

Walk-In Single Session Therapy: A Study of Client Satisfaction

by

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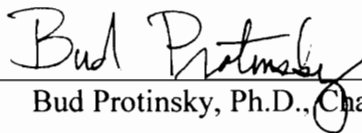
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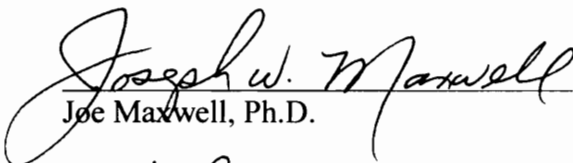
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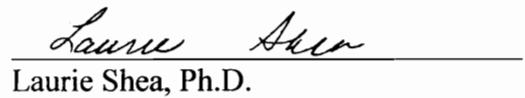
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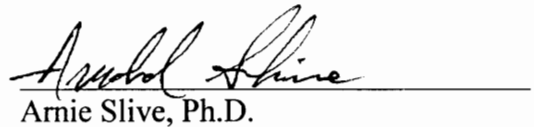
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WALK-IN SINGLE SESSION THERAPY: A STUDY OF CLIENT SATISFACTION

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(Abstract)

Walk-in single session therapy is a new, emerging model of clinical service delivery. This new form of therapy has grown as clinical service providers respond to the changing face of society. These changes are marked by society's growing expectation for low cost, immediate, and convenient services.

The Eastside Family Centre of Wood's Homes in Calgary, Alberta, Canada was chosen as the site for the study. The purpose of the study was to evaluate client satisfaction in a walk-in single session therapy format. The relationship between various treatment variables and clients' ratings of overall assistance received in their session was investigated. Clients' feedback about the service's greatest strengths and recommended changes was also explored.

Client satisfaction with various treatment variables and overall assistance received in their walk-in single session was evaluated through a sample of 417 client satisfaction questionnaires returned immediately after the therapy session. Client satisfaction with the walk-in single session service offered at the Eastside Family Centre was high, with 83.3% of the clients in the sample reporting general satisfaction with the overall assistance

received. Multiple regression analysis revealed that clients' satisfaction with the team approach used at the centre had the greatest influence on clients' overall rating of assistance received, while 19% of the variation in clients' overall rating was explained by the various treatment variables examined. Clients' satisfaction with the explanation of confidentiality also contributed significantly to the variation of clients' overall rating of assistance received.

Persons recovering from childhood or adult abuse were hypothesized to be less likely to benefit from a single session service (Hoyt, 1995), but surprisingly 100% (N=27) of the respondents with this presenting concern reported general satisfaction with their walk-in single session therapy. Thirty percent of the clients who responded reported that the greatest strength of the walk-in single session therapy service was its immediate accessibility. Eighteen percent reported that providing someone to talk to was the greatest strength, while fifteen percent reported the caring attitude of the therapist was the greatest strength.

Dedication

This work is dedicated to my wife, Stephanie, and my family:

Ken, Laura, Susan, June, Amy, Jim, John, David, Elizabeth, Michael, Laura, Andrew,
Emily, Larry, Steve, Mary, Megan, & Greg.

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In our view, the definition of the self, the relationship, and the other are an indivisible whole. We especially do not isolate or abstract the individual from the individual-in-this-relationship-with-this-other.

--Don D. Jackson, (1965)

As Don D. Jackson has suggested to in the above quote, individual accomplishments can not be evaluated without also looking at the individual's relationship with important others. I would like to recognize the following people for their contribution to this project...and my development as a therapist, researcher, teacher and human being.

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Chapter One

Introduction

At some time or other the conscience of society will awake and remind it that the poor man should have just as much right to assistance for his mind as he now has to the life-saving help offered by surgery; and that neuroses threaten public health no less than tuberculosis, and can be left as little as the latter to the impotent care of individual members of the community. When this happens, institutions or out-clinics will be started.
--Sigmund Freud (1919)

Walk-in single session therapy is a new, emerging model of clinical service delivery (Clouthier, 1996; Hoyt, 1995; Liske, 1991). This new form of therapy has grown as clinical service providers respond to the changing face of society. These changes are marked by society's growing expectation for convenience and immediacy of services (Slive, MacLaurin, Oakander, & Amundson, 1995). New clinical services, such as walk-in single session therapy, have also grown out of the need to meet requests for services at a time when funding for mental health agencies is diminishing (Hoyt, 1995; Spoerl, 1975).

This study was designed to evaluate client satisfaction in a walk-in single session therapy format. The Eastside Family Centre of Wood's Homes in Calgary, Alberta, Canada was chosen as the site for the study. Calgary is a city of over 700,000 people, geographically divided into four segments: northeast, southeast, northwest and southwest. Central Calgary lies between the Bow River in the north and the Elbow River to the South and was founded just over a century ago (Garrard, Godwin, & Wood, 1994). The Eastside Family Centre was developed to meet the needs of the northeast and

southeast quadrants of the city, commonly known as the “eastside”. This part of the city has often been described as being under serviced, even though it contains a disproportionate number of Calgary’s youth and families that struggle economically. Rather than accessing more traditional clinical services (such as weekly outpatient sessions), these families tend to seek services at moments of need (Hoffart & Hoffart, 1994).

History of the Eastside Family Centre

As documented in the Eastside Family Centre’s 1994 “State of the Centre Report” (Hoffart & Hoffart, 1994), the Eastside Family Centre was conceived in early 1990. The centre was organized through meetings with community representatives and service providers in the Calgary area in order to gather a wide range of opinions about the kind of mental health services that would best meet the mental health needs of the people living on the eastside of Calgary. From these meetings it was decided that this new service would offer a multi-faceted, multi-partnership service that would be linked to existing services in the eastern half of Calgary. The centerpiece of this new service would be a unique, walk-in counseling service allowing clients immediate access to clinically trained professionals at no cost.

As the name suggests, the walk-in counseling service would offer individuals or families an opportunity to “walk-in” and meet with a qualified professional for one hour. No appointments would be required or taken. Services would be offered on a “first come,

first served” basis. It was expected that for many people one session would be all that would be required, but the service would invite clients to return or refer to other agencies and organizations depending on client requests and needs. The Eastside Family Centre opened its doors in November of 1990, and, to date, has served over 5,000 walk-in clients. The formal mission of the centre is to promote community well-being through affordable and accessible counseling services (Hoffart & Hoffart, 1994; Slive, et al., 1995). This mission is accomplished largely through the implementation of the Community Therapist Program. This program is comprised of about 30 mental health professionals who donate their time for clients of the walk-in counseling service in exchange for training, American Association for Marriage and Family Therapy (AAMFT) supervision, and networking opportunities. These community therapists each offer approximately eight hours per month to the centre. All community therapists hold a graduate degree in counseling or a related field, and engage in ongoing training offered at the Eastside Family Centre.

Other clinical services offered at the Eastside Family Centre include: a 24-hour crisis line and mobile outreach service, brief counseling service, home based treatment program for families and youth, psychiatric consultation services, information referral services, educational clinics and services (legal, family, financial, wellness, adolescent etc.), and counselor training programs. (See Appendix A for a more detailed description of the services offered at the Eastside Family Centre).

Statement of the Problem

Michael F. Hoyt (1995), in his recent book, Brief Therapy and Managed Care, indicated that, overall, the research that is needed in the field of brief therapy must include both how well clients feel they have achieved their treatment goals and client satisfaction. Walk-in single session therapy is new to the field of therapy, and little research has been conducted to determine client satisfaction. It is also unclear how key characteristics of the therapy setting (treatment variables) contribute to successful outcomes (Talmon, 1990).

Purpose of the Research Project

The purpose of this research project was to determine the overall level of client satisfaction as a result of walk-in single session therapy. A secondary purpose of the study was to determine how specific treatment variables, such as the nature of the presenting concern, related to client satisfaction. This part of the study examined the relationship proposed by Hoyt (1995) and his associates that clients with certain presenting concerns and contexts would be less likely to benefit (and be satisfied) from single session therapy.

The relationship of clients' satisfaction with specific treatment variables was investigated to determine their relationship with clients' overall level of satisfaction with the assistance received in the therapy session. The treatment variables included: clients' rating of satisfaction with the therapists' explanation of confidentiality, clarity of the forms used, impression of the reception service, and use of the team approach. As some

researchers have suggested (Gordon, Alexander, & Dietzan, 1979), clients represent a voice to be heard and what they say should both instruct and encourage the professionals who serve them. The results of this study inform those clinicians currently working in walk-in single session formats about overall client satisfaction with this service. This type of research is crucial for the continuing development of this therapeutic modality.

As Doherty and Simmons (1996) reported in their recent national outcome study of family therapy: *Client satisfaction and outcome findings are critically important to third-party payers in the public and private sectors, managed health companies, and self-insured companies that are concerned about efficiency, effectiveness, and quality of services. Increasingly, these payers are seeking consumer input about which services and providers to include in health care benefits package* (pg. 11). The emphasis on third party payment is specific to the American system of health-care (Lebow, 1982; Zastowny & Lehman, 1988). In Canada the issue of efficiency, effectiveness and quality of services seems to be more a concern among government funders.

Research Questions

Little is known about the level of client satisfaction in a walk-in single session therapy (Talmon, 1990). In this study the researcher investigated key questions about this model of therapy. Primary research questions included:

1. What is the overall level of client satisfaction in walk-in single session therapy?
2. How does the nature of the presenting concern relate to client satisfaction?

Secondary research questions in this study included:

1. How does clients' satisfaction with other treatment variables relate to overall client satisfaction with the assistance received in their walk-in single session therapy?

These treatment variables included clients' satisfaction with:

- the reception service
 - clarity of the forms used
 - explanation of confidentiality
 - use of the team approach
2. What do clients believe are the greatest strengths of the walk-in single session therapy centre and what changes do they recommend?

Chapter Two

Theoretical Framework and Literature Review

I think the development of psychiatric skill consists in very considerable measure of doing a lot with very little - making a rather precise move which has a high probability of achieving what you're attempting to achieve, with a minimum of time and words. (underline added)

--Harry Stack Sullivan (1954)

Consumer-Driven Theoretical Framework of the Eastside Family Centre

As reported in a recent article about the practice of walk-in single session therapy at the Eastside Family Centre (Slive, et al., 1995), when the walk-in counseling service at the Eastside Family Centre began operation, no single model of therapy or theoretical framework was proposed. Its aim was to provide a service in which consumers could leave their single session with a sense of a clear outcome, not limited to assessment or referral. Although the Eastside Family Centre was designed without a particular theoretical model in mind, the developers of the service have certain orientations that are systemically based with emphasis on brief therapy approaches (Berg & Miller, 1992; de Shazer, 1982, 1985; O'Hanlon & Weiner Davis, 1989; Slive et al., 1995).

Many professionals from different backgrounds and with different theoretical orientations provide therapy at the Eastside Family Centre. Regardless of the theoretical model used by each therapist, the service requires a clear focus on the part of the therapist and a pragmatic approach. The Eastside Family Centre was designed to be a laboratory for developing clinical ideas in which the therapists and clients collaborate in the learning

process. The following are some of the clinical guidelines for the practice of walk-in single session therapy as it is conducted at the Eastside Family Centre (Slive, et al., 1995). (See Appendix C for a more detailed description of the clinical guidelines).

Clinical Guidelines for Walk-In Single Session Therapy at the Eastside Family Centre

Therapy begins at the Eastside Family Centre when the clients walk in the door. The way in which clients are received by the receptionist, the forms they are asked to fill out, and the information gained is viewed as part of the treatment process and guides the therapist to begin to think about solutions. The founders of the Eastside Family Centre have stated that the overall intent of the service is to develop a long-term relationship with the community members. The opening question in the therapy session may be, “How will we know at the end of our meeting that this has been useful to you?” (Slive, et al., 1995, pg. 7). This question helps focus the client and the therapist on what the client wants from the session rather than the presenting concern and the history of the problem. There are limitations to this consumer orientation. When a child is at risk or when there is a threat of harm to the client or other people, the therapist will notify the appropriate authority.

If more than one concern is presented by clients, they are asked to prioritize their concerns or the therapist may work with them to establish a unifying “theme” for the presenting concerns. The therapist’s job is to negotiate a solvable framing of the problem while identifying resources in the client or family, exceptions to the problem and alternative ways to talk about the problem. Asking clients, “What makes this a

problem?” and, “Why now?”, (Budman & Gurman, 1988, pg. 28; Slive, et al., 1995, pg. 8) also helps orient the therapist and client in their quest for direction in a 50-minute session.

It is important for the therapist to determine the “position” the clients are in in relation to therapy. An understanding of the client’s “position” involves determining how close or available the client is for therapy (Berg, 1989; Miller, Hubble, & Duncan, 1996). As noted by Slive and his associates (1995), “attending to this dimension can restrain the therapist from providing more help than the clients want in their 50 minute session” (pg. 8).

Berg (1989) states that the most important aspect of therapy is to assess the type of relationship the therapist has with the client and how the client sees himself or herself in reference to the problem (client position). She outlines three types of client-therapist relationships--*visitor*, *complainant* and *customer*. The *visitor* relationship involves a client who comes for therapy, but has no complaint and sees no change needed. *Visitors* are often sent by someone else (spouse, parent, judge, employer etc.), and do not view the problem the same way the people who sent them view it. The *visitors*’ motivations for treatment are often to “get the person who sent them off their back” (pg. 21). The *complainants* are the clients who are bothered by the problem, but they do not see themselves as part of the solution. The *complainants* can describe the patterns, origins, and details of the problem; but because they do not see themselves as an active part of the solution, they can not take steps to solve the problem. The *customers* are the clients

who both verbally and nonverbally indicate that they are at a point of wanting to do something about the problem. Talmon suggests that there is very little chance of effective single session therapy without a customer in the room. He defines the customer as the person who is “most likely to do something different in order to solve the problem or to take the therapist’s advice” (Talmon, 1990, pg. 27). Berg warns that all clients will not be able to fit into these three categories, but that these categories suggest a thumbnail sketch of how to view clients’ position in relation to the therapist and therapy. This orientation helps the therapist begin therapy by respecting clients’ ideas and accepting their purposes and goals (Berg, 1989).

“Follow-up” with clients is not required by the therapists at the Eastside Family Centre unless the situation is assessed to be “high risk” (including risk of harm to self, others or child abuse and/or neglect). Follow up with clients may include the use of the 24-hour crisis service offered by the centre (see Appendix A), consulting with a psychiatrist, accessing a hospital emergency room, or a child protective services agency. Clients are also encouraged to return in the future if they feel the service would be useful.

Single Session Therapy

Moshe Talmon (1990) was one of the first authors to describe the process of single session therapy (SST). In his book, Single Session Therapy: Maximizing the Effect of the First (and Often Only) Therapeutic Encounter, Talmon defined single session therapy (SST) as *one face-to-face meeting between a therapist and a patient with*

no previous or subsequent sessions within one year. As such, SST is the most frequently used length of therapy (Talmon, 1990, pg. xv). In this definition, Talmon's depiction of SST is a process where the structure of therapy is not preordained to only include a single session. Moreover, it is most commonly described by therapists as those cases where the clients "no show", "drop out" or "prematurely terminate" after one session (Talmon, 1990).

Single Session Therapy Research

The paradox of single session therapy is that it appears to have been founded by the person who also founded the longest form of therapy, psychoanalysis. In 1893, Sigmund Freud treated a patient known as Katharina in a single session. He was also reported to have cured the composer Gustav Mahler's impotence during a single long walk in the woods (Bloom, 1992; Talmon, 1990).

Kogan (1957) conducted some of the earliest research on the frequency of single session therapy, examining 250 new cases at the Division of Family Services of the New York Community Service Society in 1953. Kogan found that 141 (56%) of the cases he investigated were closed after one interview and that most of the closings were planned in advance by the client and the therapist. Kogan then interviewed (in person or by telephone) 80% of the 141 cases and found that about two-thirds (about 67%) felt they had been helped by their single session therapy. It is interesting to note that Kogan found no differences in client satisfaction with the planned case closings and the unplanned case closings, although he did find that therapists consistently underestimated the help that

clients with unplanned closings judged they had received (Bloom, 1992; Kogan, 1957; Talmon, 1990).

In 1972, Spoerl conducted a study of the records at a mental health clinic serving a private Health Maintenance Organization (HMO). Spoerl found that of the 6,708 clients seen in 1972, 39% made only one visit to the clinic despite full financial coverage for up to ten visits (Spoerl, 1975). Spoerl suggested that there were many benefits for clients who only attend a single session. Although changes in the client's behavior may be slight, just reviewing one's present life situation and background with the help of a therapist might be useful. Spoerl suggested that the single session therapy interview might be helpful in educating even an unwilling client about what the therapist does, and does not do. Finally, the single session therapy interview may allay some of the client's irrational fears and set the stage for a successful therapeutic encounter in the future. Spoerl described three groups of clients who will likely benefit from single session therapy. The first group includes those clients who present with considerable concerns over rather minor symptoms. This group includes clients who ask the question "What is wrong with me - am I going crazy?" (Spoerl, 1975, pg. 284). A second group who may benefit are those who come simply to pour out their feelings. The third group includes the well organized clients with no acute distress, who consult the therapist about a clearly identified problem.

