

Single Session Interventions: An Example of Clinical Research in Practice

Alistair Campbell*

Single session consultations seem to be an efficient and effective way of providing therapeutic interventions at a time of increasing demands for services and shrinking resources. Though 'one-off' consultations have a long clinical history, specific interest in their use was sparked by Talmon's (1990) observation that 78% of his clients who had had only one consultation had experienced improvement in their presenting problems. Several Australian studies have supported Talmon's advocacy of this approach (Boyhan, 1996; Hampson, O'Hanlon, Pentony and Cramby, 1994; Price, 1994) but have significant methodological flaws. The present study used a pre-post methodology to assess the effectiveness of single session interventions and explored whether family dynamics impacted on changes in the presenting problem and in level of coping. The results indicated significant changes in both. Family pride or morale was identified as a major factor in positive response to the interventions. The implications for the use of single sessions and for further clinically based research are discussed.

INTRODUCTION

Increasing demands for services in the context of diminishing resources have required many agencies in Australia, and around the world, to look for ways of providing services in more efficient and effective ways. This provides a particular dilemma for mental health services because many psychological therapies maintain that a long-term commitment of client and therapist time is necessary for 'true' change. Yet the history of therapy is replete with anecdotal examples of 'one off' interventions leading to significant change (Bloom, 1981). Talmon (1990) foregrounded this issue when he began to investigate what happened to clients who attended for only one session. Traditionally therapists tend to consider failure to attend after the first session as a sign that the therapy has not worked but Talmon found that 78% of his clients were satisfied after one session and reported improvement in their presenting problem.

Single session therapy is not a particular intervention in itself. (However, it is known conventionally as 'single session intervention' and so, confusingly, I shall be using the term 'intervention' passim.) Rather it is a different outlook on what therapy is. The whole field of brief therapy challenges many of the assumptions of traditional therapies. These tend to locate responsibility for change in the expertise of the therapist and conceptualise change as a long-term and difficult business. Such therapies are often disempowering of clients and seek to 'correct' the 'errors' in the client's personality structure or world view. By way of

contrast, single session therapy considers that change is an inevitable process in life and that clients often need the support and assistance of therapists only for brief periods, to enable them to utilise their own resources to solve their problems (Watzlawick, Weakland and Fisch, 1974).

The practice of single session intervention involves an 'open door' approach to clients' presentations. It is accepted that people may need to have a number of brief but repeated contacts with a service at times in their lives when they are 'stuck' or 'off track'. Clients are encouraged to come in for a consultation when they feel they need it and not to expect that their problem will need lengthy and extensive analysis. This approach assumes that clients have the capacity to solve their own problems. It also assumes that clients know what they need, and encourages them to focus on what they can take away from a session that is going to be most helpful.

This approach is very focused and requires the therapist to be active in identifying the specific problem, exploring the clients' attempted solutions, looking at blocks to these solutions, identifying resources available to the client, and encouraging the client to develop a 'new' approach. Often intervention may be as simple as offering advice to the client, reframing the problem, or normalising what the client perceives as abnormal or unusual.

Obviously this type of approach is neither for every client nor for every problem. Most people using this approach suggest that it is most likely to be useful where the client has a specific problem and access to good supports. Hoyt, Rosenbaum and Talmon (1992) suggest that it is not useful for clients who are acutely psychotic or suicidal, or where the client has a long standing and major mental illness. Those in the child and adolescent field (Boyhan, 1996) also suggest that this approach is not appropriate

* Senior Clinical Psychologist and Manager, Oakrise, CAMHS, 3 Kelham St, Launceston, Tasmania. 7250; Alistair.Campbell@utas.edu.au

where there are issues of ongoing child abuse or family violence. Single session interventions may indeed be useful for assisting people to cope with the effects of distressing and traumatic events in their lives. They are not seen as ways to 'solve' deeply disturbed behaviour nor to deal with situations where there are significant power imbalances, but can be useful in supporting people who are suffering.

Centres using single session interventions report that they have been applied to a very wide range of presenting problems, some of which are quite serious. Boyhan (1996), for instance, reports using the single session approach with cases involving domestic violence, grief and loss, parent-child conflict, blended family conflict, and drug and alcohol problems. Hampson, Franklin, Pentony, Fridgant and Heins (in this issue) have identified that single session interventions are most appropriate with problems of 'mild' severity.

THE EFFECTIVENESS OF SINGLE SESSION INTERVENTIONS

Talmon (1990) has conducted a number of studies of single session interventions with adult psychiatric clients. In addition, there are other reports of research into the use of single consultations to reduce utilisation of medical services (Cummings, 1977), in the treatment of alcohol dependency (Edwards, Orford, Egert, Guthrie, Hawker, Hensman, Mitcheson, Oppenheimer and Taylor, 1977), and following one-off crisis interviews (Getz, Fujita and Allen, 1975). Generally this research suggests that single consultations can be very effective.

In the 1990s several Australian family focused centres began to utilise single session interventions as a way of providing a service to clients in the face of waiting list blow outs and decreased therapeutic resources. So far there have been four studies into whether this method of providing a service can lead to effective changes for clients. The most extensive of these is a review of five years of single session work by the ACT CAMHS team (Hampson et al., 1999). Prior to this the Bouverie Family Therapy Centre (Boyhan, 1996) used a survey style methodology to follow up 36 clients and found that 78% of these reported that the presenting problem was 'much improved' or 'a little better'. Price (1994) using a similar methodology reported that 63% of their single session clients claimed that the problem was 'much better' or 'a little better'. A previous study by the ACT CAMHS reported that 64% of their clients said that the problem was 'improved' (Hampson et al., 1994).

On the whole these results are encouraging. However, the studies that have been reported have several problems that prevent them from conclusively demonstrating the case for the efficiency and effectiveness of single session interventions. All of the studies cited use a survey type of methodology. They rely on clients' post-hoc reports of improvement following involvement in single sessions. This type of methodology is empirically little better than anecdotal reports in terms of the threats to the validity of the data (Cook and Campbell, 1979). Another difficulty

is that they use no specific measures of the presenting problem and it is impossible to evaluate whether clients' reports of change are just reflections of satisfaction with the service. In addition none of the studies included comparison groups to see whether the reported change after a single session is particular to that intervention.

