Doing Sport Psychology Briefly? A Critical Review of Single Session Therapeutic Approaches and Their Relevance to Sport Psychology

Abstract

Recent research in sport psychology has noted the potential importance of providing sport psychologists with a systematic approach to solve problems in settings constrained by time and pressure (e.g., Birrer, Wetzel, Schmid, & Morgan, 2012; Giges & Petitpas, 2000; Høigaard & Johansen, 2004; Portenga, Aoyagi, & Statter, 2012). To this end, a growing body of single session therapy (SST) research exists within psychotherapeutic literature and other domains of support work from which sport psychology might take both theoretical and practical guidance. In this article, we review the extant SST literature to provide a rationale for the potential systematic exploration of such therapeutic approaches within sport psychology. The paper contextualizes SST as a therapeutic approach and summarizes the characteristics and effectiveness of these approaches via a critical review of descriptive and outcome focused SST studies. Finally, we discuss the potential relevance, applicability, and implications of SST approaches to applied sport psychology and addresses future directions for research.

Key words: brief interventions, solution-focused, problem solving, Talmon

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Modern elite sport is a highly pressurized industry that places numerous demands on the athletes (Fletcher, Hanton, Mellalieu, & Neil, 2012), coaches (Olusoga, Maynard, Hays, & Butt, 2012), and sport psychologists (Fletcher, Rumbold, Tester, & Coombes, 2011) who operate within this sphere. As the amount of funding allocated to elite sport continues to rise, applied practitioners are increasingly required to demonstrate the merits of their work to National Governing Bodies, performance directors, coaches, and performers in return for investment in their services (cf. Fletcher & Wagstaff, 2009). Indeed, 'evaluation in the work place' has emerged as a salient category of organizational demands experienced by psychologists within stress research in sport (e.g., Fletcher et al., 2011). Related to such concerns, several other contributions have recognized the demands on *practicing* sport psychologists to deliver effective, efficient (or time sensitive), and impactful interventions in the applied arena (e.g., Portenga, Aoyagi, & Statter, 2012; Van Raalte, 1998).

Contemporary evidence on sport psychology consultancy at the Olympic Games noted that brief, single-contact interventions are central to sport psychology services at such events (Birrer, Wetzel, Schmid, & Morgan, 2012). Birrer and colleagues' (2012) systematic analysis of sport psychology services offered to the Swiss national team across three Olympic Games indicated that around 50% of interventions were brief contact interventions (i.e., single, unplanned professional interactions of short duration between practitioner and client). Their findings emphasized the pressures placed on sport psychologists to deliver brief yet effective interventions when working in the cauldron of modern elite sport. To date, the only structured approach offered to help guide such brief interventions in sport psychology is the framework proposed by Giges and Petitpas (2000). According to these authors, the practitioner's goal during these brief (15-20 minutes), unplanned, and informal meetings was to "…initiate a shift in the athlete's perception of the situation", so as to "…facilitate the small changes that can lead to performance improvements" (Giges & Petitpas, 2000, p.179).

Giges and Petitpas recommended that practitioners keep such interventions focused, active, goal-orientated, and concerned with the present. For these reasons, brief contact interventions lend themselves well to the demands of working as a sport psychologist at competition (Birrer at al., 2012; Vernacchia & Henschen, 2008). However, Giges and Petitpas' framework is perhaps less suited to single session problem solving strategies in more traditional *planned* consultation settings that occur outside of the competition arena (e.g., when a practitioner, coach, or athlete is stuck with a performance related problem in the build up for a competition).

Perhaps the only meaningful consideration of scheduled, single session solutions within sport psychology was provided by Høigaard and Johansen (2004) when outlining the potential application of solution-focused therapy to working with elite athletes. According to Høigaard and Johansen, solution-focused consultations adhere to the following structure: (a) description of the problem; (b) development of well-formulated goals; (c) exploration for exceptions; and (d) end-of-session feedback. Reflective articles from applied practitioners have discussed the effectiveness of some aspects of this approach (Collins, Evans-Jones, & O'Connor, 2013; Lindsay, Breckon, Thomas, & Maynard, 2007). These examples have included the use of techniques such as the 'miracle question' (e.g., "suppose that one night, while you are sleeping, a miracle occurs and your problem is solved. However, because you are asleep you don't know that the miracle has happened. When you wake up in the morning, what will be different that will tell you that the miracle has taken place?"), exception questions (e.g., "has there ever been a time when this is/was not a problem?"), and scaling questions (e.g., "on a scale of 1 to 10, how bad is the problem currently?"). Høigaard and Johansen concluded that the discipline should continue to explore effective methods for creating rapid behavior change; commenting that, "…in high pressure sporting environments characterized by numerous challenges and a lack of time, the counselor needs strategies to create change quickly with minimal use of time" (p.227). Despite such suggestions, very little attention has been afforded to the topic of structured single session problem solving

interventions within sport psychology. This is somewhat surprising given the exploration of *single session therapy* (SST) within other domains of psychology.