Spoerl (1975) calls for the continued discussion and research of the impact of single session interviews, recognizing that many clients and therapists do not view it as

therapy. He states, "I believe, therefore, it is useful and necessary to establish the idea of single interview psychotherapy as a concept in order to allow therapists to work with some of their patients in this way instead of universally aiming for a more prolonged contract, and instead of having to view any one-interview client necessarily as a dropout or failure" (Spoerl, 1975, pg. 285). Spoerl also highlights the possible "placebo effect" clients experience after making a decision to see the therapist. The "placebo effect" and the client's often heightened sense of arousal and alertness in a initial interview are other reasons Spoerl suggests a single session is often sufficient to meet clients' needs (Spoerl, 1975).

Talmon began his study of single session therapy in the early 1980's while working at the Kaiser Permanente Medical Center in Hayward, California. Talmon examined computer printouts of the practice patterns of approximately thirty psychiatrists, psychologists, and social workers working at Kaiser Permanente. Talmon continued this investigation from 1983-1988, studying 100,000 scheduled outpatient appointments during this five year period. He found that the modal length of therapy for every one of the therapists in the study was a single session. He also found that about thirty percent of all the clients seen chose to come for only a single session in a period of one year, despite often being offered another appointment. He also found that the therapeutic orientations of the therapists had no impact on the percentage of single sessions seen by each therapist.

One of the only detailed studies of the therapeutic process of planned single session therapy was conducted by Bernard Bloom (1981, 1992; Talmon, 1990). Bloom saw ten single session therapy clients for two-hour interviews at a Colorado community health center. Bloom saw clients for two hours after finding that he could not do all that he wanted to do with clients in a fifty minute session. Although Bloom scheduled these cases for two hours, he was usually able to conclude the sessions in sixty to eighty minutes. When meeting with clients, Bloom explained that he would try to be as helpful as possible in a single session and that clients could return for further sessions if requested. Bloom then telephoned these ten clients three to four months after their session and found that all were doing well, and nearly all were helped by their single session therapy. Only one client sought additional therapy.

Only a small number of objective and empirical studies have been reported regarding the therapeutic impact of a single session therapy. Talmon's study with Michael Hoyt and Robert Rosenbaum (Talmon, 1990) of planned single session therapy represents one of the best examples of such research (Bloom, 1992). Hoyt, Rosenbaum, and Talmon each had over ten years of clinical experience as clinical psychologists and were the only therapists in their study. Although similar in experience, the therapists differed in orientation (experiential, strategic, direct, and indirect). Rather than trying to develop a universal approach to single session therapy, the researchers/therapists agreed to be supportive of their different styles of intervention during the study. The sample in the study was heterogeneous rather than highly restricted and included 60 client cases

randomly assigned to the therapists. The sample of clients included whites, blacks, Hispanics, and Asians with a wide variety of presenting concerns (i.e., depression, insomnia, panic attacks, adjustment to divorce, family violence etc.). The age range for clients was four to ninety three years with education levels from high school dropout to Ph.D. Clients who were actively psychotic, suicidal, or seeking therapy for drug and alcohol problems were excluded from the sample. The clinic where the study took place was equipped with a one-way mirror (similar to the facilities at the Eastside Family Centre), but of the sixty cases seen, only ten were observed by a team. Talmon and his associates developed a protocol for follow-up interviews to be administered over the phone by someone other than the treating therapist, three to twelve months after the session (an adapted form of this outcome protocol is presented in Appendix E). The researchers were able to contact 58 of the 60 participants for a follow-up interview. Fifty-eight percent of the clients contacted did not require additional treatment. Eighty-eight percent of those contacted reported either “improvement” or “much improvement” since the session (see item # 2 on the Walk-In Single Session Therapy Follow-Up Interview Protocol, Appendix E). Seventy-nine percent thought that the single session therapy had been sufficient. Sixty-five percent reported having positive changes that were clearly unrelated to the presenting concern. Talmon and his associates attributed this to a “ripple effect” (Talmon, 1990, pg. 16). Only three of the clients (5%) reported no improvement or felt that their therapy was not sufficient.

A notable feature in most of the previous research about the process of single session therapy is that it was conducted with cases where it was not planned that there would only be a single session in the course of therapy (Kogan, 1957; Spoerl, 1975; Talmon, 1990). Although Talmon, Hoyt, and Rosenbaum's (1990) work offered the most in-depth analysis of planned single session therapy, what they have described is somewhat different than walk-in single session therapy. Talmon's planned single session study with Hoyt and Rosenbaum (1990) involved clients who were seen by appointment only (as opposed to walk-in clients). Talmon, Hoyt, and Rosenbaum also excluded from the sample in their study those clients who were actively psychotic, suicidal, or seeking treatment for drug and alcohol problems. The walk-in service at the Eastside Family Centre treats clients with these presenting concerns and will refer to other agencies and services only when it is judged to be necessary during or after a single session intervention. Finally, Talmon, Hoyt, and Rosenbaum's study did not evaluate the effect of the team approach, although Talmon calls for such investigation in his discussion of the research (Talmon, 1990). The differences in Talmon's planned single session therapy make for a substantially different therapy context than the walk-in single session therapy conducted at the Eastside Family Centre. Nonetheless, much can be learned from Talmon's work and the obvious similarities to the therapy conducted at the Eastside Family Centre. The following is Talmon's (1990) outline for how to conduct a single session interview, including similarities to the therapy at Eastside Family Centre.

Talmon's Outline for Conducting Therapy in a Single Session

Talmon suggests that one of the first questions the therapist should be concerned with when meeting with the client is, "What changes have you noticed since you called?" (Talmon, 1990, pg. 35). This question sets the stage for a kind of therapy where change is the focus (as opposed to extensive history taking). This also orients the therapist to the idea that change is happening for clients all the time, even when they are not in a therapy session. This idea appears to have some similarity to Spoerl's discussion of the "placebo effect" of clients' decision to seek therapy (Spoerl, 1975). Because clients usually do not call the Eastside Family Centre before coming in (because it is a walk-in service), therapists at the centre often ask questions such as, "What changes have you noticed since you decided to come in for a session?"

The second question of interest for the therapist is, "What have you done to make these changes possible?" (Talmon, 1990, pg. 35). The answer to this question informs the therapist about existing client strengths and abilities. It also conveys to the client that they (the client(s)) possess within them the ability to bring about changes independently.

Talmon advocates that therapists make an opening statement about single session therapy to help orient the clients to the uniqueness of the service. A version of Talmon's opening statement has been developed for use at the Eastside Family Centre and usually is delivered to clients as follows:

We have recently learned that 1/3 of the people who come to therapy do so for only one session and very often find it helpful and sufficient. Yet, I want you to know that if today

or at any point in the future you and I find that further work is needed, therapists at the Eastside Family Centre will be available and will be glad to see you for more sessions.

Is that OK with you? Now, what is it that you would like to accomplish today?

The following is another slightly abbreviated version of the opening statement used at the Eastside Family Centre:

We have found that a large number of our clients can benefit from a single session here.

Of course if you need more therapy, we can provide it or assist you in getting it. But I want to let you know that I am willing to work with you hard today to help you resolve your problem quickly, perhaps even in this single visit, as long as you are ready to start doing whatever is necessary.

The next task of the therapist is to find a focus for the session. As mentioned previously, the founders of the Centre (Slive, et al., 1995) suggest questions that orient the therapist to what the client is looking for in the session, “right now”. Questions that yield this information include: “How will we know at the end of our meeting that this has been useful to you?”; “What will work for you today?”; “How will you and I know things are on the road to getting better?” (Slive, et al., 1995, pg. 7). Talmon cautions therapists not to overlook the obvious when finding a focus for the session (Talmon, 1990).

Finding a captivating metaphor, identifying clients’ strengths, and practicing solutions in the session are also a part of Talmon’s outline for single session therapy. Metaphors that are most useful for clients will often be derived from the clients’ own

statements about the problem and attempted solutions. A captivating metaphor can aid in providing a different way for the clients to view the situation in which they are involved. Identifying client strengths provides an opportunity for the therapist to capitalize on what is already working. Finally, practicing solutions in session can serve as the beginning of new change. Enactment, Gestalt two chair work, visualization, imagery, family sculpting, and use of ceremony are all examples of practicing solutions in the therapy session.

Talmon also suggests that therapists should allow for last minute issues the client might have by asking questions like, “Is there anything we did not cover at all today that you would like me to know about?” (pg. 49-50). Therapists must be careful not to wait to ask this question too late in the session, in case it prompts clients to begin another therapy session.

Finally, Talmon suggests therapists offer final feedback to clients about the session and their concerns. The feedback the therapist offers should incorporate the four areas of content listed below:

1. Acknowledgment-underline the reasons the clients came in for treatment. This should be about one to two sentences, empathically connecting with the emotional state of the clients.
2. Compliments (or Commendations)-underline what has been learned about the client’s thinking, affect, and behavior that is useful in solving the problem.
3. “Diagnosis”-not as a label from the Diagnostic and Statistical Manual (American Psychiatric Association, 1987), but as a reframing of the problem.

4. Prescription-(task)-smallest and simplest is best.

Another notable difference between Talmon's single session therapy and the walk-in single session therapy of the Eastside Family Centre includes the use of a therapeutic consultation team. The use of this team approach to therapy is one of the unique features of the services offered at the Eastside Family Centre.

In Resource Focused Therapy (Ray & Keeney, 1993), the authors include a single session focus as one of the basic theoretical maps for Resource Focused Therapy (RFT). The following quote epitomizes their approach: "All sessions aim at being a whole therapy. This helps create a focus on achieving a beginning, middle, and end. Should the clients return for a subsequent session, that session is treated as a new case. Of course, this new case will have to consider the session that took place with that other therapist the time before. That other therapist, who might be you at another time, will have to be considered now as part of the therapy." (Ray & Keeney, 1993, pg. 12). In this approach, therapists are encouraged to take a position of viewing each session as a whole therapy. When/if clients return, the therapy is viewed as a new therapy, taking into account the previous therapist (who may be the same therapist, at a different point in time). In the walk-in single session therapy conducted at the Eastside Family Centre, if clients should return for subsequent sessions, they will almost certainly see a different therapist than the one they saw previously. There are over 30 therapists providing services at the Eastside Family Centre, and the odds of a returning client meeting with the same therapist are small. No appointments are required or taken for the walk-in service (Slive, et al., 1995).

All client session notes at the Eastside Family Centre are kept on a centralized and networked computer system that allows for immediate accessibility for therapists working at the centre. If a client returns to the centre, the session notes from previous sessions are reviewed by the shift coordinator and the team, prior to the session. The approach at the Eastside Family Centre is consistent with the work of Ray and Keeney in that even though information from past sessions is taken into account in subsequent sessions, each session is viewed as a “whole therapy” unto itself. Others would suggest that therapists enter each session “without desire, memory, or understanding”, so that each interaction would have “no history and no future” (Bion, 1967, 1977 as cited by Hoyt, 1995). Hoyt (1995) suggests that this approach fosters creativity and new learning opportunities.

Talmon (1990) shares Keeney and Ray’s idea of viewing each session as a “whole, complete in itself” (pg. 117). Talmon suggests that this orientation is more useful, and that once therapists make the shift in thinking from a fragmented view of the session to a more wholistic one, they can expect therapy to start immediately. He also asserts that therapists who adopt this idea will also view assessment as an ongoing process that continues throughout therapy.

The Therapeutic Consultation Team and the Structure of Therapy at the Eastside Family Centre

In the mid 1970’s, The Brief Therapy Project of the Ackerman Institute pioneered the methods used in the team approach. This team approach was developed to aid in the treatment of clients and the training of therapists (Nichols & Schwartz, 1995; Papp,

1977; Piercy & Sprenkle, 1986). The development of the team approach at the Ackerman Institute was based on the work of the “Milan Group” (Gurman & Kniskern, 1991; Palazzoli, Boscolo, Cecchin, & Prata, 1978). From its creation, the function of the team was to help in the formulation of hypotheses and the construction of interventions to be delivered by the therapist (Nichols & Schwartz, 1995; Papp, 1977; Piercy & Sprenkle, 1986).

Teams are a useful aid to the therapist as they attempt to understand the complexity of family interaction. Teams also aid in helping therapists remain objective and avoid taking sides. The team approach is most common in structural, Milan and strategic therapies. One of the primary advantages of this approach is that the team can provide additional information, advice, and feedback to the therapist than is typically available in other training situations (Nichols & Schwartz, 1995).

The field of family therapy has witnessed an explosion in the use of the team approach, probably due to the enormous influence of the Milan and Ackerman groups. Team supervision may be the norm in most family therapy training programs where live supervision is practiced (Piercy & Sprenkle, 1986), but there is little data on the actual prevalence of their use (Nichols & Schwartz, 1995). The use of teams is probably uncommon in private practice settings due to the physical and mechanical requirements involved (Nichols & Schwartz, 1995). One possible disadvantage of the team approach is that it has the potential to undermine the therapist’s confidence (Beroza, 1983).

The Eastside Family Centre strives to utilize a therapeutic consultation team in the treatment of all clients. The structure of this approach was also informed by the work of the “Milan Group” in treating families (Palazzoli, Boscolo, Cecchin, & Prata, 1978). This structure involves five distinct phases of therapy involving the team: 1) the pre-session, 2) session, 3) discussion of the session with the therapist and the team, 4) the conclusion of the session, and 5) the post-session meeting with the therapist and the team (also called the “synthesis of the session”) (Palazzoli, Boscolo, Cecchin, & Prata, 1978, pg. 15-16).

In the use of the team approach at the centre, the team is led by a *Shift Coordinator* who is often an AAMFT Approved Supervisor or experienced professional. The clinical responsibilities of the shift coordinator include consulting to other therapists who are working during the shift. The shift coordinators are as available as possible to therapists during the shift and are, therefore, the last to see clients. A shift is usually four hours long (four hours in the afternoon and four hours in the evening). The shift coordinator assigns cases to therapists as they walk in and works with the receptionist to manage the client flow throughout the shift. The use of the team approach also helps to insure a homogeneity of services in a context where therapists often have varying levels of clinical education and experience. All therapists at the Eastside Family Centre are required to have a masters degree in counseling, therapy, or a related field. Beginning therapists receive extensive training including: a period of training where they observe

teams during shifts (usually two to three shifts of observation); an orientation workshop; and regular weekend training workshops (offered for all therapists).

The team is used in several different ways by therapists and families at the centre, including in-session consultation and consultation during a break in the therapy session. The team consists of the shift coordinator and the community therapists working during the shift. The size of the team is usually two to four therapists, including the shift coordinator.

The team begins its work in the consultation room¹ before the therapist starts a session. Typically, this pre-session consultation begins when the receptionist brings the shift coordinator the “user friendly” form (Slive et al., 1995) the clients have filled out about their visit. This form is read aloud to the team as the team members generate ideas about what the client is seeking from the session as well as what questions should be asked during the first half of the session. The case is then assigned to a therapist by the shift coordinator.

If an in-session consultation is used,² the team may then move to an observation room complete with a two-way viewing mirror, video equipment, and telephone line to the therapy room. When the therapist meets with the family, the team approach is explained, and clients are welcome to meet the team behind the mirror if they so desire.

¹ The consultation room is a private room where the therapists and shift coordinator meet to discuss cases and coordinate the shift.

² Clients indicate on the intake form as to whether or not they are willing to be observed by the team.

Clients are also informed that the team may call into the therapy room with questions and comments during the session.

The purpose of the team when conducting an in-session consultation is to provide insights and feedback to the client(s) and therapist. The team serves to help keep the therapist “on track” in the session and also to help create interventions for the therapist and the client at the end of the session. Finally, the team is often useful in helping therapists achieve their supervision goals.

The therapist usually will take a break from the session at the half-way point (usually 30-40 minutes). During this break the family is occasionally asked to discuss a certain topic or carry out an in-session intervention. The therapist uses this time to meet with the team and gain feedback, develop subsequent questions, and create potentially useful interventions.

Families who do not use the in-session team approach meet with a therapist in a “side room”. These “side room” sessions are not observed by the team, but the team approach is usually still utilized during the break in the session. During the break the therapist will explain to the team what has happened so far in the session and solicit feedback about how to proceed. Occasionally, it is not possible for the therapist to meet with the team because other therapists are unavailable for consultation. After concluding the session with the clients, the therapist usually meets with the team to discuss the intervention and the case in general, in an effort to synthesize the events of the session.

Research addressing the therapeutic impact of the team approach on families is scant (Kerns & Markowski, 1996). Kerns and Markowski's recent study of 51 cases treated in a family therapy training clinic indicated that there were no differences in the mean scores of selected treatment factors between clients seen without a team (N=30) and clients seen with a therapy team (N=21). These selected treatment factors included the status of the presenting problem at the end of treatment, the degree to which treatment met client's goals, and the direction of change made during treatment. The researchers summarized that no definitive conclusions could be drawn about the effects of the team approach on families; although, client satisfaction scores were significantly higher for those clients who used a team approach in treatment. In Kerns and Markowski's study, clients who used a team approach indicated that they received more affirmation, encouragement, and feedback about patterns of behavior than non team clients.

The structure of the therapy context at the Eastside Family Centre is one factor that makes this service unique. This new model of therapy delivery, combining a walk-in single session therapy with the use of a team approach is a hallmark in the delivery of therapeutic services to clients. Talmon suggests that the effect of the one-way mirror/team approach on the clients and the outcome of single session therapy has not been investigated and should be the subject of future study (Talmon, 1990).

Prevalence of Single Session Therapy - Planned and Unplanned

Much of the research in the area of single session therapy indicates that some patients make significant life changes facilitated by a single therapeutic encounter

(Bloom, 1981; Hoyt, 1995; Kogan, 1957; Talmon, 1990). Hoyt also reports that “within our own psychiatric clinic, part of a large Health Maintenance Organization (HMO), approximately 30% of our clients are seen for only a single session, despite having prepaid coverage entitling them to additional sessions if indicated” (Hoyt, 1995, pg. 141).