Another deficiency in previous research is that it has not addressed what factors might impact on the effectiveness of single session interventions. There is evidence that more functional families do better with brief interventions than less functional families (Hampson and Beaver, 1996), but this factor has not been taken into account in the research to date. More generally there is increasing evidence that a major factor in therapeutic improvement is the client's level of morale or hope (Schwartz, 1997). It seems likely that the effectiveness of single sessions will depend on the family's level of morale prior to their involvement in the therapy.

Research in clinical settings is notoriously difficult and it is not surprising that these studies have tended to use methods that allow for the most resource-effective way of gathering evidence. But, if single session interventions are to be promoted as the best way to provide services to our clients, we must be as certain as possible that what we are offering actually works. There is an increasing demand that clinicians should use evidence based interventions (Davis and Spurr, 1998; Knapp, 1997; Schwartz, 1997). This necessarily requires clinicians to begin to assess their practice empirically. The question to be answered is whether it is possible to conduct valid research in clinical settings in an efficient way. I would argue that many of the procedures in clinics allow for the use of empirical methodologies such as pre and post assessment of variables, waiting list controls, and long-term follow-up. The challenge for clinicians is to extend their practice to include these methodologies and to develop valid and efficient outcome measures.

If the research is too rigorous we risk losing our intuitive sense of the 'flavour' of the clients and end up not being able to say anything interesting—particularly to clinicians. However, if there is not sufficient rigour, anything that we might be able to say is lost in disputes about the validity, reliability, and credibility of the data.

The present research seems to me to have straddled the divide between the clinical and the empirical positions adequately enough. But, there are some clear lessons to be learned from having done this which I will cover in more detail in the conclusion.

METHOD

Oakrise has been offering a single session interview for clients since early in 1996. When clients contact the service they are offered such an appointment, if appropriate, after a telephone screening interview. The criteria used by Oakrise are generally very broad and focus on exclusion of high risk clinical cases. If the problem appears to involve long-term issues such as psychosis, immediate suicidality, family violence, or ongoing abuse, the families are not offered a single session. If they are offered the

single interview, then the whole family is invited to the appointment which is conducted by one therapist and one consultant (our team members rotated these tasks) over a 90 minute period.

The single session interventions at Oakrise follow a relatively structured format. The consultant may be in the room with the family or may observe through a one way screen. The therapist conducts the interview. The session follows a problem focused model. The therapist concentrates on what has brought the family to Oakrise and establishes as clear a picture of the presenting problem as possible from each family member's point of view. When there is some consensus about what problem the family are wanting to work on, the therapist then investigates previous attempts by the family to solve the problem, getting a detailed picture of what has worked and what hasn't. If previous solutions were working, why are they not working now? And if an attempted solution didn't work, why does the family think it did not?

Following this, the therapist investigates the constraints on the family in an attempt to identify what interventions might 'fit'. These constraints would include the family's understanding of why the problem is there, the family's perception of what solutions are 'acceptable', and the family's access to resources and supports in being able to deal with the problem. The therapist then takes a break from the family and talks with the consultant to formulate a hypothesis and explore intervention messages. Once an intervention is decided, the therapist returns to the family and delivers the message. Some time is then allowed for the family to give feedback to the therapist about the intervention, following which the therapist and family decide what to do next.

From February to June 1998, all clients who were assigned to a single session appointment were asked to fill in three instruments prior to their appointment. The instruments were: the Problem Evaluation Summary (PES), a measure of the presenting problem and coping; the Self-Report Family Inventory (FACES III) and the Family Pride Inventory, both developed by Olson, McCubbin, Barnes, Larsen, Muxen and Wilson (1982).

Following the single session appointment, clients were phoned after six weeks and asked to complete the Problem Evaluation Summary over the phone. If the

clients were satisfied with the outcome, no further follow-up occurred. If the clients continued to have problems they were offered further services from Oakrise. The clients were generally spoken to by the consultant, though frequently the therapist involved would phone. The questions were described as part of our procedure to help the family decide whether they might like to talk to us again. Obviously, this was not ideal in terms of guarding against clients reporting what they thought the therapist wanted to hear. However, the general impression of the therapists involved was that clients honestly stated what was going on for them. Part of this may have been due to the straightforward and behavioural nature of the questions in the PES. This procedure enabled us to assess the clients' report of the problem before and after the single session and to explore the impact of family functioning on response to the single session.

MEASURES

The Problem Evaluation Survey

This was a measure developed locally specifically for this research: the therapists at Oakrise generated a range of questions about problem and coping, and these items were then sorted through to identify common elements, and eliminate or blend similar questions. The aim was to develop a simple set of questions that quickly and accurately captured behavioural aspects of problems and people's sense of coping with them.

The result is a seven item questionnaire (see Appendix 1) that asks clients to rate the frequency of the problem, its intensity, the level of disruption it causes, the degree of distress experienced, how much control the clients feel they have, their confidence in being able to deal with the problem, and their level of understanding about it. The scoring is quite simple, as clients rate each question using tick-boxes ranging from 'No Problem' to 'Severe', and the administration of the measure takes no more than five minutes. The PES has a high degree of content validity. A correlation analysis of the clients' pre-intervention responses suggested that we had achieved the structure that we were trying for insofar as there were significant positive correlations between all of the problem items and significant positive correlations between all of

Table 1. Intercorrelation of items on the Problem Evaluation Survey (N = 44)

	Intensity	Disruption	Distress	Control	Confidence	Understanding
Frequency	0.67*	0.50*	0.50*	-0.11	-0.21	0.03
Intensity		0.58*	0.60*	-0.17	-0.28**	0.01
Disruption			0.60*	-0.19	-0.23	0.18
Distress				-0.27**	-0.22	0.15
Control					0.61*	0.34*
Confidence						0.41*

*p < 0.005, **p < 0.05

the coping items, but minimal or negative correlations between the problem and coping items.

On the basis of these results the PES was scored to yield two summary scores. The Problem Score is the sum of the frequency, intensity, disruption, and distress items, which leads to a possible range of 0–17. The Coping Score is the sum of the control, confidence, and understanding items, which leads to a possible range of 0–12. There was no significant correlation between these summary measures ($r(44) = -0.14, ns$) which further supports the construct validity of the PES as measuring two independent aspects of the problem situation.

FACES III

This is a measure based on Olson, Portner and Lavee's (1985) circumplex model of family functioning (Figure 1). It assesses families on two dimensions. The first is Cohesion and is defined as the emotional bonding that family members have with one another. Cohesion is conceptualised as ranging from loose involvement to over involvement. The second dimension is Adaptability and is defined as the ability of a family system to change its power structure and relationships in response to stress. Adaptability ranges from chaotic to rigid.

