

When One Hour
is All You Have



EFFECTIVE THERAPY
FOR WALK-IN CLIENTS

Edited by Arnold Slive, Ph.D. & Monte Bobele, Ph.D.



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Phoenix Arizona

When One Hour is All You Have EFFECTIVE THERAPY FOR WALK-IN CLIENTS

Arnold Slive, PhD & Monte Bobele, PhD

"Highly efficient runners can cover a lot of ground in an hour, and the same is true of highly efficient therapists. Both succeed by wasting no effort—every move contributes to a clearly articulated goal. Slive and Bobele and their contributors are efficiency experts. They know how to provide a complete therapeutic experience for clients in the time it takes many clinicians to just begin warming up. They also know how to provide a complete learning experience for readers. This book provides you with the necessary principles, research, practical how-to's, and in-the-trenches case illustrations for inspiring a fine-tuning (or complete overhaul!) of your therapeutic assumptions and practices. Lace up your shoes and get reading!"

—Douglas Flemons, Ph.D.

Professor of Family Therapy, Nova Southeastern University,
author of *Of One Mind* and co-editor of *Quickies: The Handbook of Brief Sex Therapy*

"In this era of reduced budgets and surging mental health needs, this book should find its way into as many hands as possible. It shows a respectful, effective way of using whatever time is available, even an hour, to help people. Most therapists don't even accept that this is possible, let alone know how to use that time effectively. This book shows that it is not only possible, but how to do it. Buy it for the whole staff."

—Bill O'Hanlon, M.S.,

author of *Change 101* and *A Brief Guide to Brief Therapy*

"Arnie and Monte have gathered a confab of fellow professionals to join them in a noble effort—to communicate with clarity and precision exactly what it takes to truly help people in a world where it may be that 'one hour is all you have.' All of the contributors bring their own perspective on what it takes to deliver quality counseling in a single session, while describing the various successful approaches sustaining organizations or agencies have implemented to support that delivery. If you are a therapist, offering single or multiple sessions, and you want to maximize the impact of your work, *When One Hour is All You Have* will be an effective and enlightening resource."

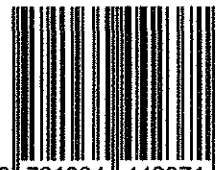
—Scott Miller, Ph.D.

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The editors and their conferees very ably describe their particular methods, which dovetail nicely with the most frequently cited generic components of brief treatment (see Budman et al., 1992; Hoyt, 2009):

1. Rapid and generally positive working alliance between therapist and client.
2. Focality, the clear specification of achievable treatment results and goals.
3. Clear definition of client and therapist responsibilities.
4. Emphasis on the client's strengths, competencies, and adaptive capacities, which can serve to empower, engender hope, and invite a relatively high level of client participation.
5. Expectation of change, the belief that improvement is within the client's immediate grasp.
6. Here and now (and next) orientation, the primary focus being on current functioning and patterns in thinking, feeling, and behaving—and their alternatives.
7. Time sensitivity, making the most of each session, as well as the idea of intermittent treatment replacing the notion of a once-and-for-all definitive "cure."

It was at the Brief Therapy Conference held in San Francisco in December 1988 that my esteemed colleagues Moshe Talmon, Robert Rosenbaum and I first presented our own research (funded by Kaiser Permanente) on "Single Session Therapy: When the First Session May Be the Last." Operating from the assumptions that each session is a whole, potentially complete in itself; that the power ultimately is in the patient; that all you really have is now; and that helping people to make small changes can make a big difference, we found that, when given a choice, many patients were able to make significant and lasting changes after one session. These findings were reported in two well-received books (Talmon, 1990, 1993), numerous articles and book chapters (authored jointly and independently), and have been presented in workshops held throughout the United States and internationally. Noting that each case is unique, we described a series of clinical guidelines to facilitate the possibility of one session being adequate and sufficient:

1. "Seed" change through induction and preparation.
2. Develop an alliance by co-creating, with the client, obtainable treatment goals.
3. Allow enough time for the session to be a complete process or intervention.
4. Look for ways to meet the clients in their worldview while, at the same time, offering a new perspective or hope about the possibility of seeing and act-

ing differently.