Talmon (1990) has indicated that a single session is the most frequently occurring number of sessions for all models of psychotherapy. For more than 60% of the clients seen at the Eastside Family Centre, a single session is sufficient to address their concerns. About 10% of the sessions at the Centre are clients returning for another walk-in session with the same or a different concern (Slive et al., 1995). Bloom (1981) found that about the same ratio of clients (one in ten) seek additional assistance after planned single session therapy. Spoerl (1972) found that of the 6,708 client cases treated through a mental health clinic serving a large HMO, 39% were seen for only a single session despite having prepaid coverage for up to ten sessions. Some authors in the brief therapy movement have suggested that while single session therapy is not a panacea appropriate for every clinical situation (Cade & O’Hanlon, 1993; Hoyt, 1995), given a choice many clients will elect a single treatment session and find it useful (Hoyt, 1995). Others who have created single session therapeutic services include Talmon’s single session practice (by appointment) and the Minneapolis Walk-In Counseling Center. The latter has been in service since 1969 (Slive, et al., 1995).

Some of the common reasons for unplanned single session therapy included: the therapist making a referral to another practitioner; the client choosing not to come back for a second session (commonly known as “drop-outs”, “pre-mature terminations”, or “treatment failures”); and agreement between the client and therapist that one session is all that is needed (Hoyt, 1995; Talmon, 1990).

Maximizing the Therapeutic Utility of Single Session Therapy

As mentioned previously, clients who only attend one therapy session often show impressive gains (Bloom, 1981, 1992; Hoyt, 1995; Kogan, 1957; Talmon, 1990). Reports by Lambert, Shapiro, and Bergin (1986) indicate that even without psychotherapy, psychological difficulties have a spontaneous remission rate of around 40%. This percentage was drawn from the authors’ reviews of psychotherapy outcome research with various designs, such as, naturalistic observations, epidemiological studies, comparative clinical trials, and experimental analogues. However, no statistical procedures were used to derive this percentage and Lambert (1986) warns that this percentage “appears more precise than is warranted” (pg. 438).

There has been no empirical research on different treatment styles designed to maximize the therapeutic utility of single session therapy. Talmon’s initial study of unplanned single session therapy from 1983-1988 (Talmon, 1990) reported that the therapists’ orientations did not effect the percent of unplanned single sessions seen. Hoyt suggests that one of the first steps in maximizing the therapeutic utility of single session

therapy is recognizing therapists' resistances. These resistances include the following "erroneous beliefs and barriers" (Hoyt, 1995, pg. 109):

1. *For therapy to be effective, "deep" character changes must be accomplished.*
2. *"More is better."*
3. *It is important to develop a therapeutic alliance cautiously; working relationships are fragile and hard to come by.*
4. *Client resistance is inevitable.*
5. *Countertransference to termination, including therapists' "need to be needed."*
6. *Brief therapy is hard work and requires special brilliance on the part of the therapist.*
7. *Confusion of the patient's interests with those of the therapist.*
8. *Economics and other payoffs.*

Many of the "resistances" to brief therapy listed by Hoyt have also been outlined by other authors as the basic differences between the values of long-term therapists and short-term therapists. Budman and Gurman outline these differences in their book, Theory and Practice of Brief Therapy (1988, pg. 11). Their connections to Hoyt's "resistances" are evident.

Dominant Values of the Long-Term and Short-Term Therapist

Long-Term Therapist Values	Short-Term Therapist Values
1. Seeks change in basic character.	1. Pragmatic, parsimonious; uses least radical interventions and does not believe in the notion of cure.
2. Significant psychological change is unlikely in everyday life.	2. Significant psychological change is inevitable (adult developmental perspective).
3. Presenting concern is reflection of more basic pathology.	3. Emphasis on patient strengths and resources; presenting problems are taken seriously.
4. Wants to “be there” as patient makes significant changes.	4. Accepts that many changes will occur “after therapy” and will not be observable to the therapist.
5. Therapy has a timeless quality, and change often takes time.	5. Does not accept the timelessness of some models of therapy.
6. Unconsciously recognizes the fiscal convenience of maintaining long-term patients.	6. Fiscal issues are often muted, either by the nature of the practice or organizational structure.
7. Therapy is always useful or benign.	7. Therapy is sometimes useful and sometimes harmful.
8. Therapy is the most important part of the patient’s life.	8. Being in the world is more important than being in therapy.

To maximize the utility of therapy, Hoyt, Rosenbaum, and Talmon (1992) address the need for the therapist to recognize when a patient may benefit from single session therapy. This process involves finding out the client’s motivation and expectation for therapy, which may be the best predictor of therapy duration (Peke, Borduin, & Archer, 1986, as cited by Hoyt, 1995). This process also involves finding out if the client’s desired change is possible now, or do other things need to happen first? This is similar to

the Eastside Family Centre's practice of determining the clients' "position" in relation to therapy (i.e. visitor, complainant, customer) (Berg, 1989).

Hoyt, Rosenbaum, and Talmon (1992) suggest that therapists who want to maximize the therapeutic utility of a single session follow these recommendations when conducting a session (Hoyt, 1995, pg. 114). Bloom's writings on focused single session therapy call for a similar orientation to maximize therapeutic utility (Bloom, 1992):

1. *Identify a focal problem.*
2. *Do not underestimate client's strengths.*
3. *Be prudently active.*
4. *Explore, then present interpretations tentatively.*
5. *Encourage the expression of affect.*
6. *Use the interview to start a problem-solving process.*
7. *Keep track of time.*
8. *Do not be overambitious.*
9. *Keep factual questions to a minimum.*
10. *Do not be overly concerned about the precipitating event.*
11. *Avoid detours.*
12. *Do not overestimate a client's self-awareness (i.e. don't ignore stating the obvious).*

Hoyt (1995) states that there is no single theory or method for successful single session therapy; however, the research he summarized and conducted with Talmon and Rosenbaum indicates a constructive, competency based perspective is apparent. Bloom's planned single session research (Bloom, 1981, 1992) of ten clients seen in a Colorado community mental health center utilized a psychodynamic theoretical orientation in treatment. Bloom's orientation was constructive and emphasized identifying a focal problem in the session. The goal of the therapeutic encounter in this orientation was to

help clients become more aware of some aspect of their cognitive or affective lives. This orientation was also competency based, in that it called for the therapist to “count on patients’ ability to work on an identified issue on their own”, and to count on “patients’ ego strengths and on their abilities to mobilize those strengths” (Bloom, 1992, pg. 107).

Talmon, Hoyt, and Rosenbaum’s (1990) study of planned single session therapy is one of the few examples of empirical research on the subject (Bloom, 1992). This study included a sample of 60 clients seen for a planned single session. Of the 58 clients the researchers were able to contact three to twelve months after their single session, 88% reported general improvement as a result of their single session. The three researchers who served as therapists in the study utilized different theoretical orientations although all three therapists are clinical psychologists. Michael Hoyt, the principal investigator, studied with Carl Whitaker and was interested in existential therapy and rededication therapy (a form of TA-Gestalt therapy) at the time of the study. Robert Rosenbaum favored a systemic-strategic Ericksonian approach during the study and was reported to have been one of the most effective therapists in the study.

Hoyt and his associates suggest that therapists embrace the following attitudes to maximize the possibility of successful single session therapy (Hoyt, 1995, pg. 144):

1. *View each session as a whole, potentially complete in itself. Expect change.*
2. *The power is in the patient. Never underestimate your patient’s strength.*
3. *This is it. All you have is now.*
4. *The therapeutic process starts before the first session, and will continue long after it.*
5. *The natural process of life is the main force of change.*

6. *You don't have to know everything in order to be effective.*
7. *You don't have to rush or re-invent the wheel.*
8. *More is not necessarily better. Better is better. A small step can make a big difference.*
9. *Helping people as quickly as possible is practical and ethical. It will encourage patients to return for help if they have other problems and will also allow therapists to spend more time with patients who require longer treatments.*

Client Satisfaction

It is difficult to define and quantify client satisfaction in health care settings because it is a construct that represents a composite of many different variables (Kalman, 1983). Some researchers define satisfaction as simply an outcome or result of clients' experiences in using or attempting to use health care (Thomas & Penchansky, 1984). From a consumer orientation, client satisfaction is the operational definition of "quality" (Moore & Kelly, 1996). Social interactionist theory defines satisfaction as an interaction, where person A derives satisfaction from a relationship with person B, when B's response to A's activity is perceived by A to further A's achievement of goals (Ben-Sira, 1976).

Evaluating client satisfaction is viewed as one way public agencies can measure their effectiveness in the populations they serve (Gutek, 1978; Kalman, 1983; Lebow, 1982; Moore & Kelly, 1996; Sorensen, Kantor, Margolis, & Galano, 1979; Thomas & Penchansky, 1984; Zastowny & Lehman, 1988; Zastowny, Roghmann, & Hengst, 1983). Client satisfaction studies in mental health settings have grown in the last 15 years and are now a standard part of the practice of many community mental health agencies (Ellsworth, 1975; Margolis, Sorenson, & Galano, 1977; Sorenson, Kantor, Margolis, &

Galano, 1979; Windle & Paschall, 1981; Zusman & Slawson, 1972). However, the relationship between walk-in single session therapy and client satisfaction has not been addressed in previous studies.

Measurement of Client Satisfaction

No standard methodology exists to measure client satisfaction (Gutek, 1978; Kalman, 1983; Zastowny & Lehman, 1988); although, the assessment of client satisfaction is crucial in the effective design of mental health programs (Kalman, 1983). The study of client satisfaction is still in its infancy in the field of mental health, and it is probably in its early childhood in the field of medical care (Zastowny & Lehman, 1988).

The measure of client satisfaction has been described as the extent to which treatment gratifies the wants, wishes, and desires of clients (Lebow, 1982). Most investigators of client satisfaction design their own instruments and methods for collecting data; therefore, their results are difficult to generalize to other studies (Doherty & Simmons, 1996; Kalman, 1983).

Tomlinson's (1988) study of the effects of therapists' access to clients' evaluation of therapy utilized a single item question to capture global satisfaction (N=44). This item reads, "My satisfaction level with this session was", with respondents indicating their rating on a scale from one to five (one equaling "very low", five equaling "very high"). This item is very similar to the measure of client satisfaction in this study (see Appendix B). Other studies utilize single-item questions to capture global satisfaction with treatment immediately after a visit (Tomlinson, 1988; Zastowny, Roghmann, & Hengst,

1983). Talmon, Rosenbaum, and Hoyt's (1990) study of client satisfaction with single session therapy also used a single item measure of client satisfaction, with a five point response scale (see Appendix E).

Another method of research involves the use of multiple items, multivariate statistics, and component scores of satisfaction assessment (Hulka, Kupper, Cassel, & Babineau, 1975). Certainly, multiple item measures of client satisfaction offer a more in-depth and detailed description of clients' level of satisfaction, while single item satisfaction measures are more simplistic and one-dimensional. One possible advantage of single item measures is their generalizability with other single item measures and the shorter time it takes to complete them.

There are several limitations researchers have reported regarding the study of client satisfaction, such as, the lack of test and re-test reliability coefficients for measures; the lack of validity replications; and the lack of standardized methodologies (Gutek, 1978; Kalman, 1983; Lebow, 1982; Thomas & Penchansky, 1984; Zastowny & Lehman, 1988; Zastowny, Roghmann, & Hengst, 1983). Another limitation is that client satisfaction studies must deal with the possibility of serious bias occurring as a result of "yeasaying" (Couch & Kinston, 1960). It is also theorized that clients fear reporting negative satisfaction with services because of the expectation of repercussions from the caregiver (Albers, 1977). One of the biggest limitations with client satisfaction studies involves non-respondents. Some researchers (Frank, Salzman, & Fergus, 1977) conclude that dissatisfied clients often do not return questionnaires.

In the various client satisfaction studies reviewed, the differences between respondents and non-respondents in treatment and outcome have not been paralleled by demographic differences (Burgoyne, Wolken, Staples, Kline, & Powers, 1977; Denner & Halprin, 1974a, 1974b; Ellsworth, 1979; Weinstein, 1979). Zastowny, Roghmann, and Hengst (1983) have summarized much of the research in the study of client satisfaction with medical care and concluded that while most studies have focused on patient demographics, few of these characteristics relate significantly to client satisfaction.

Some researchers suggest that variables such as diagnosis and the type of treatment have the greatest effect on client satisfaction (Weinstein, 1979; Zastowny, Roghmann, & Hengst, 1983) and should be the focus of study in future client satisfaction investigations (Zastowny & Lehman, 1988). Weinstein's (1979) study of patient attitudes towards mental hospitalization reviewed over 38 quantitative studies of patient satisfaction with treatment. His results indicated that in 30 of the 38 studies evaluated (78%), clients espoused favorable attitudes regarding their treatment. Furthermore, Weinstein found that social variables such as age, education level, occupation, social class, marital status, race, and gender had a negligible effect on patient satisfaction. Weinstein notes that most researchers in the studies he investigated developed and applied their own questions, tests, and scales rather than using identical or similar methodologies. He contends that most of the objective tests have "face validity", with measures based directly on the attitude in which the investigator was interested. Sample sizes in the 25 studies listed by Weinstein ranged in size from 17 to 1,141, with an

average sample size of 277. Client diagnosis was found to be a relevant factor in clients' attitudes and satisfaction in eight of the fourteen studies in which it was considered. Type of treatment received (i.e. type of ward) reached significance in nine of the twelve studies evaluated.

Hoyt and his associates (1995) have hypothesized that those most likely to benefit (and be satisfied) from single session therapy include clients with the following presenting concerns and situations (Hoyt, 1995, pg. 145, underline added):

1. *Patients who come to solve a specific problem for which a solution is in their control.*
2. *Patients who essentially need reassurance that their reaction to a troubling situation is normal.*
3. *Patients seen with significant others or family members who can serve as natural supports and 'co-therapists.'*
4. *Patients who can identify (perhaps with the therapist's assistance) helpful solutions, past successes, and exceptions to the problem.*
5. *Patients who have a particularly 'stuck' feeling (e.g. anger, guilt, grief) toward a past event.*
6. *Patients who come for evaluation and need referral for medical examinations or other nonpsychotherapy services (e.g., legal, vocational, financial, or religious counseling).*
7. *Patients who are likely to be better off without any treatment, such as "spontaneous improvers," nonresponders, and those likely to have a "negative therapeutic reaction" (Frances and Clarkin, 1981).*
8. *Patients faced with a truly insoluble situation. It will help to recast goals in terms that can be productively addressed.*

Hoyt and his associates hypothesize that single session therapy is less likely to be adequate and beneficial for clients (and therefore clients will be less satisfied) with certain presenting concerns and contexts, listed below (Hoyt, 1995, pg. 145-146, underline added):

1. *Patients who might require inpatient psychiatric care, such as suicidal or psychotic persons.*
2. *Patients suffering from conditions that suggest strong biological or chemical components, such as schizophrenia, manic-depression, alcohol or drug addiction, or panic disorder.*
3. *Patients who request long-term therapy up front, including those who are anticipating and have prepared for prolonged self-exploration.*
4. *Patients who need ongoing support to work through (and escape) the effects of childhood and/or adult abuse.*
5. *Patients with long-standing eating disorders or severe obsessive-compulsive problems.*
6. *Patients with chronic pain syndromes and somatoform disorders.*

Relating Satisfaction and Outcome

There is a consensus in the field of psychotherapy that satisfaction may be one of the most important outcome measures, especially related to the quality of care (Zastowny & Lehman, 1988). The study of client satisfaction as it relates to issues of quality of care and delivery of services dates back to Koos' 1954 study of patient satisfaction with medical care (Zastowny, Roghmann, & Hengst, 1983). Although at times they may seem indistinguishable, therapeutic outcome and client satisfaction are distinct and separate entities (Kalman, 1983).

Treatment outcome has generally been neglected as a variable in satisfaction studies, although some researchers have shown a significant correlation between outcome and satisfaction (Edwards, Yarvis, & Mueller, 1978). Edwards, Yarvis, and Mueller (1978) studied the relationship between client satisfaction and success in treatment in a group of 155 outpatients at a California community mental health clinic. The researchers measured satisfaction after the second visit, last visit, and three months after termination.

Satisfaction was significantly related to success ratings at each point in time. Overall satisfaction scores in the study ranged from 87.2% (after the second session) and 85.6% (follow-up).

Fiester and Fort (1978) reported that when outcome is rated in a broad fashion, especially in the context of a satisfaction questionnaire, overlap is considerable. Although, when outcome is more specifically evaluated (i.e. symptom checklist), distinctions appear (Edwards, Yarvis, & Mueller, 1978; Fiester, 1979; Larsen, Atkinson, Hargreaves, & Nguyen, 1979). In some instances clients rated outcome scores higher than satisfaction scores (Woodward, Santa-Barbara, Levin, & Epston, 1978).