Olson et al. (1982) report Cronbach Alpha to be 0.77 for Cohesion and 0.62 for Adaptability. Test–retest reliability

is reported as 0.83 for Adaptability and 0.80 for Cohesion. These are quite acceptable figures and suggest a relatively robust measure with adequate content validity.

As can be seen from Figure 1, it is possible to classify families into sixteen categories or types based on their levels of both Adaptability and Cohesion. Because of the relatively small number of families involved in this study it was decided to use only the very broad categories of Balanced, Mid-range, and Extreme, by using the curvilinear transformation recommended by Olson et al. (1982)¹ to create a single score for each family and then applying the cut-offs suggested to classify families into one of the three groups.

Family Pride

This is another measure developed by Olson et al. (1982) and essentially assesses a family's sense of pride in itself, belief in its ability to solve problems, and its sense of whether there are many problems in the family. Olson et al. (1982) report a Cronbach Alpha of 0.83 for the total measure and a test–retest reliability of 0.69. Again this is a fairly reasonable measure with adequate reliability and content validity. On this measure the total group was divided into two by classifying the responses as either average to below average, or above average. This was done on the pragmatic grounds of which sorting procedure led to similar numbers in each group.

**FIGURE 1 REMOVED.
UNABLE TO OBTAIN COPYRIGHT PERMISSION**

Figure 1. Olson's (1985) Circumplex Model of Family Functioning

Research Questions

There are essentially two questions that can be explored within our chosen methodology.

1. *Are there changes in the reported nature of problems and sense of coping following single session interventions?* Our expectation was that the answer to this would be 'yes' and that we would see significant decreases in Problem scores and significant increases in Coping scores.

2. *Will the nature of the family functioning have an impact on its response to single session interventions?* This question was more exploratory, although previous research in this area would suggest that better functioning families may be able to take more from a single session than less functional families (Hampson et al., 1996); there has been no research specifically directed to this question. However, our belief was that family functioning would definitely have some impact.

RESULTS²

The data were analysed using Ecstatic for Windows (Chalmer and Chalmer, 1996) which is a small but versatile statistics package providing Analysis of Variance for Repeated Measures. Because of the repeated measures design of this clinical outcome research, this package was our preferred tool for this data analysis.

Forty-four clients completed the initial evaluation of problem and family structure and 33 were able to be followed up by phone. Because of failures to complete all of the questionnaires, some clients could not be categorised in terms of Family Structure or Family Pride. At the initial evaluation, 38 of the clients were assigned to the various family functioning categories: Balanced (19), Mid-range (10) and Extreme (9). Twenty-nine of these clients were available for follow-up: Balanced (15), Mid-range (7) and Extreme (7). Thirty six clients were initially assigned to the Family Pride categories Low-average (21) and High (15), and 27 were available for follow-up: Low-average (16) and High (11). In hindsight, we regret that we did not keep accurate records of whether clients asked for further sessions, but clearly, these were in a minority.

Overall Problem and Coping Scores

Thirty-three clients completed Problem ratings of the presenting issue both before and after the single session intervention (see Table 2). Prior to the single session the mean problem rating was 12.48 (sd = 4.20). At the follow-up phone call the mean problem rating was 8.21 (sd = 5.04). The difference in problem ratings was 4.27 (sd = 4.45).

A paired samples t-test showed that this was a significant decline in the degree of disturbance for the presenting problem ($t(32) = 5.512, p < 0.0005$).

Thirty-two clients rated their degree of coping with the presenting issue on the PES both before and after the intervention (see Table 2). Prior to the single session the mean Coping score was 4.87 (sd = 2.46). Following the intervention the mean Coping score was 7.75

Table 2. Means and Standard Deviations for Problem and Coping Ratings on the PES before and after intervention

	Problem Rating (PES)			Coping Rating (PES)		
	Pre	Post	Difference	Pre	Post	Difference
N	33	33	33	32	32	32
Mean	12.48	8.21	4.27	4.87	7.75	-2.87
SD	4.20	5.04	4.45	2.46	3.30	4.29

(sd = 3.30). There was an increase in Coping score of 2.87 (sd = 4.29). A paired samples t-test indicated that this was a significant increase ($t(31) = -3.79, p < 0.0005$).

These results can be seen quite clearly when they are graphed (Figure 2). For ease of presentation both the Problem and Coping scores have been shown on the same graph but it should be remembered that the range of the two scales is different. The upper range of the Problem scores is 17 whilst the upper range for the Coping scores is 12.

This graph quite neatly demonstrates that clients experienced significant overall gains from the single session intervention both in the degree to which their issue was felt as a problem and in their own sense of being able to cope with it.

Family Type

Problem scores on the PES by family type

The clients were classified, by virtue of their scores on the FACES III prior to the single session, into three broad family 'types'. As can be seen from Table 3, not all clients could be classified nor were all those who were classified able to be followed up. The small and unequal number of clients in each cell poses a problem for statistical analysis because of the possible violation of the homogeneity of variances between cells. However, post-hoc comparisons of the equality of variance (F-test) between cells produced no significant values.

The data was analysed using a repeated measures ANOVA to compare effects of the different family structures on response to the single session intervention. There were significant reductions in the problem scores for all family types ($F(1/25) = 29.05, p < 0.005$) but there was no significant interaction between family type and response to the intervention ($F(2/25) = 0.89, ns$) and no

Table 3. Problem Scores for different Family Types

	Pre-Intervention			Post-Intervention		
	Mean	SD	N	Mean	SD	N
Balanced	12.32	4.26	19	8.71	5.06	14
Mid-Range	12.70	3.33	10	6.14	6.39	7
Extreme	13.11	2.98	9	10.00	3.92	7