In a broad sense, SST refers to "…a *planned* [emphasis added] single-session intervention – not to the situation where a client is offered more sessions but chooses to attend just one" (Hymmen, Stalker, & Cait, 2013, p.61). It is one face-to-face meeting between a therapist and client with no previous or subsequent sessions (Talmon, 1990). A growing body of SST research exists within psychotherapeutic literature and other domains of support work (e.g., social work, mental health services, humanitarian aid) from which sport psychology might take incentive or guidance both theoretically and practically (see, Campbell, 2012). In essence, the purpose of this present study is to review SST literature across a range of therapeutic settings to perhaps help provide a rationale for the systematic exploration of SST within sport psychology. Thus, this review contains three main sections. As very limited consideration of SST has occurred within sport psychology, the first section contextualizes the therapeutic approach and provides a succinct overview of the background and history of SST. The second section reviews a range of descriptive and outcome focused studies of SST against predetermined criteria to provide insight into the structure, common characteristics, and effectiveness of these approaches. The final section discusses the relevance, applicability, and potential implications of these SST approaches to applied sport psychology and addresses future directions for research.

A Brief Historical Perspective on Single Session Therapy

SST can be traced back to psychotherapist Milton Erickson (1901-1980). It has been suggested that Erikson's significant contribution to therapy was the application of hypnosis, whereas others have suggested it was his use of language (e.g., metaphor, anecdotes, suggestion) and utilization of a client's resources (Zeig & Munion, 1999). However, despite this conjecture, several authors have agreed that Erickson mastered the art of doing therapy briefly (Budman, Hoyt, & Friedman, 1992; Haley, 1993; Watzlawick, Weakland, & Fisch, 1974), as he would frequently assist his clients to solve their problems in only one session

(e.g., O'Hanlon & Hexum, 1990). Hence, it could be argued that Erickson's legacy exists in the numerous brief approaches to therapy that subsequently built on his formative work, some of which are discussed below.

The success and novelty of Erickson's methods inspired a new wave of *brief* psychotherapy. This movement emerged in the 1950s when Gregory Bateson and his team began a research project concerning the patterns and paradoxes of human communication (e.g., Bateson, Jackson, Weakland, & Haley, 1956). As part of this project, Bateson's team studied the ways in which Erickson helped clients resolve their problems quickly. Bateson and his team's research became the origin of many interactional approaches to psychotherapy. In 1959, Don Jackson founded the Mental Research Institute (MRI) in Palo Alto to build on these foundations. The MRI group dedicated their attention to the phenomenon of behavior change and the use of psychotherapy for individuals, couples, and families from a systemic perspective. Almost a decade later, the Palo Alto group began practicing therapy at the MRI in the Brief Therapy Centre, guided by the MRI's research.

The primary focus of therapy at the MRI was rapid problem resolution. The institute's psychotherapists deliberately worked to a limit of 10 sessions per client. However, on many occasions, the MRI group would resolve problems in one session and maintained the overarching goal of providing resolution in a minimal amount of sessions (Watzlawick et al., 1974). In contrast to traditional therapy, which sought to explain behavior based on previous experiences or mental processes, the MRI group viewed problems to be interactional in nature (Watzlawick & Weakland, 1977). Problems were viewed systemically, maintained by an ongoing pattern of communication or behavior. Watzlawick and colleagues (1974) noted that this would often be represented in the form of continued attempts at previously failed solutions. Working as a team of psychotherapists, the MRI group strategically intervened to deliberately change these problem-maintaining patterns of behavior using reframing strategies and paradoxical instructions (e.g., telling a dental technician, who suffered from a debilitating level of anxiety due to a fear of making a mistake, to make one small error at

work each day; Watzlawick et al., 1974).

Steve de Shazer, a former student of MRI-based John Weakland, later went on to develop solution-focused therapy (see de Shazer, 1985; de Shazer et al., 2007). Although similar in its systemic philosophy, this approach differed from the original work of the MRI as it focused on the rapid generation of solutions whereas the Palo Alto group focused their efforts on understanding and interrupting problematic patterns of behavior. It was these original works of de Shazer and of the MRI that influenced the brief approaches that have filtered into the margins of sport psychology (e.g., Giges & Petitpas, 2000; Høigaard & Johansen, 2004). These brief therapeutic approaches developed by Paul Watzlawick, Steve de Shazer, and their respective colleagues owed much to the seminal thinking of Milton Erickson and Gregory Bateson. However, to a varying extent, the MRI and solution-focused models of therapy have influenced the majority of SST research subsequently published over the last 25 years.

Talmon's (1990) *Single Session Therapy* is one of the most widely cited texts in SST research. In this seminal piece, and in his later work (1993), Talmon acknowledged the influence of de Shazer's work and the psychotherapeutic approach of the MRI group on his single session approach to psychotherapy. Talmon noticed the potential for SST when he realized that the modal length of therapy for every therapist at the medical center where he worked was a single session. An exploratory study subsequently revealed 34 of 58 of clients only required a single session and, upon follow-up, 88% of these clients indicated that their problem was improved. Through this initial analysis, and ensuing SST guidelines, Talmon ignited the recent interest in research and application of SST in therapeutic domains of psychology. Indeed, Talmon helped SST to become a distinct approach from other brief methods (i.e., solution-focused therapy, MRI strategic therapy). However, SST is not a therapeutic model itself, but rather an alternative perspective on what therapy is (Young, Dick, Herring, & Lee, 2008). It is an approach that can be adapted across many different settings, but one that is guided by several other traditional psychological approaches (e.g.,

cognitive behavioural therapy, narrative therapy, solution-focussed therapy; Young et al., 2008). But, perhaps the central tenet distinguishing SST from traditional therapeutic models is the intention to solve client's problems and promote substantial change within only one session.