Relating Satisfaction and Utilization of Services

Satisfaction is viewed by some researchers as a major factor in clients' decisions to utilize health care services, with less utilization expected from dissatisfied clients (Becker, Haefner, & Kasl, 1977; Hulka, Zyzawski, & Cassel, 1971; Roghmann, Hengst, & Zastowny, 1979; Rosenstock, 1966; Thomas & Penchansky, 1984; Wan & Soifer, 1974; Ware, Wright, & Snyder, 1975). Utilization, treatment compliance, and treatment outcome are strongly influenced by client satisfaction (Kalman, 1983). Ware and his associates (1975) suggest that due to the inconsistencies among the satisfaction measures employed in most studies, aspects of satisfaction that are important in influencing utilization remain unclear. A five year study of patients seen for only one session at the Kaiser-Permanente Medical Center in San Francisco found that those patients seen for a

single session had a significantly lower level of utilization of the medical facilities offered (Cummings & Follette, 1976, as reported by Talmon, 1990).

Relating Therapists' Expectations and Client Satisfaction

Some researchers have shown (Doherty & Simmons, 1996; Gutek, 1978; Kalman, 1983) that there is often a great deal of variance between professional's expectations of client satisfaction and outcome, and the actual levels of client satisfaction and positive outcome reported by clients. It is a recurring theme in many research studies of client satisfaction that professionals underestimate the level of client satisfaction in the populations they serve (Kalman, 1983). Gordon, Alexander, and Dietzan's (1979) study of psychiatric patients' satisfaction with the services they received reported markedly positive attitudes and a high degree of satisfaction in the patient population. The authors also pointed out that the actual levels of patients' satisfaction were generally higher than predicted by the researchers.

Gutek (1978), in her article reviewing strategies for the study of client satisfaction, found that all the respondents in the studies reported higher levels of satisfaction than had been hypothesized by the researchers. Gutek (1978) reviewed satisfaction studies in many different areas including job satisfaction, assembly line worker satisfaction, and satisfaction with government agencies. In her review of Quinn and Shepard's (1974) study of American working people, Gutek found that 90% of the people were satisfied with their jobs. Imberman (1972) reported that 79% to 85% of the assembly line workers in his sample reported satisfaction with their work. Katz, Gutek, Kahn, and Barton's

(1975) national study of adult Americans found that over two-thirds of the respondents were satisfied with their recent contacts with government agencies. Gutek has pointed out in her review of these various satisfaction studies that the levels of satisfaction were almost always higher than the researchers had expected. She suggests that satisfaction results should be interpreted carefully due to the consistently high frequency with which positive satisfaction is reported. She attributes this lean towards positive satisfaction to the notion that people seem to be satisfied with everything that social scientists ask them about.

Doherty and Simmons' (1996) recent national study of marriage and family therapists and their clients indicate that of the 492 clients and therapists surveyed, therapist's reports of positive outcomes were somewhat lower than their client's reports. Of all the cases in the study, 83% of the clients reported that their therapy goals were achieved while only 69.6% of the therapists believed the goals were achieved. Doherty and Simmons also reported that 97.4% of all clients surveyed reported themselves to be generally satisfied with the family therapy services they received. Therapist predictions on the level of client satisfaction were not reported. Of the 850 cases reported by the therapist in the study, depression was the most prevalent presenting problem (43%), followed by individual psychological problems (35.1%), and marital problems (30.1%)³.

³ The percentages total more than 100% because more than one presenting problem could be assigned for each case.

Common Factors Related to Client Satisfaction

Lambert and his associates (1986) have reviewed much of the research on psychotherapy outcome, including research on a large range of disorders with a variety of research designs. Although lacking statistical procedures in their assessment, Lambert and his associates have concluded that in the studies they reviewed, a substantial number of outpatients (40%) improved without formal therapeutic intervention (spontaneous improvers). The authors also concluded that 30% of the improvements in clients' conditions were due to "common factors" (Lambert, 1986, pg. 437). These common factors included variables that were found in a variety of therapy models with varying therapeutic orientations. Common factors included characteristics of the therapist such as warmth, respect, empathy, acceptance, and being genuine. Re-assurance, structure, trust, catharsis, and release of tension were also listed as common factors of the therapy setting associated with positive outcomes. This study examined the impact of various "structure" factors on clients' ratings of overall assistance received in their walk-in single session therapy. Structural factors examined in the study included the therapists' explanation of confidentiality, the clarity of the forms used, and the impression of the reception service. Clients' comments were also evaluated for evidence of other "common factors" related to positive outcomes.

Summary

Walk-in single session therapy is a new, emerging model of clinical service delivery (Clouthier, 1996; Liske, 1991; Slive, et al., 1995), and there has been little research concerning the level of client satisfaction with this type of service (Talmon, 1990). Client satisfaction studies have been utilized as one of the predominant methods for assessing program effectiveness (Gutek, 1978; Kalman, 1983; Lebow, 1982; Moore & Kelly, 1996; Sorensen, Kantor, Margolis, & Galano, 1979; Thomas & Penchansky, 1984; Zastowny & Lehman, 1988; Zastowny, Roghmann, & Hengst, 1983). The use of the therapeutic consultation team at the Eastside Family Centre is one of the unique characteristics of the service. Talmon (1990) has called for research investigating the impact of the team approach on clients' perceptions and outcomes in single session therapy.

The emerging field of single session therapy lacks a specific theoretical orientation, but a review of the research conducted on the subject reveals that a constructive, competency based perspective has been apparent in the various procedures that have been investigated (Bloom, 1992; Hoyt, 1995; Talmon, 1990).

Chapter Three

Methodology

Also worthy of evaluation, planning and thought by the therapist are the matters of time spent, of effective utilization of effort, and above all of the fullest possible utilization of the functional capacities and abilities and the experiential and acquisitional learnings of the patient. These should take precedence over the teachings of new ways in living which are developed from the therapist's possibly incomplete understanding of what may be right and serviceable to the individual concerned.

--Milton H. Erickson (1980)

Sample

The sample in the study was comprised of 417 individual adults (over the age of 18), couples or families who received therapeutic services at the Eastside Family Centre's walk-in single session therapy service during a nine month period between May 1, 1995 and January 31, 1996. The centre serves the communities in the northeast and southeast quadrants of the city of Calgary, Alberta, Canada. The sample population represents 23% of the 1,790 cases seen during this period at the Eastside Family Centre's walk-in service. Demographic information such as the age, gender, and income of the respondents was not collected, although it is expected that the sample in this study is demographically similar to a larger sample in a previous study at the Eastside Family Centre. A program evaluation study conducted at the Eastside Family Centre in 1994 (Hoffart & Hoffart) reported that of the 2,187 sessions held between March 1993 and February 1994, 36.8% of the clients seen were male, 56% were female, and in 7.2% of the cases seen, the gender

of the clients was not reported. The age range of the clients seen during this period is presented in the following table:

Table 1
Age Range of Clients Treated at the Eastside Family Centre (Hoffart & Hoffart, 1994)

Age Range	Percent
0-9	6.9%
10-19	20.1%
20-29	18.6%
30-39	29.5%
40-49	19.7%
50-59	4.3%
60+	.1%

Information Collection Process

This study was directed at determining the overall level of client satisfaction with the walk-in single session therapy as it is conducted at the Eastside Family Centre. A total of 417 client satisfaction questionnaires (see Appendix B) were voluntarily completed at the Eastside Family Centre from May 1, 1995 to January 31, 1996. This existing data set was used to assess client satisfaction at the centre. These questionnaires were returned anonymously by clients either immediately after their session or were mailed to the centre in a pre-addressed and stamped envelope provided by the centre. Questionnaires returned immediately after the session were collected by the centre receptionist. The therapists who provided services to the respondents delivered the questionnaires at the end of each session. Therapists were instructed to give the

questionnaires to each of the individual adults, couples, or parent(s) of the families treated during the data collection period. The questionnaires returned by mail were usually received within a week after services were delivered. Centre receptionists approximate that 30% of the questionnaires that were completed were returned by mail, and 70% were delivered by hand after the therapy session, before the clients left the centre.

Questionnaires were dated and numerically coded by the centre receptionist so that key information, such as the nature of the presenting concern, and whether or not a team approach was used, could be recorded. No information identifying the individuals treated was recorded in the data set.

Each client satisfaction questionnaire included a printed description of the questionnaire and its purpose. Therapists were also instructed to explain the questionnaire to the respondents. Respondents were informed that collecting feedback from clients was a way the therapists at the centre can learn about what they were doing right, what they were doing wrong, and what they could do differently to help the service be as useful as possible. Clients were also informed that record-keeping for the questionnaires was set up so that the centre staff would know what kinds of difficulties were discussed, but they would not know the client(s) name. Thus, all comments and suggestions could be made anonymously. The name of the centre, address, phone, and fax number also appeared at the top of each questionnaire so that clients would have a way to contact the centre should they have questions after they leave.

Measurement Instruments

In 1990, the first *Client Satisfaction Questionnaire* was designed by the Eastside Family Centre Advisory Counsel to be a straightforward, face valid method to assess client satisfaction with the walk-in single session therapy service. The questionnaire was revised in early 1995, and this revised version was the one used in the study. The major revision of the questionnaire included a simplification of the scaling response for each item, reducing the scale from a one to ten range, to a one to five range.

The revised questionnaire asked six questions about the services received, with a five point Likert scale (one equaling “poor” or “disruptive” and five equaling “excellent” or “helpful”) response set and a space for clients to add comments for each question. These questions asked for information about the impression of the centre by phone, reception service at the centre, impression of the forms used, explanation of confidentiality by the therapist, the use of the team approach, and overall assistance received. The last two questions asked for clients to write what they perceived to be the centre’s greatest strength and one change that they may recommend.

The questionnaire consisted of one 8” x 14” page with the content of the questionnaire (Appendix B) printed on one side of the page. The other side of the page was blank, and respondents were encouraged to use this space to write additional comments if needed. None of the respondents used the space on the back of the questionnaire. A stamped envelope with the centre’s printed address was stapled to each questionnaire.

The Eastside Family Centre's clinic utilizes a taxonomy of presenting concerns, represented by three letter codes and organized by category (see Appendix D). There are 14 categories of concern codes, with up to 16 individual codes for each category. Each client who receives therapeutic services from the Eastside Family Centre's walk-in clinic is classified by their therapist using this system. Combinations of concern codes (up to three, when necessary) are utilized to describe the client's presenting concerns for the therapy session. During the therapy session clients are asked to prioritize their concerns, and the therapist records the concern codes in the order of priority (most important concerns first). Only the first concern code (highest priority) listed by the therapist was used in this study.

Each therapist who provides therapy at the Eastside Family Centre is instructed to record his or her expectation as to whether or not the session met the client's identified requests. Therapists also record whether or not a team approach is used in the session. The structure of therapy at the Eastside Family Centre is designed so that in the majority of cases seen the therapist utilizes some form of the team approach (either in-session consultation with the use of the mirror, or a case consultation during a break in the session). In the sample examined for this part of the study (N=403), 78% (N=315) of the cases seen included some form of the team approach. In 20% of the cases seen (N=79), a team approach was not used, and in 2% of the cases (N=8) team use was not recorded.

The presenting concern code(s), therapist expectations as to whether or not the session met the identified requests of the clients, and whether or not a team approach was

utilized in the session were recorded on the returned client satisfaction questionnaires by the researcher. No client names or identifying information was recorded on the returned client satisfaction questionnaires or in the data set used in the study.

Responses to the questionnaire items were coded and entered into a Microsoft Excel program, then transferred to a computer disk. All analyses were calculated using the Statistical Package for the Social Sciences, Release 6.0 (SPSS) (Norusis, 1993).

Data Analysis

Measuring Overall Client Satisfaction at the Eastside Family Centre

The mean scores for each of the six items relating to client satisfaction on the *Client Satisfaction Questionnaire* (items # 1-6; see Appendix B) were calculated and a histogram was utilized to display the findings. Furthermore, clients' responses to each item were analyzed to determine the percent of respondents that rated each area (item # 1-6) between four and five (indicating general satisfaction), and the percent of those that rated satisfaction between one and three (less satisfied).

Clients' Voices: Greatest Strengths and Recommended Changes in Walk-In Single Session Therapy

Client comments on the returned *Client Satisfaction Questionnaires* were examined to attempt to identify common themes. Client comments that had common themes were grouped together, and the percentage of each type of comment for each item was presented. This was the primary method of analysis for items #7 and #8 relating to clients' perceptions of the greatest strength of the service and one change that they might recommend. Comments from Question #6 (regarding overall assistance received) were unique and could not be grouped by similar themes.

The Relationship Between Client Satisfaction and Presenting Concerns

Hoyt and his associates have hypothesized that clients whose presenting concerns fall in the following categories are less likely to benefit and be satisfied with single session therapy (Hoyt, 1995):

1. persons needing psychiatric care;
2. suicidal or psychotic persons;
3. persons suffering from strong biological or chemical components (i.e. schizophrenia, manic depression, alcohol/drug addition or panic disorder);
4. persons recovering from childhood or adult abuse;
5. persons with eating disorders or severe obsessive-compulsive problems;
6. persons with chronic pain syndromes and somatoform disorders.

The data set was analyzed to determine if/how the various concern codes in the data set fall in the above listed categories. A table was created to denote which of the presenting concern codes fell into the above listed categories of people/clients hypothesized by Hoyt (1995) to be less likely to benefit from single session therapy. Under each category (1-6), the presenting concern codes that corresponded to that category were listed. The number of cases in the data set that included these as the highest priority concern codes was also listed. One hundred and two of the cases in the data set (24% of total sample) fell under one of the six categories listed above. Clients' rating of overall satisfaction (as measured by item #6) by each category described by Hoyt (1995) was also analyzed. The 15 most frequently reported presenting concerns were also analyzed and the level of satisfaction for each concern was investigated.

The Relationship Between Client Satisfaction and Other Treatment Variables

A simultaneous multiple regression analysis was conducted to determine the relationship between persons with the presenting concerns categorized above and their rating of overall assistance received in the session as measured by item #6 on the *Client Satisfaction Questionnaire*. Other treatment variables in the regression analysis included:

- clients' level of satisfaction with their therapist's explanation of confidentiality, as measured by item #4 on the *Client Satisfaction Questionnaire*. Clients rated the therapist's explanation of confidentiality on a scale of one to five, with one indicating "poor" and five indicating "excellent".

- clients' level of satisfaction with the simplicity and straightforwardness of the forms filled out when they began therapy, as measured by item # 3 on the *Client Satisfaction Questionnaire*. Clients rated the forms on a scale of one to five, with one indicating "not at all" and five indicating "excellent".
- clients' impression of the reception service when entering the Eastside Family Centre, as measured by item #2 on the *Client Satisfaction Questionnaire*. Clients rated the reception on a scale of one to five, with one indicating "poor" and five indicating "excellent".
- clients' evaluation of the use of the team approach (one-way mirror, phone calls, taking a break in the session) as measured by item #5 on the *Client Satisfaction Questionnaire*. Clients rated the use of the team approach on a scale of one to five, with one indicating "disruptive" and five indicating "helpful".

Chapter Four

Results

Why can't therapy be interesting in each hour as it appears and not try to thread those hours together into what's called a process, a journey, developmental growth?
--James Hillman (Hillman & Ventura, 1992)

What Is the Overall Level of Client Satisfaction in Walk-In Single Session Therapy?

The first six questions on the *Client Satisfaction Questionnaire* asked clients to rate their satisfaction with different aspects of the service on a scale of one to five (five equaling “excellent” or “helpful”). There was also space provided for clients to add further comments about their experience in each area. The majority of people chose not to write comments on the form, except for the question about the greatest strength of the centre.

Figure 1 includes a histogram of the total mean scoring of each item on a five point scale (N=403). The mean scores were highest for clients' satisfaction with the explanation of confidentiality (4.63) and clients' overall satisfaction (4.37). The lowest mean scoring of client satisfaction was in the area of clients' first impression of the centre by phone (4.14) and satisfaction with the use of the team approach (4.23). Clients' mean score of satisfaction with the reception service was 4.36 while their satisfaction with the clarity of the forms used at the centre was 4.25.

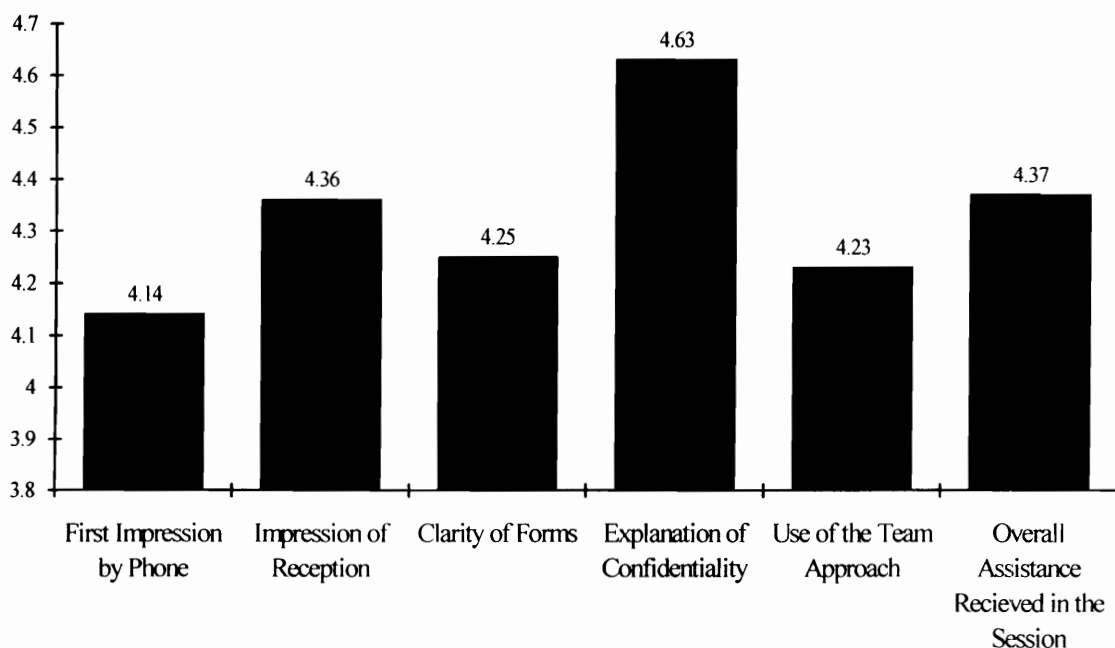


Figure 1

Clients' Mean Scores of Satisfaction by Item (N=403)*

* 14 cases were omitted from this part of the analysis due to incomplete client responses.