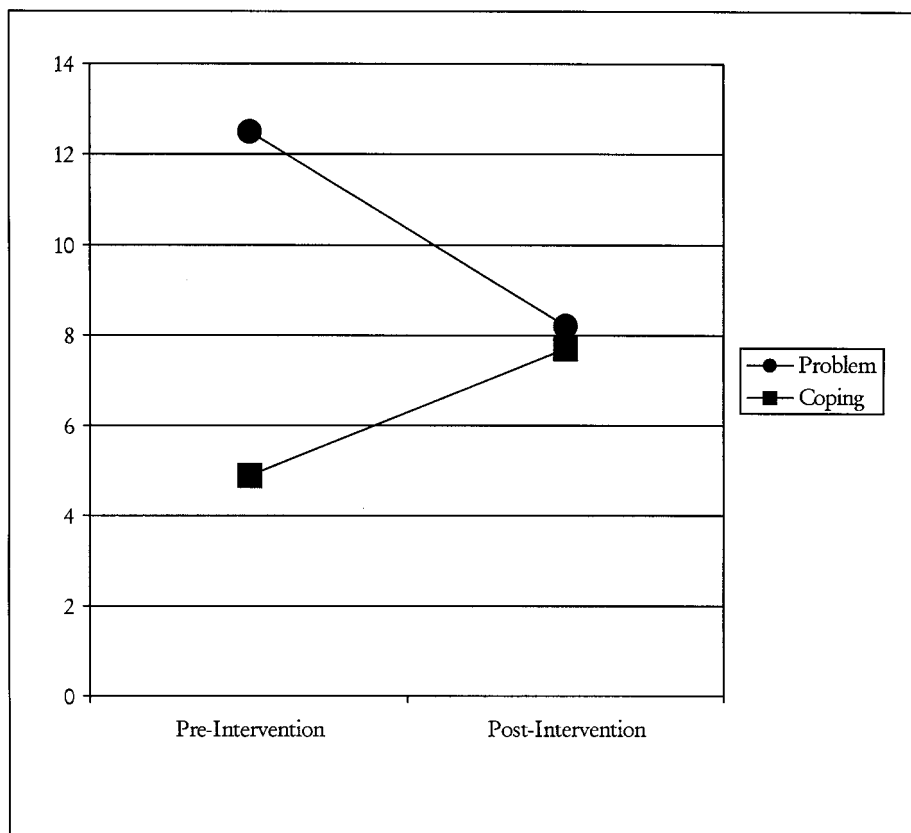


Figure 2. Problem and Coping Scores on the PES before and after the Single Session Intervention

significant effect for family type on its own ($F(2/25) = 0.64$, ns).

Post-hoc analyses showed that there were no significant differences between the mean Problem scores for the different Family Types before (Balanced vs Mid-range, Mean Difference = -0.38 , $t(27) = -0.25$, ns; Balanced vs Extreme, Mean Difference = -0.79 , $t(26) = -0.50$, ns; Mid-range vs Extreme, Mean Difference = -0.41 , $t(17) = -0.28$, ns) or after (Balanced vs Mid-range, Mean Difference = 2.57 , $t(19) = 1.00$, ns; Balanced vs Extreme, Mean Difference = -1.29 , $t(19) = -0.59$, ns; Mid-range vs Extreme, Mean Difference = -3.86 , $t(12) = -1.36$, ns) the single session intervention.

The graph of these results (Figure 3) shows the effect most clearly: a clear decline in the Problem scores for all the groups (Balanced [Pre-Post] = 4.29 , $t(13) = 3.53$, $p < 0.005$; Mid-range [Pre-Post] = 6.71 , $t(6) = 3.45$, $p < 0.05$; Extreme [Pre-Post] = 3.71 , $t(6) = 2.49$, $p < 0.05$) and although, by inspection, it appears that the Mid-range families have a greater decline in problem scores, the differences are obviously not significant.

Coping scores on the PES by family type

As with the Problem ratings, there is an uneven distribution of clients within the various conditions on the Coping scores (Table 4). Post-hoc comparison of the

equality of variance between the Balanced and Mid-range groups following the intervention indicated that the variances were not homogenous ($F(13/6) = 11.62$, $p < 0.05$); between the Extreme and Mid-range groups following the intervention the comparison approaches significance ($F(5/6) = 4.79$, $p < 0.1$). All other comparisons were not significant. These results suggest that comparisons of the Mid-range group after the intervention must be approached cautiously.

A repeated measures ANOVA was used to compare effects of different family structures on response to the intervention. There were significant increases in the Coping scores for all family types ($F(2/24) = 12.07$, $p < 0.005$) but there was no significant interaction between family type and response to the intervention ($F(2/24) = 0.65$, ns). The effect of family type by itself approached significance ($F(2/24) = 2.90$, $p < 0.1$).

Post-hoc analyses showed that there were no significant differences between the mean Coping scores for the different family types before the single session intervention (Balanced vs Mid-range, Mean Difference = -0.52 , $t(27) = -0.58$, ns; Balanced vs Extreme, Mean Difference = 0.02 , $t(26) = 0.02$, ns; Mid-range vs Extreme, Mean Difference = 0.54 , $t(17) = 0.50$, ns) or after the single session intervention (Balanced vs Mid-range, Mean Difference = -2.93 , $t(19) = -1.81$, ns; Balanced vs Extreme, Mean

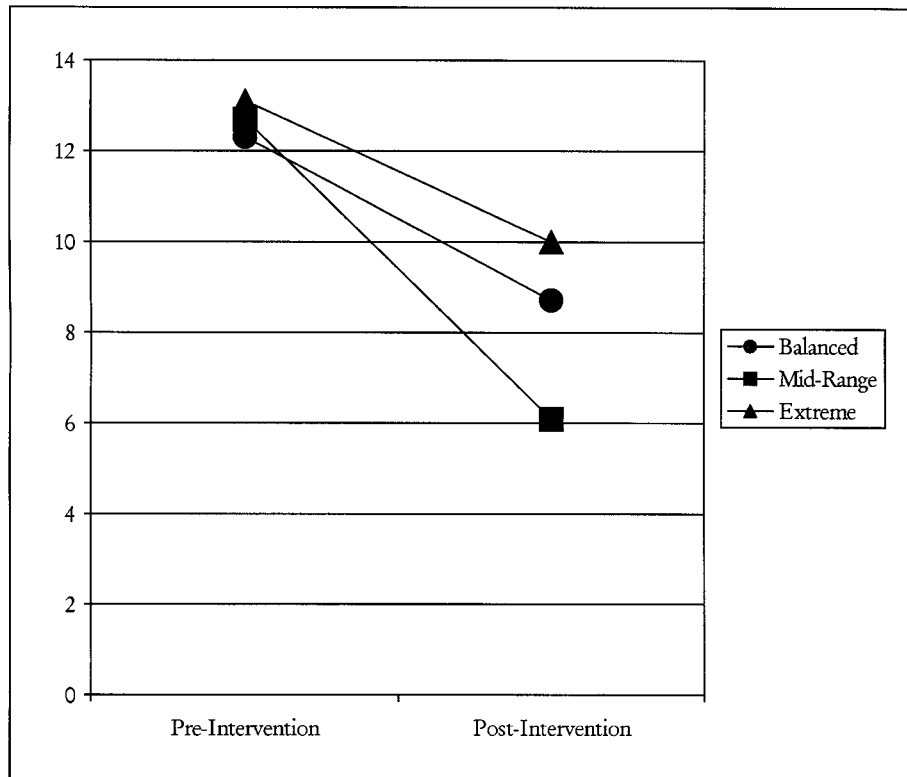


Figure 3. Problem Scores for different Family Types before and after the Single Session Intervention