5. Go slowly and look for the clients' strengths and resources.
6. Practice solutions experientially, using the session to help clients rehearse solutions, thus inspiring hope and forward movement.
7. Consider taking as time-out, a break or pause during the session to think, consult, focus, prepare, and punctuate.
8. Allow time for last-minute issues, to help clients have the sense that the session has been complete and satisfactory.
9. Give feedback, emphasizing the client's understanding and competency to make changes.
10. Leave the door open, letting the client decide if the session has been sufficiently helpful or if another session (or more) is needed.

It is interesting to see how well these suggestions hold up in *When One Hour is All You Have*, as well as the new directions and ideas the contributors and clients generate in their various and original ways. Client competency and empowerment are consistently emphasized as the different authors draw upon a variety of approaches—such as solution-focused, narrative, systemic, and hypnotic—that I have elsewhere (Hoyt, 1994a, 1996, 1998, 2000, 2001, 2009) referred to as *constructive therapies* to highlight their basis in social constructionist theory and to convey the connotations of positive, productive, and creative. Constructive therapies are based on the recognition that we are constructing, not simply uncovering, our psychological realities. How we make sense of our worlds—the stories we tell ourselves and each other—does a lot to determine our experiences, our actions, and our destinies. The authors of the volume in hand all endeavor to help clients look at their situations and themselves in ways that help them get "unstuck" and move forward in their lives.

Before turning to the exciting chapters that follow, please allow me to make a few additional comments.

1. "*Strike while the iron is hot*" and "*The readiness is all*" meets "*Be here now*." As my colleague Bob Rosenbaum wrote in one of our early papers: "My desire is not to see everyone for one session; my desire is to see everyone for one full moment, as long as that takes" (in Hoyt et al., 1992, p. 80). In a more recent letter to the *Monitor on Psychology*, he elaborates:

Dr. Talmon and I have recently altered our focus somewhat. Psychotherapy is not long or short; to view it this way sets up a false dichotomy. Psychotherapy depends instead on "good moments" where something profound shifts for a client. All the rest is preparation and consolidation. Because we feel psychotherapy needs to fo-

cus more on these critical incidents of change, we no longer talk of “single-session therapy” but prefer, instead, to examine ‘therapy moment by moment’ (Rosenbaum, 2008, 4).

I agree, but prefer to retain the catchy term *single-session therapy* because it emphasizes the idea that therapy can happen in “one hour,” as well as to maintain continuity with existing literature.

2. *One at a time*. This is not to say that clients necessarily should only be seen once. It simply says we should not assume that more sessions would be required. The choice of whether to have more meetings usually is best left to the client. Put simply, there are essentially three ways to have a single-session therapy: (1) client stops unilaterally—often called “no shows” and “premature termination”—if the therapist is not open to the possibility that one session can be adequate and sufficient; (2) therapist stops unilaterally—usually only if the patient is poor and can’t pay or can pay but is too difficult or challenging to make it appear worth continuing; or (3) client and therapist mutually agree that the one session has been enough—at least for now. Obviously, the third is generally the best. The work should not feel frantic or pell-mell; introducing the possibility of one-session being enough concentrates the mind and sets expectations that something will happen. Longer involvement should be available for those who need long term therapy, and doing very brief therapy with many folks will conserve resources for those who need them. Also, knowing that they can serve for a single visit and not be obligated (read: trapped) can serve as a way for people both to access help and to enter the larger system, if more services are needed and desired.

3. *The importance of expectations*. As Stephen Appelbaum (1975; also see Batino, 2006) noted in his paper, “Parkinson’s Law in Psychotherapy,” clinical work often expands or contracts to fit the time allotted. In the original single-session therapy project that my colleagues and I did at Kaiser in the 1980s, patients came to the Psychiatry Department expecting an intake interview and approximately half got the help they needed in one visit. In *When One Hour is All You Have* clients usually came to the walk-in clinic expecting a self-contained episode in which something would get accomplished in the one visit. As editors Slive and Bobele note in their Introduction, the walk-in approach is an especially good fit for clients who have become accustomed to other walk-in services: church confessionals, government offices, barbers’, beauty shops, and garages. Extended therapy, in which intake procedures must be completed before prolonged therapy can begin, may be something of a middle- and upper-class notion—although as our Kaiser experience showed, many clients can and will utilize one ses-

sion if given the choice. Along related lines, Jay Haley (1969, p. 76), in a paper in which he sarcastically mocked ways to endlessly extend therapy, advised ignoring the real-world problems of patients in favor of discussions about their infancies and inner-life fantasies, and added: “Avoid the poor because they will insist upon results and cannot be distracted with insightful conversations.”