Table 2 describes clients' ratings of satisfaction for each item on the *Client Satisfaction Questionnaire*. This table includes the percentage of clients whose ratings were between four and five (generally satisfied), one and three (less satisfied) and one and two (dissatisfied). The means, range of scores, number of responses for each item, and standard deviations are also presented. Clients' overall satisfaction with the service they received in their walk-in single session therapy was high (83.3% were generally satisfied).

scoring between four and five). Sixteen percent were less satisfied (one to three), with only 2% rating their satisfaction as poor (one or two). Clients also reported being generally satisfied with therapists' explanations of confidentiality (95%), reception service (85.4%), clarity of forms (83.8%), team approach (80.1%), and first impression by phone (77.6%).

Table 2

Client Satisfaction Questionnaire Results by Item (N=403)

	Phone Item #1	Reception Item #2	Forms Item #3	Confid. Item #4	Team Item #5	Overall Item #6
Means	4.14	4.36	4.25	4.63	4.23	4.37
Range	1-5	1-5	2-5	1-5	1-5	1-5
N=	299	397	394	398	292	395
Standard Deviation	.80	.78	.76	.61	.91	.83
Percent of Ratings Between 4-5	77.6%	85.4%	83.8%	95%	80.1%	83.3%
Percent of Ratings Between 1-3	22.4%	14.6%	16.2%	5%	19.9%	16.7%
Percent of Ratings Between 1-2	1.3%	1.8%	1.5%	.5%	4.1%	2%

Tables three through seven represent an analysis of client comments for questions one through five on the Client Satisfaction Questionnaire. Client comments that were similar in theme were grouped together, and the number of comments by theme was reported (N=417).

Only 8% (N=35) of the total sample contributed a comment about the first impression of the centre by phone (Table 3). Of those who responded, 83% (N=29) reported favorable comments, usually regarding some characteristic of the phone receptionist (i.e., kind, courteous, pleasant).

Table 3

Analysis of Client Comments Organized by Theme for Question #1

My first impression of the Centre by phone was:

<u>Comments:</u>	<u>N=</u>	<u>Percent of total:</u>
Very kind, courteous, pleasant, very warm, inviting, professional, accommodating, very friendly, bubbly, cheery, informative, quick response, gave directions; I think it's great; Made me aware that there are people out there that do care and are willing to listen; I am not alone anymore.	28	80%
I wasn't sure where to go. The directions could have been simplified.	2	6%
I was emotionally upset when I called.	1	3%
I was surprised no appointments were booked.	1	3%
I did not really know what direction to go in trying to explain the reasons for coming. The receptionist finally said we needed a counselor, which brought a sense of relief.	1	3%
Receptionist spoke too quickly.	1	3%
Slow getting in to session.	1	3%
TOTAL:	35	

Eighteen percent (N=77) of the total sample contributed a comment about the first impression of the reception service at the centre. Eighty-seven percent of these respondents (N=67) reported positive comments, usually regarding some characteristic of the receptionist's personality (i.e., friendly, polite, helpful).

Table 4

Analysis of Client Comments Organized by Theme for Question #2

My first impression of the reception service was:

<u>Comments:</u>	<u>N=</u>	<u>Percent of total:</u>
Friendly, polite, helpful, sincere, warm, welcoming, put me at ease, calming, compassionate, kind, nice, professional, open, reassuring, knowledgeable, easy to understand; let me know how long I had to wait; offered coffee; I expected a long wait and there wasn't anyone else present (I don't like crowds); she could see that I was upset and tried to get me to a counselor as quick as she could.	67	87%
There was no eye contact when I entered the room; no one greeted us or asked why we were there; no acknowledgment of any kind; I felt out of place.	3	4%
The wait was a little long (slow); a TV or something would help.	3	4%
Seemed disorganized and uncaring.	2	3%
Could be more private.	2	3%
TOTAL:	77	

Therapy at the Eastside Family Centre is viewed as beginning when the clients walk in the door, and the reception service and the paperwork clients are asked to fill out represents part of the therapy process. When clients enter the centre they are asked to complete a "user friendly" (Slive et al., 1995) intake form regarding the nature of their

presenting concern, who is involved, any attempted solutions to the problem, and inner strengths of the client(s). Of the 8% (N=32) of the total sample who contributed a comment about the forms used, half (N=16) reported positive comments. Twenty-five percent (N=8) reported difficulty communicating their thoughts on the form, while 19% (N=6) reported difficulty listing inner strengths they (the clients) possessed.

Table 5

Analysis of Client Comments Organized by Theme for Question #3

The forms I filled out were simple and straightforward:

<u>Comments:</u>	<u>N=</u>	<u>Percent of total:</u>
Clear, helped me focus, showed you care.	16	50%
It was hard to say what I wanted to; didn't know how to answer/confusing.	8	25%
The questions made me think about specifics...this was difficult; questions about inner strengths were tough; if I felt I had inner strengths, I wouldn't be here.	6	19%
(I am) concerned about the paper trail.	1	3%
Questions should be more specific about individual vs marital counseling.	1	3%
TOTAL:	32	

Six percent (N=25) of the total sample contributed a comment about the counselor's explanation of confidentiality (Table 6). Eighty-eight percent of those who commented (N=22) reported positive comments about the counselor's explanation. Positive comments frequently included statements about the clarity of the counselor's explanation, and the reassurance offered by the counselor.

Table 6

Analysis of Client Comments Organized by Theme for Question #4

The way the counselor explained confidentiality was:

<u>Comments:</u>	<u>N=</u>	<u>Percent of total:</u>
Clear; The counselor gave the reassurance I needed.	22	88%
Counselor didn't stress confidentiality; too quick.	2	8%
(I) never trust professional people fully.	1	4%
TOTAL:	25	

Thirteen percent (N=52) of the total respondents offered a comment about the use of the team approach. Of these, 69% (N=36) reported favorable comments about the use of the team. Half of the total comments were clients' favorable responses about the multiple levels of input regarding the problem. Nineteen percent of those who offered a comment about the team (N=10) reported that the break in the session gave them time to talk with each other and gather their thoughts. Seventeen percent (N=9) found the use of the mirror and the team approach "uncomfortable" or "intimidating".

Table 7

Analysis of Client Comments Organized by Theme for Question #5

The use of the team approach (mirror, phone calls, taking a break) was:

<u>Comments:</u>	<u>N=</u>	<u>Percent of total:</u>
I like the idea of having more than just one person's input; the team was helpful; Made me look at something differently to find a connection.	26	50%
I was able to take time during the break to focus in on myself (to think, gather my thoughts); It gave us time to talk with each other.	10	19%
I don't like the mirrors, so it made me uncomfortable, takes time to get used to; intimidating.	9	17%
The break was too long.	3	6%
I would have rather had the team in the room.	2	4%
I found the phone to be disruptive, and wished the teams comments had come at the break.	2	4%
TOTAL:	52	

There were relatively few comments for question six regarding clients' perceptions of the overall assistance they received in their session (N=13). Of the 13 comments contributed by respondents, all but two were positive.

How Does the Nature of the Presenting Concern Relate to Client Satisfaction?

Table 8 displays the six categories of presenting concerns hypothesized by Hoyt (1995) to be concerns held by people who are less likely to benefit from a single session therapy setting. This table lists the presenting concern codes (see Appendix D) used at the Eastside Family Centre that correspond to the categories of presenting concerns described by Hoyt. Of all the clients in the sample, 102 (24%) clients' primary presenting

concerns were under one of Hoyt's six categories. More than 50% of this group fell under category 3--persons suffering from strong biological or chemical components (i.e. schizophrenia, manic depression, alcohol/drug addition or panic disorder). The second largest group (N=27) was under category 4--persons recovering from childhood or adult abuse. The third largest group (N=15) was under category 2--suicidal or psychotic persons. Only seven respondents fell under the remaining three categories (1, 5 & 6).

Table 8

Presenting Concern Codes Listed by Hoyt's (1995) Categories (N=102)

Category 1

<u>Persons needing psychiatric care;</u>	<u>N=2</u>
PSY	Psychiatric diagnosis
DIS	Dissociative states

Category 2

<u>Suicidal or psychotic persons;</u>	<u>N=15</u>
SSH	Suicidal/Self harm
PAS	Past thoughts of suicide
PRS	Present thoughts of suicide
PSH	Past self-harming behavior
SHB	Present self-harming behavior
ASS	Attempted suicide in past
RSS	Recent suicide attempt
HRE	High risk (of self harm or suicide) in current environment
OSS	Other (suicide or self harming concerns)

Category 3

<u>Persons suffering from strong biological or chemical components (i.e. schizophrenia, manic depression, alcohol/drug addition or panic disorder;</u>	<u>N=53</u>
ADH	Attention deficit hyperactivity disorder
MHI	Mental health issues
DEP	Depressed/withdrawn
GAS	Anxiety/Stress (includes post traumatic stress response)
PPD	Post partum depression/psychosis
ADD	Addictions
ALC	Alcohol addiction
PDA	Abuse of prescription drugs
OCD	Abuse of over the counter drugs
SFT	Abuse of soft drugs (i.e. marijuana, hash)
HRD	Abuse of hard drugs (i.e. cocaine, crack, LSD)
SOL	Abuse of solvents (glue, liquids)
IDU	Intravenous drug use
OAI	Addictions (other)

Category 4

<u>Persons recovering from childhood or adult abuse;</u>	<u>N=27</u>
VOA	Abuse/Violent Issues (victim of)
PNV	Physical neglect (victim of)
PAV	Physical abuse (victim of)
EAV	Emotional neglect/abuse (includes verbal abuse/degradation) (victim of)
SAV	Sexual abuse/assault (victim of)

Category 5

<u>Persons with eating disorders or severe obsessive-compulsive problems;</u>	<u>N=1</u>
EAT	Eating Disorder

Category 6

<u>Persons with chronic pain syndromes and somatoform disorders;</u>	N=4
HEI	Health issues (mental/physical handicap, acute/chronic illness)

Table 9 provides a description of the overall satisfaction rating (item # 6) by the categories of presenting concerns listed in Table 8. The overall satisfaction rating for the 293 respondents whose presenting concerns were not under Hoyt's six categories was 83.3%, (with scores between four and five). This was the same average rating of general satisfaction for the entire sample (N=403, see Table 1). Overall satisfaction ratings were slightly lower for clients whose primary presenting concerns were under category 3 (persons suffering from strong biological or chemical components), with 81.1% reporting general satisfaction (N=53). Overall satisfaction ratings were also lower for client's whose primary presenting concerns were under category 2 (suicidal or psychotic persons), with 80% reporting general satisfaction with their single session therapy (N=15). In contrast to Hoyt's hypothesis, 100% of the clients with presenting concerns under category 4 (persons recovering from childhood or adult abuse) reported general satisfaction with the assistance received in their walk-in single session therapy (N=27). Those with chronic pain/health issues (category 6, N=4) rated their satisfaction as substantially lower than the mean, with only 50% reporting general satisfaction. The two clients in the sample with psychiatric diagnoses listed as the primary concern both reported lower satisfaction, with scores between one and three. The one client in the

sample under category five (eating disorder) reported general satisfaction. It is difficult to draw any significant conclusions from the satisfaction results of the clients with presenting concerns of chronic pain/health issues, psychiatric diagnosis and eating disorder due to the small sample sizes for these categories.

Table 9

Client Satisfaction Ratings by Selected Categories of Presenting Concerns

<u>Presenting Concern Category</u>	<u>N=</u>	<u>SD</u>	<u>Percent Between 4-5</u>	<u>Percent Between 1-3</u>
Psychiatric Diagnosis	2	.00	0%	100%
Suicidal Thoughts/Behaviors	15	.83	80%	20%
Biological Components	53	.89	81.1%	19.9%
Childhood or Adult Abuse	27	.48	100%	0%
Eating Disorder	1	na	100%	0%
Chronic Pain/Health Issues	4	1.15	50%	50%
All Other Presenting Concerns Not Listed in Above Categories	293	.83	83.3%	16.7%

Table 10 lists the 15 most common presenting concerns in the sample population, as organized by the primary presenting concern code recorded by the therapist. This listing represents 67% of the primary concern codes for the sample (N=269). By far the most common primary presenting concern was marital and couple conflict (MCC, N=61), with 83.6% of the clients with this presenting concern reporting general satisfaction (scoring between four and five) with the assistance received in their walk-in single session therapy. Satisfaction ratings were highest for clients whose presenting concerns

included sexual abuse/assault (SAV, N=8) and self esteem issues (SEI, N=8), with 100% reporting general satisfaction with their walk-in single session therapy. Clients whose primary presenting concern included child behavior problems (CBP) also reported high levels of satisfaction, with 93.1% (N=29) scoring between four and five. Satisfaction ratings were lowest for clients whose primary presenting concerns included anxiety and stress, including post traumatic stress response (GAS), with only 54% (N=11) reporting general satisfaction. Clients whose primary presenting concern included parenting issues (PTI) also reported lower levels of satisfaction, with only 68.8% (N=16) reporting general satisfaction.

Table 10

Client Satisfaction Ratings by Primary Presenting Concern Code (N=269)

<u>Primary Presenting Concern</u>	<u>N=</u>	<u>SD</u>	<u>Percent Between 4-5</u>	<u>Percent Between 1-3</u>
Marital/Couple Conflict (MCC)	61	.76	83.6%	16.4%
Depression/Withdrawn (DEP)	30	.92	86.7%	10.3%
Child Behavior Problems (CBP)	29	.74	93.1%	6.9%
Separation Issues (SEP)	23	.88	82.6%	17.4%
Family Breakdown Issues (FBI)	19	.69	89.5%	10.5%
Defiant/Non Compliant Child (DNC)	17	1.03	82.4%	17.6%
Parenting Issues (PTI)	16	1.2	68.8%	31.2%
Life Transition/Developmental Issues (DTI)	12	.67	91.7	8.3%
Anxiety/Stress (includes post traumatic Stress Response (GAS)	11	1.00	54.5%	45.5%
Parent/Adolescent & Parent/Child Conflict (PAC)	11	.82	81.8%	18.2%
Alcohol (ALC)	8	.76	87.5%	12.5%
Custody/Co-Parenting Issues (CUS)	8	1.06	87.5%	12.5%
Relationship Issues (Individual/Family/Couple) (FRI)	8	1.13	75%	25%
Sexual Abuse/Assault (SAV)	8	.46	100%	0%
Self Esteem Issues (SEI)	8	.46	100%	0%

How Does Clients' Satisfaction with Other Treatment Variables Relate to Overall Client Satisfaction with Walk-In Single Session Therapy?

The results of a simultaneous multiple regression analysis for the five variables explaining overall client assistance received is presented in Table 11. Variables explaining clients' ratings of overall assistance received include:

- Category of Presenting Concern - this variable denotes whether the client's primary presenting concerns were under one of the six categories listed in Table 8 (N=102).

- Explanation of Confidentiality - this variable represents clients' ratings of satisfaction with counselors explanation of confidentiality, as rated by item # 4 on the *Client Satisfaction Questionnaire*.
- Clarity of Forms Used - this variable represents clients' ratings of satisfaction with the simplicity and straightforwardness of the forms filled out when clients first enter the Eastside Family Centre's walk-in service. This was measured by item # 3 on the *Client Satisfaction Questionnaire*.
- Impression of the Reception Service - this variable represents clients' ratings of satisfaction with the first impression of the reception service at the Eastside Family Centre (item # 2).
- Satisfaction with the Team Approach - this variable represents clients' ratings of satisfaction with the use of the team approach (mirror, phone calls, taking a break) on a five point scale, with one equaling "disruptive" and five equaling "helpful".

Nineteen percent of the variation in clients' ratings of overall assistance received in the session was explained by the combination of treatment variables listed above ($p \leq .0005$). Regression analysis revealed that satisfaction with the team approach had the greatest influence on overall ratings of assistance received ($\beta = .295$, $p \leq .0005$). Satisfaction with the explanation of confidentiality ($\beta = .173$, $p \leq .05$), and clarity of forms

used ($\beta=.120$, $p\leq.05$) were also significantly associated with clients' ratings of overall assistance received in their walk-in single session therapy.

Table 11
Multiple Regression Analysis of Treatment Variables Explaining Overall Client
Satisfaction (N=403)

<u>Variable</u>	<u>B</u>	<u>SE B</u>	<u>β</u>
Category of Presenting Concern	.013	.025	.027
Explanation of Confidentiality	.240	.086	.173*
Clarity of Forms Used	.127	.064	.120*
Impression of Reception Service	.027	.060	.026
Satisfaction with the Team Approach	.259	.050	.295**

Note: $F=14.28^{**}$; $R\text{-Square}=.21$; Adjusted $R\text{-Square}=.19$
* $p\leq.05$, ** $p\leq.0005$

What Do Clients Believe Are the Greatest Strengths of the Walk-In Single Session
Therapy Service at the Eastside Family Centre?