Table 4. Coping Scores for different Family Types

	Pre-Intervention			Post-Intervention		
	Mean	SD	N	Mean	SD	N
Balanced	4.58	2.48	19	6.93	4.14	14
Mid-Range	5.10	1.91	10	9.86	1.21	7
Extreme	4.56	2.79	9	6.67	2.66	6

Difference = 0.26, $t(18) = 0.14$, ns), except for the comparison of the Mid-range and the Extreme groups following the intervention (Mid-range vs Extreme, Mean Difference = 3.19, $t(11) = 2.86$, $p < 0.05$). However, this last comparison must be dealt with cautiously because of the very small numbers involved.

Inspection of the graph (Figure 4) of these results makes the above comparisons clear. Coping scores appear to increase across all the groups following the single session intervention. However, there is a significant increase in coping for Mid-range families (Mid-range [Pre-Post] = -4.57, $t(6) = -5.43$, $p < 0.001$) whilst the changes in the Balanced families approach significance (Balanced [Pre-Post] = -2.43, $t(13) = -1.79$, $p < 0.1$) and the difference in the Extreme group is not significant (Extreme

[Pre-Post] = -2.33, $t(5) = -1.34$, ns). In general, these results need to be treated with some caution because of the low number of families in the Extreme and Mid-range groups and because of the lack of homogeneity of variance between the Mid-range and the other two groups.

Overall, there is no clearly independent effect of family type on response to the single session intervention. Following the intervention, all the groups show significant decreases in problem ratings. Those families in the Mid-range group appear to have better levels of coping following the intervention compared to those families in the Balanced and Extreme groups, but the small sample size suggests that this generalisation can be only tentatively supported.

Family Pride

Problem scores on the PES by family pride

Thirty-six families could be classified on the Family Pride measure prior to the intervention and 27 of these were available for follow-up. Because of the less complex distinction, the groups are of a more robust size (Table 5). Fifteen families were classified as falling into the high pride category, of whom eleven were available for follow-up and 21 families fell into the low pride category, of whom sixteen were available for follow-up. Post-hoc analysis demonstrated that the groups were homogenous

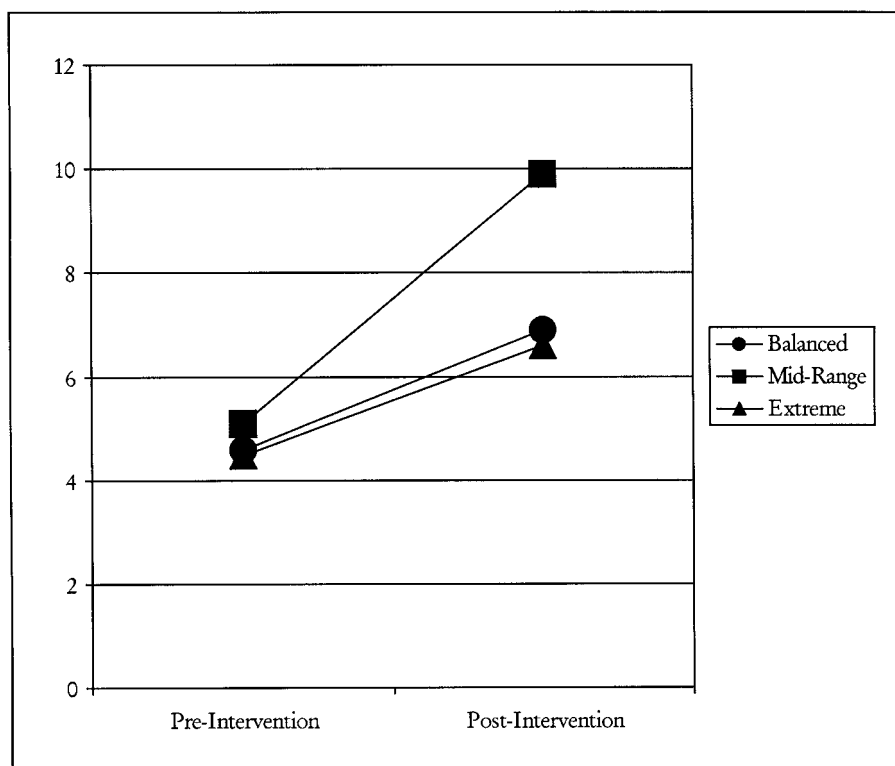


Figure 4. Coping Scores on the PES before and after the single session intervention for different family types

in their variance which enables comparisons between the groups to be undertaken with some confidence.

Table 5. Problem scores before and after the single session for different pride categories

	Pre-Intervention			Post-Intervention		
	Mean	SD	N	Mean	SD	N
High	11.57	3.42	15	4.00	3.55	11
Low	13.48	3.54	21	10.87	3.77	16

A repeated measure ANOVA indicated that there was a main effect for the pride category ($F(1/25) = 15.96$, $p < 0.005$), a main effect for the intervention ($F(1/25) = 45.42$, $p < 0.005$) and a significant interaction effect of level of family pride and response to the intervention ($F(1/25) = 7.79$, $p < 0.05$). Post-hoc analyses indicated that there was no significant difference between the problem scores for the two groups before the intervention (Mean Difference = 2.01, $t(34) = 1.70$, ns) but that following the intervention there was a significant decrease in problem scores for the high pride group compared to the low pride group (Mean Difference = -6.87, $t(25) = -4.76$, $p < 0.005$).