4. *Psychohealth, solution, and partnership*. As Moshe Talmon wrote in his fine 1993 book, *Single Session Solutions*: “These concepts represent an alternative to the traditional model in psychiatry and psychotherapy: psychohealth replacing psychopathology, solutions replacing problems, and partnership replacing patronization, domination, and hierarchy” (p. 73). Working the way we and the contributors to *When All You Have is One Hour* like to work—drawing from a variety of approaches that privilege clients’ ways of knowing and competencies to help them achieve outcomes they define as successful—can entail a collision of several paradigms that upsets the psychiatric-industrial complex: Who’s in charge here? Whose therapy is it? Who really holds the keys and the power? And how do you make a lot of money if they only come one time? To my mind, focusing on and working with clients’ strengths and resources, their personal theories of change, values and worldviews is in the best spirit of Milton Erickson’s (Haley, 1973; Short, Erickson & Klein, 2005) competency-seeking ideas about *utilization* and also fits nicely with evidence that it is the client’s (not therapist’s) contributions that most influence good outcomes (Miller et al., 1997; Duncan & Miller, 2000). Alas, as my colleague Steve de Shazer once cogently quipped in an interview, when discussing the difficulty of getting many trained clinicians to focus on clients’ strengths and abilities: “[T]hey’re not ‘mental health,’ they’re ‘mental illness’ professionals. It’s not a mental health industry; it’s a mental illness industry” (Hoyt, 1994b, p. 20). The view that we prefer is optimistic, respectful, resource-focused, and pragmatic.

5. *What’s good for the goose...* Clients sometimes come in with the expectation that a meeting will yield some sort of process and result that will not necessarily “cure” them or completely solve a problem but nonetheless will be of help to them. I recall an incident during our original Kaiser single-session therapy study during which I realized something valuable. We were consulting by phone through a one-way mirror. I discovered that it was often more helpful if we tried to align ourselves with the therapist’s intention—making suggestions to help whoever was the therapist to do what they were trying to do—rather than reframing and redirecting the whole enterprise into our pet theories and making suggestions that jerked the process around to fit where we wanted to go. I thought about it some,

then realized that there was a parallel process going on: The therapist did better with the patient, just as we did better with the therapist, when we supported the other person's intention and worldview.

This seems to me a very respectful way of appreciating diversity, attempting to learn from and work with whatever the client brings to the situation.

Currently, insurance companies, health maintenance organizations, clinics, counseling centers and consumers themselves all desire, and often require, brief treatment for psychological problems. Moreover, healthcare reform will open services for more people, perhaps creating democratic and cost-effective delivery systems where people can walk in and meet with a mental-health professional when they are ready. This is what many people want, need, and benefit from. True to Jay Haley's comment (Talmon, 1993, flyleaf) that "We once assumed that long-term therapy was the base from which all therapy was to be judged. Now it appears that therapy of a single interview could become the standard for estimating how long and how successful therapy should be." *When One Hour is All You Have* gives readers much to consider and apply. I am grateful to editors Arnie Slive and Monte Bobele and the other contributors for this fine volume.

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the underlying tenets of our work and the “how to’s” of the practice framework. The chapter concludes with a detailed case example.

A Single-Session Mindset

A therapist’s own belief in the effectiveness of brief therapy is a crucial element in conducting successful walk-in sessions. We encourage our trainees to familiarize themselves with the research about length of therapy (Chapter Two) emphasizing:

- the frequency with which single-sessions occur in all models of therapy,
- the fact that change occurs early in the course of therapy, and
- the effectiveness of single-session and brief therapy.

Jay Haley said to a student preparing for a first session with a client: “Maybe you don’t have a case really, except for the first interview. That would be nice I think. Every therapist should shoot for one session (Haley & Richeport-Haley, 2003 p.33).”

Consistent with Haley, in our training of graduate students we have developed a motto:

Every Case Has The Potential To Be A Single-Session Case!

This motto, like a mantra, is repeated continuously throughout the training period. It serves to keep our students focused on the idea that this first session may be the only one. Walk-in counseling does not necessarily mean a single-session. Clients are routinely invited to return for a subsequent walk-in session or to make an appointment for further services. Some return and some do not. However, with a walk-in mindset, therapists are always thinking that the current session is potentially the final one. We organize our sessions with that thought in mind and strive to be maximally effective in every session. We expect our students to be aware that many clients will not return. They learn that many of our clients come to counseling expecting to have only one session and that some clients are surprised and disappointed when asked to make further appointments. Often, it is the therapists, rather than the clients, who expect therapy to continue after an initial session.

