the person's life cycle – it's not a one-shot deal

Throughout our lives, when we are physically ill, we will, in the first instance, consult our GP, who will manage our problem unless it appears more serious, in which case we will be referred for further investigation. However, this model of consulting a therapist as and when help is needed over the life cycle is regarded more suspiciously. However, SST therapists are generally comfortable

with the idea of such consultations and will endeavour to help the person as quickly as possible within the SST framework.

Build on what's there, don't start from scratch

Clients generally come to SSI-CBT with a history of having tried various things to help them solve their problems. Therefore, rather than start from scratch, SST assumes that you can build on what clients have already tried to do to solve their problem, encouraging them to desist from using strategies that have not worked and to employ methods that have yielded some benefit and can be developed.

Clients are helped most by taking away one meaningful thing from the session rather than by being overloaded with too many takeaways

If you are working within a single-session framework, there is a temptation to want clients to go away with as much as possible so that they get the most out of the process. I call this the 'Jewish mother' syndrome, which points to the idea that the archetypical Jewish mother is only happy if their prodigal children leave after a visit during which they have eaten everything put in front of them, which is usually a considerable amount, and been given more food 'for later!' In the same way as a well-digested meal is more satisfying than leaving fully stuffed, single-session therapy clients who leave the process having digested one important therapeutic point, principle or method will generally get more out of the process than those armed with a plethora of such points, principles or methods, but without having digested any of them. Thus, aim to equip your SSI-CBT clients accordingly and resist the urge to throw everything, including the kitchen sink, at them.