Seventy-nine percent of the total sample contributed a comment about the perceived strengths of the service. An analysis of clients' comments on the Client Satisfaction Questionnaire (item # 7, N=329) revealed that about 30% of the people who responded to this question (N=100) listed the immediate accessibility and the walk-in

service as the Eastside Family Centre's greatest strength. "Having a person who will listen" was listed by 18% of the respondents (N=60). Counselor characteristics such as caring attitude and personal touch were listed by 15% (N=48) as the greatest strength, while 7% (N=23) listed the advice and direction provided by the counselor.

Table 12

Analysis of Client Comments About the Centre's Greatest Strength - Organized by Theme

<u>Comments:</u>	<u>N=</u>	<u>Percent of total:</u>
Walk-In services (immediate accessibility); availability.	100	30%
A person who will listen; being able to talk to someone; to confide in someone.	60	18%
Caring attitude of the counselor; personal touch; friendly manner; kindness; support; encouragement; understanding; frank; honest; congenial.	48	15%
Advice; direction; guidance for my life; objective professional assessment and suggestions.	23	7%
No charges for services.	19	6%
Talking to someone not directly involved in my problem -someone with better perspective (objective point of view); different point of view; venting to someone neutral, non-judgmental.	18	5%
Team resource (teamwork).	17	5%
Helping with communication.	10	3%
Referral to other resources.	8	2%
Confidentiality.	7	2%
Reassurance & hope offered.	4	1%
Relaxed atmosphere (calm surroundings); welcoming.	3	1%
Good reflective questions.	3	1%
A place to let the family talk rationally to each other & try to work out problems.	2	1%
Information that was available (explained things); literature received.	2	1%
Validation that I'm normal (OK).	1	.3%
Offering alternatives (other options).	1	.3%
Giving me things to think about.	1	.3%
I wasn't rushed.	1	.3%
Helped me focus.	1	.3%
TOTAL:	329	

What Changes Would Clients Recommend for the Walk-In Single Session Service?

Only 12% of the sample (N=50) completed item # 8, regarding one change they would recommend for the service (Table 13). Of this group, 18% (N=9) listed ongoing counseling with the same counselor as a recommended change. Longer sessions was listed by 12% of the respondents as a recommended change (N=6), while more advertisement of the centre's services was listed by 12% (N=6).

Table 13

Analysis of Client Comments About Recommended Changes - Organized by Theme

<u>Comments:</u>	<u>N=</u>	<u>Percent of total:</u>
Ongoing counseling with the same counselor.	9	18%
Longer sessions.	6	12%
More advertisements letting people know you are here; sign in front.	6	12%
Open longer hours.	3	6%
Take appointments.	3	6%
More privacy.	3	6%
More emphasis on follow-up.	2	4%
Legal advice services.	2	4%
Another location; different location.	2	4%
Shorter waiting time; More attentive reception.	2	4%
Ask more questions.	1	2%
More reading material (magazines) in lobby.	1	2%
More staff/counselors.	1	2%
Counselors should wear name tags.	1	2%
Positive feedback.	1	2%
Remove mirrors; no team approach.	1	2%
More Kleenex.	1	2%
Patrons pay for coffee.	1	2%
Therapists should not take sides...it isn't nice.	1	2%
Therapist could have listened more.	1	2%
Take "family" out of name of service, this is deceiving.	1	2%
Smoking rooms.	1	2%
TOTAL:	50	

Chapter Five

Discussion

In the most general terms, we are all much more simply human than otherwise, be we happy and successful, contented and detached, miserable and mentally disordered, or whatever.

--Harry Stack Sullivan, (1953)

Overall Client Satisfaction with Walk-In Single Session Therapy

The overall client satisfaction at the Eastside Family Centre was quite high with 83.3% of the respondents reporting general satisfaction (between four and five) with the assistance they received in their walk-in single session therapy. Mean scores of satisfaction indicated clients were most satisfied with the therapists' explanation of confidentiality (4.63) and the overall assistance received (4.37). Clients reported general satisfaction with the explanation of confidentiality 95% of the time, while 4.5% rated their satisfaction with the explanation of confidentiality as a three.

Talmon, Rosenbaum, and Hoyt's (1990) study of client satisfaction and outcomes in single session therapy by appointment offered the most comparable research on the subject. Talmon and his associates found that of the 58 single session therapy clients in their sample, 88% reported "improvement" or "much improvement" as a result of their therapy (three to twelve months after therapy, as measured on a similar five point scale). Seventy-nine percent of the respondents in Talmon's study reported that their single session therapy had been sufficient to address their problems.

Kogan's (1957) study of 250 cases seen at a New York community clinic found that 56% (N=141) were seen for only a single session. Of these 141 single session cases, 67% felt they had been helped. Bloom's (1981) study of planned single session therapy by appointment found that when questioned three to four months after their single session, 90% (N=9) of the clients treated felt they were helped by their single session. One client sought additional therapy.

Client satisfaction ratings in this study were slightly lower than those reported in Doherty and Simmon's (1996) national study of client satisfaction with traditional marriage and family therapy services. In Doherty and Simmon's study, 91.2% of the clients in the sample indicated that they were satisfied with the help they received. Doherty and Simmons used a similar scale when measuring client satisfaction (Attkisson & Zwick, 1982), although their method of gaining client feedback was somewhat different. In their study, the therapists chose the clients to whom they would send their client satisfaction questionnaires. At the Eastside Family Centre, all clients treated in the walk-in single session service were given a questionnaire. It is also interesting to note that Doherty and Simmons (1996) excluded single session assessments and consultations from their study but included single session therapy interviews. The outcomes of these single session therapy interviews and the distinction between consultation, assessment, and single session therapy were not reported in the study.

The Relationship Between Presenting Concerns and Client Satisfaction

The most common primary presenting concern (as identified by concern codes, see Appendix D) in the sample was marital and couple conflict (N=61, see Table 10), followed by depression/withdrawal (N=30), child behavior problems (N=29) and separation issues (N=23). This finding is similar to the distribution of presenting concerns in traditional marriage and family therapy settings as reported by Doherty and Simmon's (1996) study of the national practice patterns in the field (N=850). The most common presenting concerns reported by clients in the sample for this study included predominantly relational concerns (where more than one person was involved in the problem), with the possible exception of depression/withdrawal (DEP). Talmon has suggested that clients "with significant others or family members who can serve as natural supports and cotherapists" are the most likely candidates for successful single session therapy (Talmon, 1990, pg. 31). Hoyt (1995) has a similar view regarding family involvement in single session therapy.

As predicted by Weinstein (1979) and Zastowny et al. (1983), there was much variation in client satisfaction by different presenting concerns (diagnoses). General satisfaction scores ranged from 100% (N=8) for those with self-esteem issues (SEI) as the presenting concern, to 54.5% (N=11) for those with presenting concerns of anxiety/stress including post traumatic stress response (GAS).

Hoyt's (1995) hypothesis that people with certain presenting concerns (Table 8) would be less satisfied from single session therapy was not supported by the multiple

regression analysis (Table 11) of walk-in single session therapy. A closer look at the data (Table 9) indicates that satisfaction scores for persons suffering from strong biological or chemical components (i.e., schizophrenia, manic depression, alcohol/drug addiction or panic disorder) and suicidal persons were slightly lower than the scores for the entire sample, possibly confirming Hoyt's hypothesis for these populations. Neither of the two clients whose presenting concerns included psychiatric diagnoses (PSY) reported general satisfaction with the assistance received. Only two of the four clients in the sample seen for chronic pain and health issues (HEI) reported general satisfaction. This would also seem to support Hoyt's hypothesis, although the small sample size for these populations prohibits any firm conclusions. The results did not support Hoyt's hypothesis regarding persons recovering from childhood or adult abuse, with 100% of the clients (N=27) reporting general satisfaction with the assistance they received in their walk-in single session (the general satisfaction score for the entire sample was 83.3%, N=403). This finding may be attributed to the immediate accessibility of the service, allowing these clients to get help in times of need. It is also possible that while satisfaction is high with clients who present with these concerns, they may not actually experience any long-term benefits or may require additional treatment.

The Relationship Between Selected Treatment Variables and Client Satisfaction

Nineteen percent of the variation in clients' ratings of overall assistance received in the session was explained by the treatment variables (Table 11). The treatment

variables included: category of presenting concern, explanation of confidentiality, clarity of the forms used, impression of the reception service, and satisfaction with the team approach. Satisfaction with the explanation of confidentiality ($\beta=.173$, $p\leq.05$), and clarity of the forms used ($\beta=.120$, $p\leq.05$) contributed significantly to clients' overall ratings.

Clients' satisfaction with the use of the team approach ($\beta=.295$, $p\leq.0005$) had the greatest influence on overall ratings. This finding emphasizes the importance of clients' satisfaction with the team approach in relation to the level of overall satisfaction. Clients' satisfaction ratings for overall assistance received were only slightly lower for those clients who did not use the team approach in their treatment. Of those who used a team, 83.8% reported general satisfaction with the assistance received in the session, while 82.3% of those who did not use a team reported general satisfaction. The influence of clients' satisfaction with the team approach on their overall ratings of assistance received in the session ($\beta=.295$, $p\leq.0005$) may be due to the fact that the team approach was so strongly associated with the process of therapy at the Eastside Family Centre. Some form of the team approach was used in 78% of the cases in the sample. It was difficult to make any firm conclusions about the use of an in-session team consultation because there was no distinction in the data between those clients who used an in-session team consultation (with the team behind the mirror) and those who used a consulting team approach during the session. In the consulting team approach the therapist took a break in the session and discussed the session with the team in the consultation room.

Of those who offered a comment about the use of the team approach (N=52), 69% reported favorable feedback about the use of the team in the therapy session (Table 7). Fifty percent (N=26) of those who commented reported that they liked the team approach because it provided more than one person's input and that it helped clients look at things differently. This supports Kerns and Markowski's findings (1996) that those who use the team approach received more affirmation and encouragement than non-team clients, and that they were more able to identify new ways of relating to one another.

Nineteen percent of those who commented, indicated that the team approach was useful, not because of the feedback from the team, but because it allowed individuals to collect their thoughts and family members to talk with each other during the break. This was the second most common type of comment regarding the use of the team (N=10). Kerns and Markowski's findings (1996) indicated that families' ability for catharsis in a therapy session was stifled by a team approach. Kerns and Markowski's findings may be supported by clients' comments in this study, indicating that some clients seized the opportunity for catharsis during the break in the session.

Strengths and Recommended Changes in Walk-In Single Session Therapy

One of the unique characteristics of the service at the Eastside Family Centre is that it offers a walk-in service where no appointments are required or taken (Slive et al., 1995). Clients are able to address their concerns almost immediately (clients are usually seen within 30 minutes of entering the centre, Slive et al., 1990). One hundred people

(30% of those who responded about the centre's greatest strength) indicated that the greatest strength of the centre was the walk-in availability (immediate accessibility) of services. This comment was the most common comment regarding the greatest strength of the centre. This aspect of the timing of therapy has not been addressed in the single session therapy research reviewed for this study. The idea that therapy must begin by scheduling appointments appears to be rooted in the idea that therapy involves a long standing relationship between the client and the therapist (Hoyt, 1995). Lambert (1986) has suggested that a positive relationship between the therapist and the client is a common factor associated with positive outcomes in most traditional therapy approaches. The third most common type of comment about the service's greatest strength involved some aspect of the therapist's personality and the relationship with the client (i.e., caring attitude of the counselor; personal touch; friendly manner). This would seem to confirm that characteristics of the counselor and the their relationship with the client are important aspects of client satisfaction. This would also seem to indicate that therapeutic client/therapist relationships are possible in a single session therapy format.

Spoerl (1957) suggested that single session therapy often works simply because it allows clients to pour out their feelings and to review their concerns with a therapist. Client comments confirmed this idea, with the second greatest strength (18%, N=60) listed as simply having someone there who will listen. Spoerl (1957) also suggested that single session therapy clients are often simply seeking advice and guidance. This idea was supported by the results, with the fourth most common type of comment regarding

centre strengths (N=23) listing the advice, direction, guidance or suggestions given by the counselor.

Only 12% (N=50) of those who responded offered a comment about the recommended changes for the service. The most common recommended change included ongoing counseling with the same therapist (18%, N=9) and longer sessions (12%, N=6). Although this represents a small portion of the total sample, it provides evidence that some clients may be seeking more traditional therapy services. Clients at the Eastside Family Centre are always invited by their therapist to return for another walk-in session if needed. If other services are required after the single session, clients may be referred to one of the many services offered at the Eastside Family Centre (see Appendix A) or may be referred to other agencies (Slive et al., 1995).

Limitations of the Study

Although client satisfaction at the Eastside Family Centre is quite high, as measured immediately after the session, further studies are needed to determine the outcome of services rendered after clients leave the session and return to their lives. As Gutek (1978) has pointed out, people seem to be satisfied with everything social scientists ask them about, and care should be taken when interpreting positive findings. Of the 38 client satisfaction studies reviewed by Weinstein (1978), 78% reported positive satisfaction.

Caution should be observed in generalizing these results to other clinical populations. This sample included clients who voluntarily returned questionnaires, with only 23% of the 1,790 cases seen during the study completing the questionnaire. Couch and Kinston (1960) have suggested that one limitation of client satisfaction studies is the possibility of serious bias occurring as a result of “yeasaying”. Clients may also fear reporting negative satisfaction with services because of the expectation of repercussions from the caregiver (Albers, 1977). It should also be noted that therapists’ level of experience and education were not examined as factors effecting overall client satisfaction, although these factors are likely to influence clients’ ratings. All therapists at the Eastside Family Centre hold graduate degrees in counseling or a related field and attend training workshops before seeing clients. Attempts are made to control for variation in clinicians’ experience and education through the use of the team approach. Seventy-eight percent of the clients in the sample were treated through the team approach (either with a mirror, or through case consultation during a break in the session, N=315).

As is true for most client satisfaction questionnaires (Gutek, 1978; Kalman, 1983; Lebow, 1982; Thomas & Penchansky, 1984; Zastowny & Lehman, 1988; Zastowny, Roghmann, & Hengst, 1983), the Client Satisfaction Questionnaire lacks reliability coefficients, validity replications, and a standardized methodology. Item # 3 on the Client Satisfaction Questionnaire regarding clients’ satisfaction with the forms used at the centre reads, “The forms I filled out were simple and straightforward” with an opportunity of clients to respond on a five point scale from “poor” to “excellent”. This

item is poorly worded and appears to lead clients to respond favorably by making a statement, as opposed to asking a question.

Clients' overall rating of assistance received in the session was measured with a single item. Although this is consistent with many client satisfaction questionnaires (Talmon, 1990; Tomlinson, 1988; Zastowny, Roghmann, & Hengst, 1983), it tends to be an overly simplistic, one dimensional method of measuring satisfaction. One possible advantage of a single item measure of satisfaction is that it allows for a greater degree of comparison with other single item measures, and takes little time to complete.

Finally, no demographic information was collected on the clients in the data set. This limitation of the study should be taken into consideration when generalizing these results to other populations. Future investigation of client satisfaction and outcome at the Eastside Family Centre should include demographic information about the respondents.

Recommendations for Future Research of Walk-In Single Session Therapy

A follow-up protocol (see Appendix E) adapted from Talmon's 1990 study has been created to aid in furthering this investigation. The *Walk-In Single Session Therapy Follow-Up Interview Protocol* was designed to be delivered by phone two to three months after clients are seen for their single session. Telephone inquiries should ensure a higher response rate than questionnaires (Fiester, 1979). Demographic information such as age, gender, income and race/ethnicity could also be collected and analyzed for their influence on outcome.

Although client satisfaction with the walk-in single session therapy at the Eastside Family Centre was high as measured immediately after the therapy session, it remains unclear if the positive effects of treatment endure after clients leave the centre and return to their lives. Further study is required to determine the outcome of therapy. As Edwards, Yarvis and Mueller (1978) have suggested, client satisfaction and outcome are correlated, although they must be viewed as distinct entities (Edwards et al., 1978; Kalman, 1983). Item #2 on the *Walk-In Single Session Therapy Follow-Up Interview Protocol* was designed to determine the outcome of clients' presenting concerns.

Talmon has called for future research into the effect of the team approach on single session therapy. The findings in this study indicate that it was an important factor regarding clients' ratings of overall assistance received, but it remains unclear if clients benefit from the use of an in-session team consultation approach. Recent research on the subject has proven inconclusive (Kerns & Markowski, 1996). The use of in-session team

consultations (use of the team behind the mirror) can be recorded on the Walk-In Single Session Therapy Follow-Up Interview Protocol, providing a way to investigate the impact of the in-session team consultation on outcome and satisfaction.

Although clients list the *immediate accessibility of the service, providing someone who will listen, and the caring attitudes of the therapists* as some of the greatest strengths of the Eastside Family Centre, the process of successful walk-in single session therapy remains unclear. It is difficult to determine from the present data exactly what clients find useful about the approach in resolving their problem(s). Items #3, #4, #5, # 7 and #8 on the Walk-In Single Session Therapy Follow-Up Interview Protocol were designed to investigate this aspect of treatment.