The following assumptions, borrowed from O’Hanlon & Weiner-Davis (1989), serve to reinforce a single-session mindset:

1. Rapid change is not only possible, but common in human experience.
2. Therapists’ expectations are communicated overtly and covertly about how rapid and how much change can be expected.
3. There is no direct correlation between the duration of the complaint and the duration of the treatment.

4. There is no direct correlation between the severity of the complaint and the duration of the treatment.
5. We need to know less about the history of the complaint and the person than we think.
6. Clients are far less interested in psychotherapy than are therapists.
7. The greatest opportunity for change comes in the earliest stages of therapy.

We also want our students to understand that longer is not necessarily better. Here are some of the reasons:

- One session is often the client’s preferred number of sessions. When therapists conduct their sessions with that timeframe in mind, many clients will be appreciative, and the therapeutic alliance will be strengthened.
- By communicating to clients that one session can make a significant difference, we are indirectly letting clients know that we have confidence in them. This is empowering.
- When therapy lasts a long time, clients and their significant others may come to assume that the problems are severe.
- In our time-sensitive world, the briefer the therapy the less disruptive to everyday life. Clients miss less work, school, or leisure activities.
- One session of therapy is less financially burdensome for clients.
- For nonprofit service providers, completing therapy in one session is highly cost-efficient, enables more clients to be served with the same resources, and reduces wait lists.

Description of The Context

In each of the contexts in which we provided walk-in counseling, we employed a team approach. Typically, a team consists of three to six therapists along with a supervisor (sometimes called shift coordinator). The therapists may be mental health professionals employed by an agency, graduate students receiving training, or professionals who volunteer their time as a form of contribution to their community or as a further learning experience. In some instances, a co-therapy model is used in which two therapists jointly conduct the interview. In other instances it is a solo therapist. In either case, the supervisor and other team members watch the therapy session from behind a one-way mirror or via closed circuit television. The observing team members occasionally make suggestions by telephone during the session. The team meets toward the end of the session to compare observations and plan interventions.

When clients first walk in, they are greeted in a respectful manner and wait in a comfortable waiting area. We want our clients to be as relaxed as pos-

point in time. Therefore, models of therapy that do not usually fit within the above philosophical threads, such as Cognitive Behaviour Therapy, may be a good fit for some clients at some points in time (Young, 2008 p. 34; Schoener, 5). Any approach can work that can be made to fit within the constraints of a “whole therapy” in one hour, especially if the approach is acceptable to the client. Ours is essentially a pragmatic perspective (Amundson, 1996).

The session is a consultation: We prefer to think of walk-in therapy as a consultation process in which the therapist offers ideas (many of which may have come from the client), and the client decides whether to accept them, reject them, or put them on hold. Clients leave the session and may or may not make use of the therapeutic conversation. It’s up to them. Often, the therapist has no long-term feedback from the clients about the outcomes. The consultation stance helps therapists to resist the temptation to take responsibility for client change. We believe that the client is his own greatest resource and is in the best position to evaluate the ideas generated during the session. Our job is to create a context that enables the client to discover those resources and teach us how to be their guide.

THE MODEL IN ACTION

The goal of a walk-in therapy session differs with each client. However, in a generic sense, our goal in walk-in therapy is for the client to leave the session with a sense of emotional relief, increased hope, and some sort of positive outcome as defined by the client. For one client, a positive outcome may be as straightforward as knowing that someone has heard and validated their story. For another client it could be a new way of thinking about a problem—the beginning of a new story. A new way of thinking about a problem, in another instance, may involve deciding that this situation is not a problem after all. Another client may leave the session with a specific task, a new way of approaching a troubling issue. Or a client may leave with ideas about where to get further help. We achieve these outcomes by focusing on the following ideas.

What does the client want? We want to learn, as early as possible, what the client wants from the session. We might ask: “What are you hoping for from today’s meeting? or “What needs to happen during our time together that will make you feel that it was worth your while to come here today?” (Note the use of the word “today” in these questions. This plants a seed for the client that our plan is to make today’s session work for them.) Answering this question is an opportunity for the client to guide the therapist. The therapist can then focus on this goal and avoid “snipe hunts” that do not address the client’s immediate concern. A client recently began a session by

saying, “I’ve seen two psychiatrists and three psychologists and none of them let me talk.” This client was saying to the therapist, “just listen”, so that is exactly what the therapist did for the entire session. At the end of the session, the therapist asked if the session was helpful. The client said she was greatly relieved. The first step is learning what the client wants. The remainder of the session is about giving that to the client.