It is quite clear from looking at the results (Figure 5) that those families with high levels of pride show significant decreases in problem ratings following the intervention (High[Pre-Post] = 7.54, $t(10) = 6.28$, $p < 0.005$) and so do those with low levels of pride (Low[Pre-Post] = 3.12, $t(15) = 3.06$, $p < 0.05$) but there is clearly a bigger impact for those families with higher levels of pride.

Coping scores on the PES by family pride

As with the Problem scores, there were thirty six families who could be classified as falling into higher or lower levels of pride. Of the fifteen in the high group, ten were available for follow-up and of the 21 in the lower group, sixteen. Post-hoc analysis comparing the group variances indicated that they were homogeneous.

A repeated measures ANOVA identified that there was no significant main effect for the pride category ($F(1/24) = 2.54$, ns) nor was there a significant interaction between the pride category and the response to the intervention ($F(1/24) = 0.69$, ns). However, there was a significant response to the intervention regardless of pride category ($F(1/24) = 11.54$, $p < 0.005$).

Figure 6 reveals that both groups have shown increases in their Coping scores following the single session. For the families in the high pride category, this is a significant difference (High[Pre-Post] = -3.60, $t(9) = -3.09$, $P < 0.05$) whilst for those in the low category the difference approaches significance (Low[Pre-Post] = -2.19, $t(15) = -1.94$, $p < 0.1$).

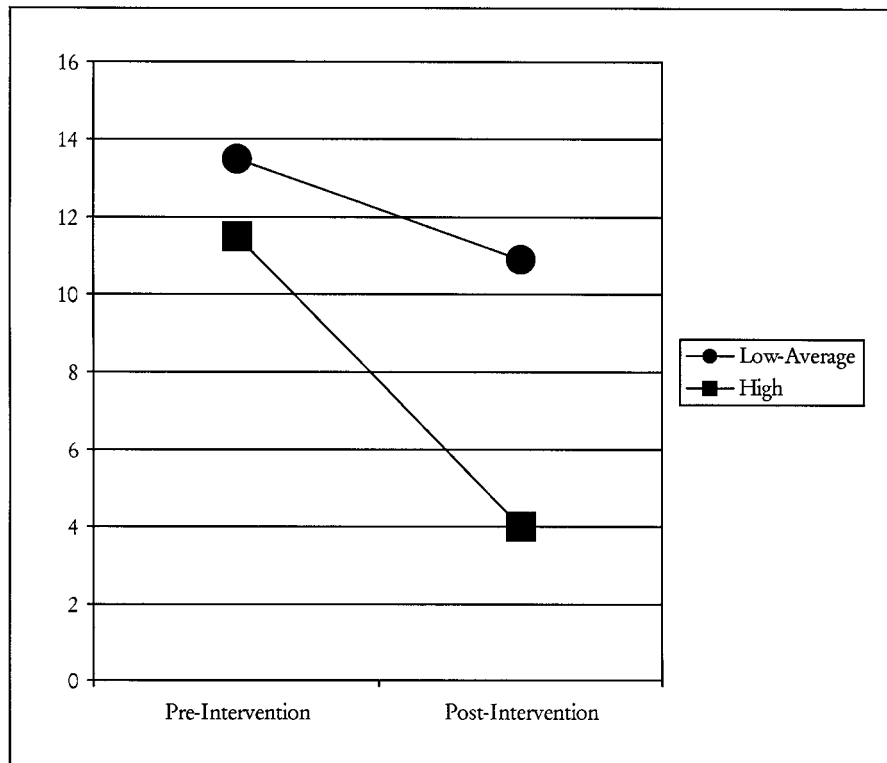


Figure 5. Problem Scores on the PES before and after the single session intervention for different levels of family pride

Table 6. Coping scores before and after the single session for different pride categories

	Pre-Intervention			Post-Intervention		
	Mean	SD	N	Mean	SD	N
High	4.80	2.37	15	8.70	3.80	10
Low	4.76	2.47	21	6.75	3.15	16

On the basis of these comparisons it would appear that the single session has a greater impact on coping scores for those families with higher levels of pride than for those with lower levels.

Overall, there is a clear difference in response to the single session between families on the basis of their scores on the Pride variable. Those families who had higher scores than average showed significantly greater decreases in their Problem scores and marginally greater increases in their Coping scores.

Summary of Results

This analysis of the data indicates that the response for the group as a whole to the single session intervention

is significant reductions on the Problem measure and significant increases on the Coping measure for the group. Those families who scored higher on the Pride measure showed significantly more reduction in Problem score and significantly more increase in the Coping score than those families who scored in the average to low range. The effect of the intervention on families grouped according to the Family Type measure was not as straightforward. There was no significant difference on the change in Problem scores between the different family types. However, there did appear to be a significantly greater increase in coping for those families categorised as Mid-range compared to those families categorised as either Balanced or Extreme. The small number of families in the Mid-range and Extreme categories makes this result questionable.

DISCUSSION

Single session interventions are a promising way of helping clients in a climate of shrinking resources and increasing demand. The risk of initiating such interventions as a way of coping with high service demand is that the single session intervention becomes recommended because it deals with the resource problem, rather than because it has proven to be effective. Previous Australian research in this area has been empirically flawed and