The therapists' level of experience, education and theoretical orientation was not considered as a factor in this study, although it is likely to effect the process of therapy. Talmon, Rosenbaum and Hoyt's (1990) study of client outcome and satisfaction in single session therapy, found that there were only minor differences in outcomes for the clients of each of the three therapists in the study. Although the therapists had similar levels of experience and education, they differed according to their theoretical orientations. Talmon's investigation of the prevalence of single session therapy in the 1980's at Kaiser Permanente reported that the frequency of single session therapy cases seen by therapists remained the same for all the therapists in the study (Talmon, 1990). The Eastside Family Centre's community therapy program is comprised of over 30 mental health professionals with a variety of theoretical orientations and levels of experience and

education. The Walk-In Single Session Therapy Follow-Up Interview Protocol was designed to record therapists' theoretical orientation, education, and years of clinical experience.

Hoyt (1995) and Talmon (1990) have hypothesized that family members often serve as natural cotherapists and that single session therapy is likely to be more beneficial to the client when family members are included in the treatment process. This hypothesis remains untested. The Walk-In Single Session Therapy Follow-Up Interview Protocol was designed to record how many family members participated in the treatment process.

Talmon (1990) reported that there was a "ripple effect" apparent in successful single session therapy, with clients reporting positive changes in areas not related to the presenting concern. Item #6 on the Walk-In Single Session Therapy Follow-Up Interview Protocol was designed to measure clients' possible improvements in other areas of life, not directly related to the presenting concern.

Finally, it was unclear how many clients find the walk-in single session therapy sufficient to address their concerns, and how many required continued treatment elsewhere. Item #10 on the Walk-In Single Session Therapy Follow-Up Interview Protocol was designed to evaluate this aspect of treatment.

References

- Albers, R. (1977). Patient satisfaction: Problems and prospects. Psychiatric Outpatient Clinics of America, 11, 11-14.
- American Psychiatric Association. (1987). Diagnostic and statistical manual of mental disorders (3rd ed., rev.). Washington, DC: Author.
- Attkisson, C., & Zwick, R. (1982). The client change questionnaire: Psychometric properties and correlations with service utilization and psychotherapy outcome. Evaluation and Program Planning, 5, 233-237.
- Becker, M., Haefner, D., & Kasl, S. (1977). Selected psychosocial models and correlates of individual health-related behaviors. Medical Care, 15, 27.
- Ben-Sira, Z. (1976). The function of the professional's affective behavior in client satisfaction: A revised approach to social interaction theory. Journal of Health and Social Behavior, 17, 3-11.
- Berg, I. (1989). Of visitors, complainants, and customers: Is there really any such thing as resistance. The Family Therapy Networker, 13 (1), 21.
- Berg, I., & Miller, S. D. (1992). Working with the problem drinker: A solution-focused approach. New York: W. W. Norton.
- Beroza, R. (1983). The shoemaker's children. Family Therapy Networker, 7 (2), 31-33.
- Bion, W. (1967). Notes on memory and desire. Psychoanalytic Forum, 2, 271-280.
- Cited by M. Hoyt, Brief therapy and managed care. San Francisco: Jossey Bass.

- Bion, W. (1977). Attention and interpretation. In W. Bion, Seven servants. New York: Jason Aronson. Cited by M. Hoyt, Brief therapy and managed care. San Francisco: Jossey Bass
- Bloom, B. (1981). Focused single session therapy: Initial development and evaluation. In Budman, S. (ed.), (1981). Forms of brief therapy. New York: Guilford.
- Bloom, B. (1992). Planned short term psychotherapy. Needham Heights, MA: Allyn & Bacon.
- Budman, S., & Gurman, A. (1988). Theory and practice of brief therapy. New York: Guilford.
- Burgoyne, R., Wolken, G., Staples, F., & Powers, M. (1977). Which patients respond to a mental health consumer survey. American Journal of Community Psychology, 5, 355-360.
- Cade, B., & O'Hanlon W. (1993). A brief guide to brief therapy. New York: W. W. Norton.
- Clouthier, K. (1996). Single session intervention: An alternative to traditional therapy. Presentation at the Brief Therapy Training Centres - International. London, Ontario, Canada.
- Couch, A., & Kinston, K. (1960). Yeasayers and naysayers: Agreeing response set as a personality variable. Journal of Abnormal and Social Psychology, 60, 151-174.
- de Shazer, S. (1982). Patterns of brief family therapy. New York: Guilford.
- de Shazer, S. (1985). Keys to solution in brief therapy. New York: W. W. Norton.

- Denner, B., & Halprin, F. (1974a). Clients and therapists evaluate clinical services. American Journal of Community Psychology, 2, 373-378.
- Denner, B., & Halprin, F. (1974b). Measuring consumer satisfaction in a community outpost. American Journal of Community Psychology, 2, 13-22.
- Doherty W. J., & Simmons D. S. (1996) Clinical practice patterns of marriage and family therapists: A national survey of therapists and their clients. Journal of Marital and Family Therapy, 22, 1.
- Edwards, D., Yarvis, R., & Mueller, D. (1978). Does patient satisfaction correlate with success? Hospital and Community Psychiatry, 29, 188-190.
- Ellsworth, R. (1975). Consumer feedback in measuring the effectiveness of mental health programs. In M. Guttentag & E. L. Struening (Eds.) Handbook of evaluation research (Vol. 2). Beverly Hills, CA: Sage.
- Ellsworth, R. (1979). Does follow-up loss reflect poor outcomes? Evaluation and the Health Professions, 2, 419-437.
- Erickson, M. H. (1980) Collected Papers, 1-4. (E. Rossi, ed.) New York: Irvington.
- Cited by M. Hoyt, Brief therapy and managed care. San Francisco: Jossey Bass.
- Fiester, A. (1979). Goal attainment and satisfaction scores of community mental health center clients. American Journal of Community Psychology, 7, 181-188.
- Frances, A., & Clarkin, J. (1981). No treatment as a prescription of choice. Archives of General Psychiatry, 38, 542-545. Cited by M. Hoyt, Brief therapy and managed care. San Francisco: Jossey Bass.

- Frank, R., Salzman, K., & Fergus, E. (1977). Correlates of consumer satisfaction with outpatient therapy assessed by postcards. Community Mental Health Journal, 13, 37-45.
- Freud, S. (1919). Lines of advance in psycho-analytic therapy. In J. Strachey (ed.), The standard edition of the complete psychological works of Sigmund Freud. Vol. 17. London: Hogarth Press, 1953-1974. (Originally Published in 1919).
- Garrard, A., Godwin, J., & Wood, M. (1994). Frommer's comprehensive travel guide: Canada 1994-1995. Toronto: Prentice Hall.
- Gergen, K. (1985). The social constructionist movement in modern psychology. American Psychologist, 40, 266-275.
- Gordon, D, Alexander, D., & Dietzan, J. (1979). The psychiatric patient: A voice to be heard. British Journal of Psychiatry, 135. 155-121.
- Gurman, A., & Kniskern, D. (1991). Handbook of family therapy. New York: Brunner Mazel.
- Gutek, B. (1978). Strategies for studying client satisfaction. Journal of Social Issues, 34 (4), 44-56.
- Hillman, J., & Ventura, M. (1992). We've had a hundred years of psychotherapy--and the world is getting worse. San Francisco: Harker.
- Hoffart, B., & Hoffart, I. (1994). Program evaluation of eastside family centre. Synergy Research Group. Unpublished Manuscript. Calgary, Alberta, Canada.

- Hoyt, M. (1993). Two cases of brief therapy in an HMO. In R. A. Wells and V. J. Giannetti (eds.), Casebook of brief psychotherapies. New York: Plenum.
- Hoyt, M. (1995). Brief therapy and managed care: Readings for contemporary practice. San Francisco: Jossey-Bass.
- Hoyt, M., & Talmon, M. (1990). Single session therapy in action: A case example. In M. Talmon. (1990), Single session therapy: Maximizing the effect of the first (and often only) therapeutic encounter. San Francisco: Jossey-Bass.
- Hoyt, M., Rosenbaum, R., & Talmon, M. (1992). Planned single session psychotherapy. In Budman, S., Hoyt, M., & Friedman, S. (eds.). (1992). The first session in brief therapy. New York: Guilford.
- Hulka, B., Kupper, L., Cassel, J., & Babineau, R. (1975). Practice characteristics and quality of primary medical care: The doctor-patient relationship. Medical Care, 13, 808.
- Hulka, B., Zyzawski, S., & Cassel, J. (1971). Satisfaction with medical care in a low income population. Journal of Chronic Disorders, 24, 661.
- Imberman, A. (1972). Is it true what they say about assembly line workers? Chicago: Imberman and Deforest Management Consultants.
- Jackson, D. (1965). The study of the family. Family Process, 4 (1), 1-20.
- Kalman, T. (1983). An overview of patient satisfaction with psychiatric treatment. Hospital and Community Psychiatry, 34 (1), 48-54.

- Katz, D., Gutek, B., Kahn, R., & Barton, E. (1975). Bureaucratic encounters: A pilot study in evaluation of government services. Ann Arbor: Institute for Social Research.
- Kerns, C., & Markowski, M. (1996). Client perceptions of family therapy with training team. Presentation at the American Association for Marriage and Family Therapy (AAMFT) Annual Conference in Toronto, Ontario, Canada, October 17, 1996.
- Koos, E. (1954). The health of regionville. New York: Hafner.
- Lambert, M. (1986). Implications of psychotherapy, In J. Norcross (ed.), Handbook of eclectic psychotherapy. New York: Brunner/Mazel.
- Lambert, M., Shapiro, D., & Bergin, A. (1986). The effectiveness of psychotherapy. In S. Garfield & A. Bergin (Eds.) Handbook of psychotherapy and behavior change (3rd ed.). New York: John Wiley & Sons.
- Larsen, D., Attkisson, C., Hargreaves, W., & Nguyen, T. (1979). Assessment of client/patient satisfaction: Development of a general scale. Evaluation and Program Planning, 2, 197-207.
- Lebow, J. (1982). Consumer satisfaction with mental health treatment. Psychological Bulletin, 91, (2), 244-259.
- Liske, C. (1991). The eastside family centre: Walk-in support for parents and youth - A profile interview with Dr. Arnie Slive. The Calgary Participator: A Family Therapy Newsletter, 1 (3), 3-10.

- Margolis, R., Sorenson, J., & Galano, J. (1977). Consumer satisfaction in mental health delivery services. Professional Psychology, 8, 11-16.
- Miller, S., Hubble, M., & Duncan, B., (Eds.). (1996). Handbook of solution focused brief therapy. San Francisco: Jossey Bass.
- Moore, S., & Kelly, M. (1996). Quality now: Moving human services organizations toward a consumer orientation to service quality. Social Work, 41 (1), 33-40.
- Nichols, M., & Schwartz, R. (1995). Family therapy: Concepts and methods, 3rd Ed. Boston: Allyn & Bacon.
- Norusis, M. (1993). Statistical package for social sciences for Windows™: Base system users guide. Chicago, IL: SPSS.
- O'Hanlon, W., & Weiner-Davis, M. (1989). In search of solutions: A new direction in psychotherapy. New York: W. W. Norton.
- Palazzoli, M. S., Boscolo, L., Cecchin, G., & Prata, G. (1978). Paradox and counter-paradox. New Jersey: Jason Aronson.
- Papp, P. (1977). The family who had all the answers. In P. Papp (Ed.), Family therapy: Full length case studies. New York: Gardner Press.
- Peke, T., Borduin, C., & Archer, R. (eds.). (1986). The relationship between client's expected and actual treatment duration. Psychotherapy, 23 (4), 532-534. Cited by M. Hoyt, Brief therapy and managed care. San Francisco: Jossey Bass.
- Piercy, F., & Sprenkle, D. (1986). Family therapy sourcebook. New York: Guilford.

- Quinn, R., & Shepard, L. (1974). The 1972-1973 quality of employment survey. Ann Arbor: Institute for Social Research.
- Ray, W., & Keeney, B. (1993). Resource focused therapy. London: Karnac Books
- Rockwell, W., & Pinkerton, R. (1982). Single session psychotherapy. American Journal of Psychotherapy, 36, 32-40.
- Roghamann, K., Hengst, A., & Zastowny, T. (1979). Satisfaction with medical care: Its measure and relation to utilization. Medical Care, 17, 461.
- Rosenbaum, R. (1990). Strategic psychotherapy. In Wells, R., & Giannetti, V., (eds.). (1990). Handbook of the brief psychotherapies. New York: Plenum.
- Rosenbaum, R. (1993). Heavy ideals: Strategic single session hypnotherapy. In Wells, R., & Giannetti, V., (eds.). (1993). Casebook of the brief psychotherapies. New York: Plenum.
- Rosenstock I. (1966). Why people use health services. MMFQ, 44, 94.
- Slive, A., MacLaurin, B., Oakander, M., & Amundson, J. (1995). Walk-in single session therapy: A new paradigm in clinical service delivery. Journal of Systemic Therapies, 14 (1), 3-11.
- Sorensen, J., Kantor, L., Margolis, R., & Galano, J. (1979). The extent, nature, and utility of evaluating consumer satisfaction in community mental health centers. American Journal of Community Psychology, 7 (3), 329-336.
- Spoerl, O. (1975). Single session psychotherapy. Diseases of the Nervous System, 36, 283-285.

- Sullivan, H. S. (1953). Conceptions of modern psychiatry. New York: W. W. Norton.
- Sullivan, H. S. (1954). The psychiatric interview. New York: W. W. Norton. Cited by
M. Hoyt, Brief therapy and managed care. San Francisco: Jossey Bass
- Talmon, M. (1990). Single-session therapy: Maximizing the effect of the first (and often only) therapeutic encounter. San Francisco: Jossey-Bass.
- Talmon, M. (1993). Single session solutions. Reading, MA: Addison-Wesley.
- Talmon, M., Hoyt, M., & Rosenbaum, R. (1990). Effective single session therapy: Step by step guidelines. In M. Talmon. (1990), Single session therapy: Maximizing the effect of the first (and often only) therapeutic encounter. San Francisco: Jossey-Bass.
- Thomas, J., & Penchansky, R. (1984). Relating satisfaction with access to utilization of services. Medical Care, 22 (6), 553-568.
- Tomlinson, D. (1988). A study of the effects of therapist access to client evaluation of therapy. Unpublished doctoral dissertation, University of Oregon, Eugene, OR.
- Wan T., & Soifer, S. (1974). Determinants of physician utilization: A causal analysis. Journal of Health and Social Behavior, 15, 100.
- Ware, J., Wright, W., & Snyder, M. (1975). Consumer perceptions of health care services: Implications for the academic medical community. Journal of Medical Education, 50, 839.
- Weinstein, R. (1979). Patient attitudes toward mental hospitalization: A review of quantitative research. Journal of Health and Social Behavior, 20, 237-258.

- White, M. (1986). Negative explanation, restraint and double description: A template for family therapy. Family Process, 25 (2).
- Windle, C., & Paschall, N. (1981). Client participation with community mental health care program evaluation. Community Mental Health Journal, 17, 66-76.
- Zastowny, T., & Lehman, A. (1988, September). Patient satisfaction with mental health services. Quarterly Research Bulletin, 284-289.
- Zastowny, T., Roghmann, K., & Hengst, A. (1983). Satisfaction with medical care: Replications and theoretical reevaluation. Medical Care, 11 (3), 295-322.
- Zusman, J., & Slawson, M. (1972). Service quality: Development of a technique for measuring quality in mental health services. Archives of General Psychiatry, 22, 692-698.

Appendix A

Review of Clinical Services Offered at the Eastside Family Centre from the “State of the Centre Report” by Hoffart and Hoffart, March 1994

1. **24-Hour Community Resource Team:** This service offers immediate crisis intervention for people in crisis through linkages with a citywide 24-hour crisis line that also provides mobile outreach crisis visits to the community.
2. **Focused Counseling Service:** This service offers clients the opportunity to meet with the same counselor for up to five sessions at a subsidized cost. For those who are financially challenged, volunteer opportunities, or “therapyships” can be arranged as forms of payment. There is no wait for these services.
3. **Home Connections:** This service is a home based treatment program designed to assist families in their efforts to prevent out of home placements or to facilitate a youth’s return from an alternative placement.
4. **Clinical Consultation:** The Eastside Family Centre offers opportunities for psychiatric consultation around mental health issues two afternoons per week to clients of the Eastside Family Centre, or other community programs and specified school programs for troubled youths.
5. **Hypnotherapy Program:** A community professional experienced in the practice of hypnotherapy is available one afternoon per week. Referrals to this service come through the walk-in counseling services.

6. **Multi-Language Counseling Services:** This service supports clients to receive assistance from a counselor in their own language. Counseling is currently available in Vietnamese and Spanish.
7. **Regenerations:** This service matches senior volunteers (age 55+) with single parents (and their families) who are in need of additional social support.
8. **Information Referral Services:** Callers to the Eastside Family Centre are offered up-to-date information about services available through the Eastside Family Centre and other community agencies.
9. **Educational Services:** The Eastside Family Centre offers a wide variety of clinics and educational services including weekly legal clinics, family and community mediation services, budget and money management clinics, “family wellness” seminars and adolescent issues groups.
10. **Certificate Training Program:** This program offers professionals an opportunity to receive theoretical instruction and supervised clinical practice in single session and brief therapies. This program was begun in September of 1993, and is taught by twelve professionals (some of whom are physicians).
11. **Community Therapist Program:** It is through this program that the Eastside Family Centre is able to offer its no-fee walk-in services. The Community Therapist Program is comprised of about 30 mental health professionals who donate their time for clients of the he walk-in counseling service, in exchange for training, American Association

for Marriage and Family Therapy (AAMFT) supervision and networking opportunities. These 30 professionals each offer approximately eight hours per month to the centre.