It is important to note that what the client wants may be unrelated to the presenting concern. For example, one depressed client might want a referral for medication while another might want to develop new goals for herself.

Developing a contextual understanding: We find a useful question that helps to narrow the database is “why now?” Why has this parent, who has been struggling for three years to get her son to get to school on time, decided to come for a session on this particular evening? The answer to this question can help the therapist to put context to the problem and to place the problem in present interactions. The answer might tell us, for example, that the school is threatening a suspension. Or, perhaps mother and son had a physical altercation that morning as the mother tried to get her son out of bed. Or, perhaps the divorced father is threatening a custody battle by saying that the son’s lateness is a sign of the mother’s inadequate parenting. Each answer to the “why now” question provides different ideas to the therapist about the next questions to be asked. Other contextual questions could be:

- How is this a problem for you now?
- Why did you choose to come today?
- Who else is aware of your situation?
- If your spouse/partner were here, what would he say about your situation?
- Who in your life would be most affected if the problem disappeared?

Client Resources: We adhere strongly to the notion that only clients can solve their problems, and all clients have resources that can be directed toward problem solving. The job of the therapist is to direct the conversation in such a way that resources that could be used for problem solving are mutually discovered. Questions could include:

- What have you done to prevent the problem from completely taking over your life?
- How have others in your life been helpful to you?
- What has worked even a little bit in the past?
- What has given you the strength to endure?
- What would family members, friends, or co-workers say are your greatest assets?

Client resources might include the personal resources of the individual client as well as the resources of the client's social network (family, friends, work colleagues, teachers, etc). It is not unusual, for example, for a session to focus on how to ask a friend for assistance or how to invite a family member to accompany the client to a future walk-in session.

Attempted solutions: Sometimes, consistent with the work of the MRI (Watzlawick, Weakland and Fisch, 1988), we find it useful to consider the notion that "the problem is the attempted solution." We want to learn what the client has tried in the past that has not worked and, equally important, what attempted solutions have worked, even if just a little bit, for a short period of time. At minimum, we do not want to disempower ourselves or the client by suggesting something that has not worked before. At best, by making use of a previously attempted positive solution, we might introduce a small change that successfully addresses the presenting concern.

In a recent walk-in session at the Austin Guidance Center, Austin, Texas, an 11-year old girl and her mother presented with the problem of the girl's refusal to attend school due to anxiety. In an attempt to deal with the issue, the mother had been driving her to school in the morning, but the girl refused to enter the school even when her teacher offered to walk her from the car to the classroom. After the therapist learned that the girl was doing well academically and had good relationships with her classmates and teachers, the following was suggested. The therapist told the mother and daughter that while it is unfortunate that fear was getting the better of the daughter, it was most important for the daughter to see that her mother could stand up to the daughter's fear. Therefore, the mother was asked to take her previous attempted solution (driving her daughter to school) one step further by accompanying her daughter to the classroom, even holding her hand if necessary, "to give your daughter comfort and support." The mother was to stay in the classroom for as long as her daughter indicated that her mother was needed. This intervention was designed to a) build on the mother's previous attempted solution of driving her daughter to school, b) take advantage of the mother's schedule which allowed her the time to do this, and c) motivate this 11-year old to get to school on her own in order to avoid the embarrassment of having her mother sit with her in class.

An example of an attempted solution is when a client tells us about something that has helped during a past difficulty, then that might be highlighted and the client encouraged to apply that solution to the present concern. For example, a client could be encouraged to use a simple self-care strategy that has worked before, such as taking a warm bath, going for a walk, or phoning a friend.

One aspect of the attempted solutions question that bears particular mention is learning about previous professional assistance. When a client reports that previous therapy has been helpful, we want to know what in particular was helpful, because we may want to build on the work of the previous therapist. There is an anecdote about a therapist who asked for advice from one of the founders of the Strategic Therapy model, Jay Haley, when a family the therapist had seen five years before returned with the same problem. After learning what the therapist had done five years earlier, Haley is reported to have said: "Do it again; it worked for five years!" Thus, we may want to take advantage of what has worked before rather than attempt something new and untested.