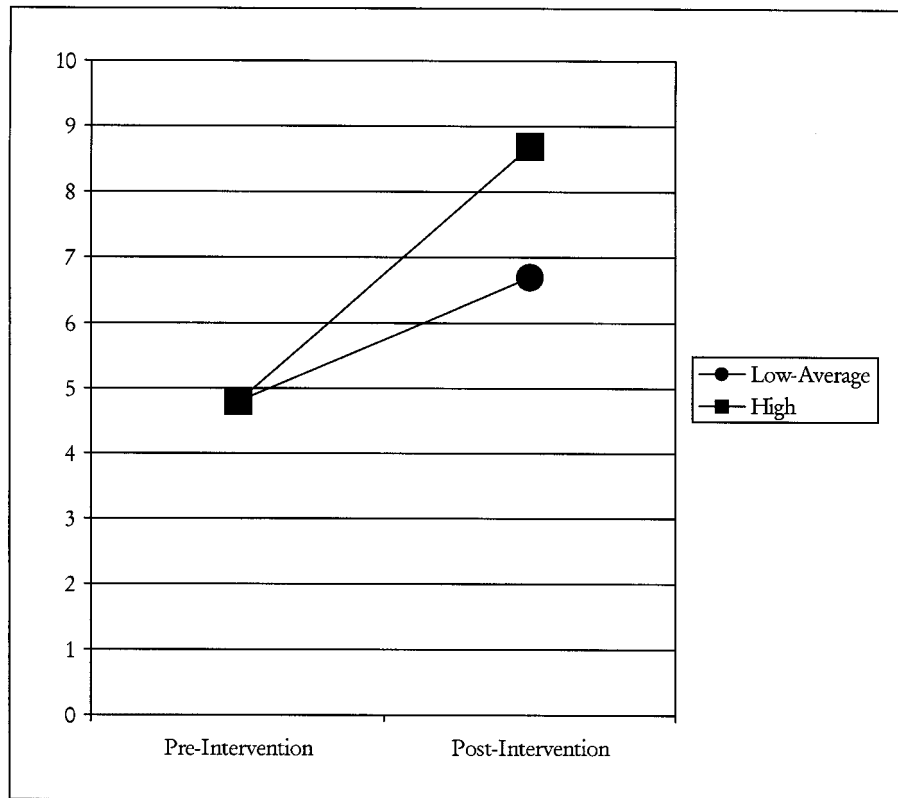


Figure 6. Coping Scores on the PES before and after the single session intervention for different levels of family pride

provides only partial support for the use of single session interventions. In addition, there is evidence that some types of family require longer term interventions (Hampson et al., 1996) but the effect of this variable on response to single session interventions has not been assessed.

Our results strongly support the hypothesis that single session interventions can be very effective at reducing the presenting problem and at increasing the sense of coping. Family type did not have any particular effect on responses to the single session intervention, though families with moderately disturbed functioning seemed to improve in their sense of coping following the single session.

It is difficult to make much of the data in relation to family structure because of the small sample sizes. Nevertheless, it seems likely that family functioning and structure would have some impact on the response of families to any form of therapeutic intervention. The results here suggest some form of 'ceiling' and 'floor' effect. It may be that for well functioning families the impact of a single session is minimal simply because they are basically coping well anyway. By contrast, for very poorly functioning families a single session has minimal impact because the problems are simply too overwhelming. This is obviously very speculative and goes beyond the data presented. What can be said most clearly is that family functioning is very probably an important variable to be considered in

relation to response to single session interventions and that further research using larger sample sizes would be valuable.

The most striking result of our study was that families with high levels of pride prior to the intervention showed very large reductions in the presenting problem compared to those families with average to lower levels. The same group showed slightly greater increases in their reported coping with the problem. This result led to much speculation in our team. It was our sense that the measure of 'pride' was tapping the family's sense of morale in relation to both the presenting problem and general problems of living. Our speculation was based on our sense of which families were scoring high and which were scoring low. If the measure is tapping morale then it makes sense of the different responses to the single session interventions. Those families that felt hope and had energy to apply to the problem would have had a lower threshold for new information. It wouldn't take much for them to 'see' and 'hear' new ideas and solutions. By contrast, those families with less hope and less energy probably had higher thresholds for new information and the single session would not have been sufficient to get over that threshold.

It would be useful from this to start to think about how we assess levels of hope, morale, and energy in families.

In a clinical setting it is something that you can often 'feel' intuitively. Trying to capture the elements of that intuition is obviously quite difficult but could be profitable in beginning to identify what types and levels of intervention may be most effective with different families.

Another implication of this research is that it would be useful to be able to identify those families with low morale so that we could explore ways to improve morale prior to specific interventions, in order to optimise their effects. I would suspect that sometimes when we 'fail' in our work with families it may be because we have not paid enough attention to the issue of 'readiness' and morale. That is, can this family or individual hear what I am saying? Or, do these clients need something else before I try and help them work on the problem?

There are a number of obvious methodological problems with the research that has been described. There was no use of a comparison or control group, so it is difficult to say whether this effect is specific to single session interventions. Further, there was no analysis of the types of presenting problems to see whether different problems responded differentially to the intervention. However, the fact that the intervention was extremely brief in conventional terms and that the follow-up occurred fairly close in time to the intervention adds weight to the argument that the changes identified were due to the intervention itself and not simply to maturation. This argument is further supported by the fact that there was a differential response to the intervention depending on the level of family pride.

Research in clinical situations can probably never aspire to the empirical clarity of experimental settings but this project clearly shows that it is possible to do valid research in this area with few extra demands on clinicians' time. The process of measuring was largely included as part of the family's contact with our service and really only involved therapists in filling out a simple form at the end of the follow-up telephone call. Generally, we were aware that we were doing 'something different' and this was unsettling, but I imagine that if this were to become part of our general practice, we would quickly become used to it. Probably the most difficult part of fitting a research perspective into the practice of the clinic was devising a system for data tracking and capture. What we ended up doing was relatively ad-hoc and paper based and, ultimately, not supportable in an ongoing way. In the future we hope to be using a computer based information management system. If this happens, we plan to improve the research design to include comparison groups and an assessment of additional variables.

A more general issue is whether the process has captured something of the clinical reality. Has the research actually assessed the family's and the therapist's experiences? Do the results make clinical sense? And do the results have applications in the clinical setting? My feeling is that we have assessed the process of our single sessions in a way that preserves the clinical reality of the family's presentations to us. The research measures and process did not take away from the family's reality for the therapist, but

added another layer. The feeling was that the research happened in the background and did not intrude into, nor dominate, the clinical framework. From our point of view, as therapists, this was the correct balance.

The findings also had an immediate impact on us insofar as they confirmed our feeling that the single sessions were useful to people. We were struck by the impact of family pride, and this led us to thinking more deeply about the issues of how families were feeling about the presenting problem and their capacity to grapple with it. Our hope is that this research will stimulate others, as well as ourselves, to begin thinking about and examining the issue of morale in relation to a family's ability to begin untangling problems for themselves.

Finally, we hope that there are other clinical teams that can be encouraged by our experience to own the process of data collection and analysis, in order to be able to critically review clinical practice. The danger in the concept of 'evidence-based practice' lies in the crucial questions of who collects the evidence, on whose practice, and for what purpose. I would argue that it is important that clinicians begin to participate in researching their practice so that they can be involved in the politics of selecting the appropriate and meaningful questions to be asked. Our experience is that conducting this research can be relatively simple, confirmatory of our clinical beliefs and, at the same time, clinically challenging.