Appendix B

Client Satisfaction Questionnaire

EASTSIDE FAMILY CENTRE
Northgate Village Mall Suite 255
495 - 36th Street N.E.
Calgary, Alberta T2A 6K3
Phone: (403)299-9696
FAX: (403)248-8851

Eastside Family Centre is committed to providing the best possible service to community members who ask for assistance during troubling times. Collecting frequent and detailed feedback from those people who use our services is a good way for us to learn about what we are doing right, what we are doing wrong, and what we might do differently in order to keep the service as useful as possible.

Could you please take a few moments to fill out this questionnaire before you leave. Record-keeping for these questionnaires is set up so that while we know what kinds of difficulties you discussed while you were at the Centre on the day of your visit, we will not know your name. In this way we can assure you that all your comments and suggestions can be made anonymously. You may use the back of the form if you need more room for your comments.

My first impression of the Centre by phone was:

poor					excellent
1	2	3	4	5	

Comments:

My first impression of the reception service was:

poor					excellent
1	2	3	4	5	

Comments:

The forms I filled out were simple and straightforward:

poor					excellent
1	2	3	4	5	

Comments:

The way the counselor explained confidentiality was:

poor					excellent
1	2	3	4	5	

Comments:

(If your counselor worked with a team)

The use of the team approach (mirror, phone calls,) ^{disruptive} 1 2 3 4 ^{helpful} 5
taking a break) was:

Comments:

The overall assistance I/we received ^{poor} 1 2 3 4 ^{excellent} 5
in the session was:

Comments:

What would you describe as the greatest strength of this service?

What is one change you might recommend for the service?

THANK YOU FOR HELPING US TO STAY ON TRACK AND TO IMPROVE OUR
SERVICES TO YOUR COMMUNITY!

Appendix C

Clinical Guidelines for the Practice of Walk-In Single Session Therapy

quoted from:

Slive, A., MacLaurin, B., Oakander, M. & Amundson, J. (1995). Walk-in single session therapy: A new paradigm in clinical service delivery. Journal of Systemic Therapies, 14 (1), 3-11.

- *The “beginning” begins when the clients walk in the door. Clients are received in a friendly, inviting, dignified manner and wait in a comfortable space with and open play area for children. They are asked to fill out a “user friendly” form that does not pry about personal information but is designed to give clients an opportunity to guide the therapist and begin to think about solutions. Some choose not to fill out the form; they are never challenged. Despite the extraordinarily brief nature of the service, the intent is to develop a long-term relationship with community members. The fact that a major referral source is now “word-of-mouth” suggests that we are succeeding at our goal.*
- *The next “beginning” begins with the very first question asked by the therapist. When a therapist has 50 minutes, every one of those minutes counts. We have been experimenting with the first questions that do not even ask about the problem; instead we focus attention upon:*
“How will we know at the end of our meeting that this has been useful to you?”
“What will work for you today?”
“How will you and I know things are on the road to getting better?”
- *What the client wants from the session is usually more important than the particular presenting concern. The fact that a client’s presenting concern, for example, is that “thoughts in my head are racing out of control” does not orient the therapist as well as learning that the client wants to know “if I am crazy” or “how I can tell my*

psychiatrist that I don't want to be on medication." This is a "consumer-driven" service, and we can borrow from the vocabulary of the salesperson:

Rule One: Find out what the customers want.

Rule Two: Give it to them!

In this approach, we are more loyal to our customers than to any particular theory.

There are limitations to these rules. We are, after all, serving our community as well as our individual clients. Thus, when children are at risk, the appropriate authority is informed. When a woman is being assaulted by her partner, she is provided with information about the cycle and impacts of abuse, patriarchal social structures, and resources that will provide for her safety, whether she asks or not!

- *In this consumer-driven approach, when clients present more than one concern, we ask them to tell us which is the most important one to address today, or we seek to aggregate concerns under incorporating "themes" or unifying descriptions.*
- *Once the "problem talk" begins, negotiating a solvable framing of the problem is crucial. Consistent with the work of de Shazer (1985), White (1986), O'Hanlon & Weiner-Davis (1989), and Gergen (1985), rather than elaborating on presenting concerns, we are more interested in looking for:*
 1. *resources of the client/family;*
 2. *exceptions to the problem; and*
 3. *alternative ways to tell the tale.*

We aim for definitions or framings of concerns such that action can readily follow. Framings that naturally elicit client competence are most facilitative of brief interventions.

- *Two questions that facilitate the therapist's quest for direction in the 50-minute session are "What makes this a problem?" and "Why now?" The "What makes that*

a problem?” question helps a therapist appreciate a client’s idiosyncratic basis for defining something as problematic while the “Why now?” question addresses the immediate factors that led to a decision to seek therapy now.

- *The “position” of the clients in relation to therapy (i.e., how close or available they are for therapy-proper) needs to be addressed. Frameworks such as the solution-focused approaches “complainant-visitor-customer” dimension (Berg, 1989) are useful to keep in mind for the ideas they provide about the relationship between client and therapist and how to address the differing positions of the clients. Attending to this dimension can restrain the therapist from providing more help than the clients want in their 50 minutes.*
- *Therapist are encouraged to conceptualize the service as a form of consultation in which the consultee is the client/family. Ideas emerge during the course of the therapeutic conversation which clients take with them to “try on for size.” This frame is empowering for clients and does not imply the need for a “follow-up” meeting.*

On the other hand, strategies for “follow-up” are employed when a situation is assessed to be high-risk. These strategies might include utilization of the Centre’s 24-hour crisis service, a return visit (by appointment) with a consulting psychiatrist, or accessing either a hospital emergency service or child protection services.

- *At the end of the session, we thank our clients for coming and for sharing a part of their lives with us.*

Appendix D

CONCERN CODES:

PRESENTING CONCERN CODES BY CATEGORY

Adapted from the Eastside Family Centre Codes for Presenting Concerns

PAC	Parent/adolescent-Parent/Child Conflict
DNC	Defiant/Non Complaint
LIE	Lying
SFF	Stealing (from other family or others)
FIR	Firesetting
NPP	Peer Conflict/Pressure
CBP	Child Behavior Problems
SCF	Sibling Conflict
OPC	Other
RUN	Running Away
RFC	Running away from the family
KDH	Kicked out of the house
NOH	No Place to Stay/Potential Placement Breakdown
LOS	Living on the Streets
NEP	Needing Protection-place of safety
ORI	Other
SCH	School Concerns
TRU	Truancy
EXP	Expulsion/Suspension
ACI	Academic Issues
BDS	Behavior Problem
ADH	Attention Deficit Hyperactivity Disorder
PCP	Peer Conflict/pressure
SCO	Other

VOA	Abuse/Violent Issues
PNV	Physical Neglect
PAV	Physical Abuse
EAV	Emotional Neglect/abuse (includes verbal abuse/degradation)
SAV	Sexual Abuse/Assault
HAV	Harassment/stalking
EEV	Economic Exploitation
OVA	Other
PRP	Perpetrator
THP	Treats of violence/Psychological abuse
PDP	Property damage/destruction
PAP	Physical aggression/assaultive behavior (parents/sibs/spouse/peers/community)
VAP	Verbal aggression (threats/put-downs/intimidation/degradation)
SAP	Sexual Abuse/assault
EEP	Economic Exploitation
CAP	Cruelty to Animals
OPR	Other
LAW	Illegal Activity
ALT	Alternative measures (e.g. doing community service work
PRO	On Probation
CHP	Pending Charges
HCB	History of Criminal Activity
ACT	Criminal Activity (e.g. homicidal)
OLW	Other
MHI	Mental Health Issues
DEP	Depressed/withdrawn
GAS	Anxiety/Stress (includes post traumatic stress response)
EAT	Eating Disorder
PSY	Psychiatric diagnosis
PPD	Post partum depression/psychosis
DIS	Dissociative States
OMH	Other

SSH	Suicide/Self Harm
PAS	Past thoughts of suicide
PRS	Present thoughts of suicide
PSH	Past self-harming behavior
SHB	Present self-harming behavior
ASS	Attempted Suicide in past
RSS	Recent suicide attempt (1 year)
HRE	High risk in current environment
OSS	Other
ADD	Addictions
ALC	Alcohol
PDA	Abuse of prescription drugs
OCD	Abuse of over the counter drugs
SFT	Soft Drugs (e.g. marijuana, hash)
HRD	Hard Drugs (e.g. cocaine, crack, LSD)
SOL	Solvent (glue, liquids)
IDU	Intravenous drug use
OAI	Other
FRI	Relationship Issues (Individual/Family/Couple)
DEA	Loss (Death/Bereavement)
DTI	Life transitions/Developmental issues
HEI	Health Issues (mental/physical handicap, acute/chronic illness)
SEI	Self Esteem Issues
PTI	Parenting Issues
FBI	Family Breakdown Issues
SEP	Separation
DIV	Divorce
ABD	Abandonment
SPI	Single Parent Issues
BFI	Blended Family Issues
CUS	Custody/co-parenting issues
FTM	Frequent Moves
EFI	Extended Family Issues
SSB	Support System Breakdown
ADI	Adoption Issues
MCC	Marital/Couple Conflict

INF	Infidelity
ORI	Other (relationship issues)
SCI	Social Issues
CCI	Cross cultural issues
CAI	Cultural adaptation issues
GEN	Gender issues
OSC	Other
SEX	Sexual Concerns
SXI	Sexuality issues
PRG	Pregnancy concerns
STD	Sexually transmitted diseases
USP	Unsafe sexual practices
PST	Prostitution
PMP	Pimping
POR	Pornography, stripping
SII	Sexual Identity
OSI	Other
LSI	Larger System/Support Issues
LSC	Legal system concerns
SSC	Social service system concerns
HCC	Health care system concerns
ESC	Education system concerns
OLS	Other
SES	Socioeconomic Issues
JLS	Job loss/stress
DAW	Discrimination at work
FIN	Financial Issues
HFS	Homeless/lacking food or shelter
OEI	Other

Appendix E

WALK-IN SINGLE SESSION THERAPY FOLLOW-UP INTERVIEW PROTOCOL

adapted from **Resource A: Follow-Up Interview** presented in
 Talmon, M. (1990). Single-session therapy: Maximizing the effect of the first (and often only) therapeutic encounter. San Francisco: Jossey-Bass.

Identified Client:	Age of Identified Client:
Client's average household income:	Race/Ethnicity:
Therapist:	Date of Walk-In Single Session:
Therapist's Clinical Experience Level (in years)?	Date of Follow-Up:
Therapist's Level of Education: Masters---Doctorate---M.D. other:	Use of Mirror with Team? (yes or no) Use of Team during Break? (yes or no)
Theoretical Orientation of Therapist:	Number of Family Members Present During Session:
Presenting Concern Codes:	Interviewer:

After reaching the identified client, the interviewer should identify themselves as calling from the Eastside Family Centre, calling to follow-up as discussed with their therapist when they were treated at the centre, (naming the therapist, date and place the session took place). Make sure the client has time now and is willing and available to talk freely.

1. Read to the clients verbatim their original statement of the problem or complaint.
 Ask: "Do you recall that?" and "Is that accurate?" If this is not accurate, please ask the client to restate the problem and record here:

2. Would you say that (restate the problem as described by the client) is about the same or has it changed?

If it has changed, list where the problem is on a five point scale from (1) much worse to (5) much improved.

(circle one)

1	2	3	4	5
much worse	worse	same	improved	much improved

3. How are you doing? (pause, open-ended question)
In what way have your thoughts, feelings, and behaviors changed since your session at the Eastside Family Centre?

4. How do people around you say you have changed?

5. What do you think made the change (for better or worse) possible?
(If conditions are the same, ask, “What makes it stay the same?”)

6. Besides the specific issues of (restate the main problem), have there been other areas that have changed (for better or worse)? If so, what?

7. Now let me ask you a couple of questions about the therapy you received. What do you remember from the session? (pause, open ended question)

8. What do you recall was particularly helpful or harmful?

9. How satisfied are you with the therapy you received on a five point scale, with (1) being very dissatisfied and (5) being very satisfied.

1	2	3	4	5
very dissatisfied	dissatisfied	neutral	satisfied	very satisfied

10. Did you find that your walk-in single session was sufficient?

YES

NO

(circle one)

If not, was treatment continued here or elsewhere?

HERE

ELSEWHERE

(circle one)

If not, would you wish to resume treatment at the Eastside or elsewhere?

EASTSIDE

ELSEWHERE

(circle one)

11. What are your recommendations for improvement of the services at the Eastside Family Centre?

12. Is there anything that I have not specifically asked that you would like me to know?

13. It is OK for us to contact you again in the future? (yes or no)⁴

Thank clients for their time and participation. Remind them that they can return to the Eastside Family Centre at any time.

⁴ To attain test-retest reliability coefficients

Appendix F

HUMAN SUBJECTS APPROVAL




Office of Sponsored Programs

301 Burruss Hall
Blacksburg, Virginia 24061-0249
(540) 231-5013 Fax: (540) 231-4822

MEMORANDUM

TO: John K. Miller and Bud Protinsky
FCD

FROM: H. T. Hurd 
Director

DATE: November 05, 1996

SUBJECT: IRB EXPEDITED APPROVAL/"Walk-In Single Session Therapy:
A Study of Client Satisfaction" - IRB #96-262

I have reviewed your request to the IRB for the above referenced project. I concur that the activity is of minimal risk to the human subjects who will participate and that appropriate safeguards have been taken. On behalf of the Institutional Review Board for Research Involving Human Subjects, I have given your request expedited approval.

This approval is valid for 12 months. If the involvement with human subjects is not complete within 12 months, the project must be resubmitted for re-approval. We will prompt you about 10 months from now. If there are significant changes in the protocol involving human subjects, those changes must be approved before proceeding.

Best wishes.

HTH/pli

*A Land-Grant University—The Commonwealth Is Our Campus
An Equal Opportunity / Affirmative Action Institution*

VITA

John K. Miller

EDUCATION:

Doctorate of Philosophy, December 1996

Virginia Polytechnic Institute and State University, Blacksburg, Virginia

Major: Marriage and Family Therapy, AAMFT accredited

- *AAMFT Clinical Member & Supervisor-in-Training*

Master of Arts, May 1993

Northeast Louisiana University, Monroe, Louisiana

Major: Marriage and Family Therapy,

AAMFT and CACREP accredited

Bachelor of Arts, August 1989

Northeast Louisiana University, Monroe, Louisiana

Major: Psychology

EXPERIENCE:

NORTHWEST CHRISTIAN COLLEGE, Eugene, Oregon

Assistant Professor - Marriage and Family Therapy Program

(August 1996 - Present)

WOOD'S HOMES, Calgary, Canada.

Pre-Doctoral Internship in Marriage and Family Therapy.

Eastside Family Centre - Walk-in Single Session Therapy Service

- Community Family Therapist
- Shift Coordinator

Phoenix Program - Treatment program for adolescent sex offenders

Exceptional Needs Program - For children with a dual diagnosis

(September 1995 - August 1996)

WEST VIRGINIA GRADUATE COLLEGE,

Beckley, West Virginia.

Adjunct MFT Faculty. for Graduate Counseling 732,

Adult and Family Development and Transition/The Family Life Cycle

(Spring Semester, 1995)

THE FAMILY INSTITUTE OF WEST VIRGINIA, Inc.

Beckley, West Virginia.

Family Therapist.

(September 1994 - February, 1995)

VIRGINIA TECH'S CENTER FOR FAMILY SERVICES,
Blacksburg, Virginia
Marriage and Family Therapy Intern.
(October 1993 - May 1995)

BRIEF THERAPY CENTER OF LOUISIANA, Monroe, Louisiana
Research Assistant. Supervised by Wendel A. Ray, Ph.D.
• Assisted in the organization of the *Don D. Jackson Archive of the Mental Research Institute* of Palo Alto, CA
(May 1992 - August 1993)

MARRIAGE AND FAMILY THERAPY CENTER,
Monroe, Louisiana
Marriage and Family Therapy Intern.
(February 1992 - May 1993)

ACADEMIC PRESENTATIONS

Northwest Counsel on Family Relations (NCFR) 1996 Annual Conference: Families in the Information Age

Presenter: *Virtual Therapy? Resources for Families on the Information Superhighway.*
Seattle, Washington, June, 1996.

American Association for Marriage and Family Therapy (AAMFT), 1995 Annual Conference

Presenter: *Bateson's Research Team: A Multi-Media Raw Data Encounter.*
Baltimore, MD, November, 1995.

Quint State Annual Conference at the University of Georgia, Athens

Presenter: *Electronic Group Counseling.* 1995 Southeastern Symposium on Child and Family Development

University of Georgia, Atlanta

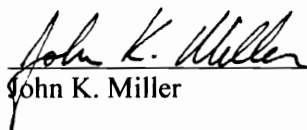
Presenter: *Parenting Today: Parenting Resources on the Information Superhighway.*
1995 Southeastern Conference on Family Relations (SCFR)

Quint State Annual Conference at the University of Tennessee, Knoxville

Presenter: *From the Medical Model to the Postmodern Age: A Paradigm Shift.* 1994
Southeastern Symposium on Child and Family Development

Texas Association for Marriage and Family Therapy (TAMFT), Houston

Co-presenter: *Video Taped Feedback: A New Angle on Group Supervision*
with Dr. Harper Gaushell
1993 Annual Conference


John K. Miller