Occasionally, a client who comes to a walk-in service is actively involved in treatment with another mental health professional. Unless the client is highly dissatisfied with that professional, we will ask the client to describe the work she is doing in that other treatment so that we can use the present session to support that work.

Making use of client motivation: We do not adhere to the concept of resistance in our walk-in therapy work. We agree with de Shazer (1986) that it is best to think in terms of client-therapist cooperation and that it is the therapist's responsibility to build a cooperative relationship. We believe that all clients are motivated. Therefore, we attend closely to what motivates clients to attend their walk-in session. Some clients attend because they want help in solving problems. Some come in order to complain about someone else. Some feel coerced by others (parent, probation officer).

Some models of therapy (e.g., SFT, MRI) have given particular attention to the question of how to turn lack of cooperation into cooperation. We utilize those ideas as well as the work of Prochaska and DiClemente (1982) on client readiness for change. Our neophyte practitioners of walk-in therapy tell us that by focusing on client readiness and the therapist-client relationship, they learn to avoid producing resistance by not doing more than the client wants them to do.

Think small: Many clients who attend walk-in sessions have experienced a recent crisis. It helps in those situations to compress time. This can be done by "anchoring the pain in the immediate past, presupposing that today is different, that it is better..." (Lipchick, 2002). The session then becomes a search for small changes, such as "How did you get out of bed today and come to this session?" In this approach, we believe change is constant and that small change leads to big change. An end of session task might be to ask that client to do one small self-care act in the next 24 hours. Therapists who think small take pressure off of themselves and do not make the error of promoting more change than the client wants.

Solution Focused Therapy (SFT): Solution Focused Therapy (deShazer,

1986; Berg & Dolan, 2001) introduced a number of clinical interviewing techniques that we find useful in walk-in sessions. These ideas are designed to move clients away from focusing primarily on the problem and toward focusing on solutions. Some of these ideas include: attending to exceptions to the problem (already existing periods when the problem is not occurring); future oriented questions (what the client might be doing once the problem is not dominating his/her life); developing focused goals; scaling questions ("If the problem intensity is currently rated as a 6 on a 10 point scale, what needs to happen to reduce the problem to a 5?"); and coping questions ("In spite of the problem, how is it that you are doing as well as your are?"). We invite the reader to review the Solution SFT references named above for further explication of these techniques.

Client theory of change: According to Duncan & Miller (2000):

Because all approaches are equivalent with respect to outcome, and technique pales in comparison to client and relationship factors, an evolving story casts the client as not only the star of the therapeutic stage, but also the director of the change process. We now consider our clients' world-views, their maps of the territory, as the determining "theory", directing both the destination desired and the routes of restoration (p.78).

In walk-in therapy, we invite clients to guide us in how to be most helpful to them. We do this by asking them what they want from the therapy process, their beliefs about the problem ("theory of the problem"), and their ideas about what would help ("theory of change"). Examples of questions might be:

- What will work for you *today*?
- Are there any questions that you wish to ask that I did not get to?
- For many people, a single-session with a therapist is sufficient to take action; what would be the smallest step that would tell you that you are headed in the right direction?

A mother and her 15-year-old son recently came for a walk-in session. The mother, convinced that her son had been unhappy since the parents' separation, explained that she had taken her son to numerous therapists, and he had not liked any of them. The son, who looked sullen and had not spoken until that point, said, "I liked one." He then spoke of how he had been helped by a therapist who told stories about the therapist's own family. The boy was invited to ask the therapist any questions he wanted, even if they were personal. The mother watched as the boy had an animated, though abstract, discussion with the therapist about family life. Mother and son left in much better spirits with the mother saying they would return, "If we need to."

Commendations: After taking an inter-session break, the therapist returns to share solution oriented ideas from the therapy team. Prior to offering solutions the therapist offers commendations from the team (McElheran & Harper-Jaques, 1994; Hougter Limacher, 2003). These are positive statements of what the team has noticed about the client/family. These commendations serve several purposes:

- They highlight strengths and resources that the client may not have noticed and thereby may point the way toward solutions.
- They positively surprise those clients who expect to be criticized for their missteps and mistakes.
- They relax clients, making them more receptive to the team's recommendations.