References

- Bloom, B. I., 1981. Focused Single-session Therapy: Initial Development and Evaluation. In S. H. Budman, (Ed.), *Forms of Brief Therapy*, NY, Guilford.
- Boyhan, P. A., 1996. Clients' Perceptions of Single Session Consultations as an Option to Waiting for Family Therapy, *ANZJFT*, 17, 2: 85-96.
- Chalmer, B. and Chalmer, M., 1996. *Ecstatic for Windows*, Bennington, Vermont.
- Cook, T. D. and Campbell, D. T., 1979. *Quasi-experimentation: Design and Analysis Issues for Field Settings*, Boston, Houghton Mifflin.
- Cummings, N. A., 1977. The Anatomy of Psychotherapy under National Health Insurance, *American Psychologist*, 32: 711-718.
- Davis, H. and Spurr, P., 1998. Parent Counselling: An Evaluation of a Community Child Mental Health Service, *Journal of Child Psychology and Psychiatry*, 39, 3: 365-376.
- Edwards, G., Orford, J., Egert, S., Guthrie, S., Hawker, A., Hensman, C., Mitcheson, M., Oppenheimer, E. and Taylor, C., 1977. Alcoholism: A Controlled Trial of 'Treatment' and 'Advice', *Journal of Studies on Alcohol*, 38: 1004-1031.
- Getz, W. L., Fujita, B. N. and Allen, D., 1975. The Use of Paraprofessionals in Crisis Intervention: Evaluation of an Innovative Program, *American Journal of Community Psychology*, 3: 135-144.
- Hampson, R., O'Hanlon, J., Franklin, A., Pentony, M., Fridgant, L. and Heins, T., 1999. The Place of Single Session Family Consultations: Five Years' Experience in Canberra, *ANZJFT*, 20, 4: 195-200.
- Hampson, R., O'Hanlon, J., Pentony, M. and Cramby, A., 1994. Weekly Open Days: Single Sessions in a Child and Adolescent Service. Draft paper, Canberra (unpublished).
- Hampson, R. B. and Beaver, W. R., 1996. Measuring Family Therapy Outcome in a Clinical Setting: Families that do Better or do Worse in Therapy, *Family Process*, 35: 347-361.
- Hoyt, M. F., Rosenbaum, R. and Talmon, M., 1992. Planned Single-session Psychotherapy. In S. H. Budman, M. F. Hoyt and S. Friedman (Eds), *The First Session in Brief Therapy*, NY, Guilford.
- Knapp, M., 1997. Economic Evaluations and Interventions for Children and Adolescents with Mental Health Problems, *Journal of Child Psychology and Psychiatry*, 38, 1: 3-25.

Olson, D. H., McCubbin, H. I., Barnes, H., Larsen, A., Muxen, M. and Wilson, M., 1982. *Family Inventories: Inventories Used in a National Survey of Families across the Family Life Cycle*, Family Social Science, St. Paul, University of Minnesota.

Olson, D. H., Portner, J. and Lavee, Y., 1985. *FACES III*, St Paul, University of Minnesota.

Price, C., 1994. Making Family Therapy Accessible in Working Class Suburbs, *ANZJFT*, 15, 4: 191-196.

Schwartz, R. M., 1997. Consider the Simple Screw: Cognitive Science, Quality Improvement, and Psychotherapy, *Journal of Consulting and Clinical Psychology*, 65, 6: 970-983.

Talmon, M., 1990. *Single-session Therapy: Maximizing the Effect of the First (and often only) Therapeutic Encounter*, San Francisco, Jossey-Bass.

Watzlawick, P., Weakland, J. H. and Fisch, R., 1974. *Change: Principles of Problem Formation and Problem Resolution*, NY, Norton.

Notes

1. Distance From Centre = $\{\sqrt{\alpha(\text{Cohesion} - 39.8)^2 + (\text{Adaptability} - 24.1)^2}\}$.
2. My thanks to Simon Kennedy, Australian Catholic University.

Acknowledgment

A previous version of this paper was presented at the Mental Health Services THE.M.H.S. Conference in Hobart, Tasmania, in September 1998. The author wishes to acknowledge the assistance of the Oakrise clinical team, Dr Colin McKenzie, Melissa Hortin, Jo Fitzallen, and Lousie Ewing, and our able receptionist, Julie Morrison, in the conduct of this research. Address for correspondence: c/- Oakrise CAMHS, 3 Kelham St, Launceston, Tasmania 7250.

Appendix 1. Problem Evaluation Summary

Family Name: _____
 Date: ___ / ___ / ___
 File Number: _____

Keeping in mind the main problem that brings you to see us—
 please complete the following ratings of the problem.

Over the past seven (7) days:

1. Did the problem happen:

Every day	<input type="checkbox"/>
Nearly every day	<input type="checkbox"/>
About half the time	<input type="checkbox"/>
A few days	<input type="checkbox"/>
Not at all	<input type="checkbox"/>

2. When the problem happened, was it:

Very strong	<input type="checkbox"/>
Pretty strong	<input type="checkbox"/>
Quite strong	<input type="checkbox"/>
Pretty Weak	<input type="checkbox"/>
Very weak	<input type="checkbox"/>
Not at all	<input type="checkbox"/>

3. How much has the problem interfered in your family's life:

Constantly in the way	<input type="checkbox"/>
In the way a lot	<input type="checkbox"/>
In the way some times	<input type="checkbox"/>
Not a lot	<input type="checkbox"/>
Not at all	<input type="checkbox"/>

4. How upset/worried have you been by the problem:

Extremely	<input type="checkbox"/>
Somewhat	<input type="checkbox"/>
A bit	<input type="checkbox"/>
Not much	<input type="checkbox"/>
Not at all	<input type="checkbox"/>

5. How much control do you feel you have had over the problem:

Quite a lot	<input type="checkbox"/>
Some	<input type="checkbox"/>
A bit	<input type="checkbox"/>
Not a lot	<input type="checkbox"/>
None at all	<input type="checkbox"/>

6. How confident have you felt in dealing with the problem:

Very	<input type="checkbox"/>
Somewhat	<input type="checkbox"/>
A bit	<input type="checkbox"/>
Not a lot	<input type="checkbox"/>
Not at all	<input type="checkbox"/>

7. How much understanding of the problem have you had:

A lot	<input type="checkbox"/>
Some	<input type="checkbox"/>
A bit	<input type="checkbox"/>
Not a lot	<input type="checkbox"/>
None at all	<input type="checkbox"/>

Office Use:

Problem Score

Coping Score

Thank you for completing this form. Please give it to the receptionist when you are finished.