Case Example: *The Girl Who Cried*

This session took place at the Community Counseling Service (CCS) of Our Lady of the Lake University (Chapter 7). It is located in a low Socioeconomic Status (SES), largely Latino area of San Antonio, Texas. Clients are seen either by appointment or by walking in. The CCS provides training to masters and doctoral counseling psychology students. It utilizes a team format in which six graduate students work with a faculty supervisor. Ordinarily, two graduate students working as co-therapists interview the client(s) while the team and supervisor observe through closed circuit television. Part way through the session the therapists take a break and consult with the team. The therapists then return to the clients and provide feedback from the team.

In the transcript below, we (Arnie Slive and Monte Bobele) agreed to conduct the session as a demonstration for the students. Carmen and her daughter Julia, age 11, had scheduled this appointment a few days earlier. They are Mexican-Americans who lived within a couple of miles of the CCS. Although this was not a walk-in session, it serves to exemplify many of the principles of walk in therapy. For the purposes of this discussion about our walk-in model, the transcript is not chronological but is divided into key themes.

The transcript that follows, which has been edited to fit within the space confines of this chapter, uses pseudonyms for the clients.

PROBLEM DESCRIPTION

Monte: We have a piece of paper here that tells us just a little bit about why you called for an appointment, but we don't have a whole lot of information. Carmen: Uh-huh. Well, the reason is I've been having a little bit of problems with her as far as she gets very irritable. It's been going on for a while,

Appendix A

THE FORMAT OF A WALK-IN SESSION

Pre-session

Clients walk in and are asked to fill out an intake form. The team reviews the form, selects therapist(s), and makes a preliminary plan.

The 20- to 30-Minute Session

Introductory Comments: "Here are a few things to fill you in on how we work, and then we can go from there. We offer services as a walk-in clinic, kind of like a medical walk-in clinic where you can come back again any time, though you may not see the same person again. When we're finished, I'll do a short write-up of this session so, if you come back again, we will have a record of what happened when you were here before. Some people find this hour is enough for them and some may like a referral for further services, and we can talk about that at the end. (*Note: Mentioning that some clients find one session sufficient plants a seed that one hour can work for them.*) The way this works is that we will meet together for about 30 minutes. I have colleagues behind the mirror who may phone in with a question for me to ask you. After 30 minutes I'll take a break and consult with my colleagues. Then I'll come back and share our collective thoughts. This way you have the ideas of multiple professionals."

The therapist then explains confidentiality and its limits.

A possible first question: "What are you hoping for in coming here today?"

- Engage and listen.
- What do the clients want from today's session?
- Set small goals.
- Highlight strengths, resources, exceptions, and what's helped in the past
- Ask contextual questions such as: "why now?", "what makes this a problem?", "who is involved in the doing and maintaining of the problem?"

We don't:

- Invite lengthy discussions about the past,

- Encourage speculation about why the problem exists, underlying cause, pathology, or unconscious motivations,
- Assume that insight produces change.

We do:

- Get descriptions of the problem in the present,
- Assume that "the problem is the problem" as presented by the clients,
- Focus on the problem as an aspect of human interaction,
- Establish specific goals described in behavioural terms,
- Assume that doing something different leads to change.

Intersession

The team discusses how the conversation has gone so far and whether a strong therapeutic alliance is developing. They identify commendations and suggestions or ideas the therapists will share with the family. (Note: If no team is available, it is still recommended that the therapist take a "think" break.)

The 5- to 10-minute feedback to clients

- First, commend/compliment the clients based on the strengths and resources they described or you've observed.
- Second, ask if the session addressed what the clients wanted. This could involve simply asking if the clients had the opportunity they wanted to share their story. It could include a new way of thinking about the problem (a reframe). Or it could involve something new to try, to do, to experiment with as a first small step toward their goal.
- Third, discuss what's next for the client such as future walk-in sessions or a referral. Always invite clients to return for another walk-in session as needed.

The feedback part of the session should not be treated as the beginning of "Session 2."

The Team Debriefs**SAMPLE CLINICAL VIGNETTE****Context**

MHWI staff meets and they divide into three small groups for 20 minutes. They hear each other's conversations.

Vignette #1

A 12 year old comes to her school counselor. She talks about risk and family violence. (Please look at any previous vignettes and share these with the whole group.)

- See the 12 year old client's presentation during the intersession.
- The Shift Coordinator notes that the young person is to be returned back with her parents.
- Without the client's consent, share these vignettes before you meet with the client.

Vignette # 2

Sheila is 25. She presents with depression, loneliness and unfilled needs. She has a limited social network. The team really likes this client. She has lost her father. I just want to take her home. During the break the