A Review of Single Session Therapy Literature

Since Talmon (1990) published *Single Session Therapy*, a number of other SST reviews have been conducted (Bloom, 2001; Cameron, 2007; Campbell, 2012; Hurn, 2005; Hymmen et al., 2013). In 2001, Bloom concluded that under appropriate therapeutic conditions SST might be effective in achieving a variety of clinical goals. However, he argued that more controlled research was required to evaluate and precisely understand what conditions are appropriate for SST. Subsequent reviews by Cameron (2007) and Campbell (2012) have concluded that SST could provide an effective means of solving a variety of problems (e.g., anxiety, phobia, addiction, self-harm). Most recently, Hymmen and colleagues (2013) reviewed the empirical evidence for SST in community-based mental health and counseling agencies. The authors reviewed 18 relevant studies and concluded that SST can lead to perceived improvements in a these settings with clients who presented a range of differing problems (e.g., depression, anxiety, distress, parenting issues). However, Hymmen et al. cautioned that as the popularity of this approach continues to grow, more rigorously designed and controlled studies are required to further evidence its effectiveness.

These previous reviews focused their attention on research that measured the outcome of SST (i.e., intervention papers) so as to demonstrate its effectiveness as a method of therapy. Our review paper will adopt a similar approach in terms of summarizing intervention type papers; however, given one of the aims is to provide the reader with an insight into the characteristics and common features of SST that distinguish this way of working from other traditional methods, our review also considers descriptive papers (i.e., overviews, case studies, reflective papers). To gather and identify relevant papers, we conducted several searches of the literature. This process was guided by (a) the procedures adopted in other

recent critical reviews within sport psychology (e.g., Holt & Tamminen, 2010; Rumbold, Fletcher, & Daniels, 2012), (b) reviews suggesting the integration of new methods into sport psychology from other domains (e.g., Cross, Acquah, & Ramsey, 2014), and (c) previous reviews of SST literature (e.g., Campbell, 2012; Hymmen et al., 2013).

The first author conducted a Boolean search of SPORTDiscus, Medline, PsycINFO, and SCOPUS on July 2, 2014, using the search words "single session therapy" *or* "single session psychotherapy" *or* "one session therapy" *or* "one session psychotherapy" *or* "walk in therapy" *or* "walk in psychotherapy" (a common form of SST; Cameron, 2007) in all fields. The decision to search these words as phrases instead of separated terms was made because we were only concerned with papers reporting the intended implementation of SST (i.e., a planned single session solution from the outset). The search was restricted to journal articles only, published between 1990 (i.e., post the year of Talmon's seminal text) to present. These initial searches returned a total of 94 hits, 23 of which were duplicates and immediately removed. Other criteria for papers to be included in the review were: (a) that the research was published in a peer-reviewed journal; and (b) that the research provided either a descriptive account (i.e., an overview, case study, reflective account, or qualitative study) or an outcome focused study (i.e., an intervention study) of SST in any context. Fifty-four papers were rejected at title, abstract, or after reading the full paper that did not meet the above criteria. Finally, a number of other papers were included in the review from other recent SST related reviews (Campbell, 2012; Hymmen et al., 2013) that did not emerge as a result of the original searches, yet met the above criteria. As a result, a total of 27 papers were included in this review. Adopting a similar approach to Rumbold et al. (2012) and Holt and Tamminen (2010), Figure 1 depicts this selection process.

Table 1 provides information on all 27 studies included in this review. These are presented in alphabetical author order in line with previous reviews (e.g., Holt & Tamminen, 2010; Hymmen et al., 2013). The column headings in Table 1 represent the key factors of SST that are to be discussed in the following sections of the review. These factors were

shaped by the original works of Talmon (1990; 1993), and also selected to give the reader an overview of the distinguishing characteristics of SST and its application to solving problems in comparison to traditional psychotherapeutic approaches. These include: *the context of single session therapy, single session therapy suitability, single session therapists guiding model of practice, explicitly stated assumptions of single session therapy, pre-session questionnaires, consultancy teams, goal directed consultancy, utilization of strengths and resources,* and *key findings.* The purpose of the latter section is to also provide a review of the effectiveness of SST approaches.

The Context of Single Session Therapy

Research on SST has been conducted in a broad range of organizational settings and contexts. Specifically, SST has been conducted in walk-in therapy centers (Slive et al., 1995), traditional psychotherapeutic centers (Rosenbaum, 1994), family therapy centers (Campbell, 1999), child and adolescent mental health centers (Perkins, 2006), university counseling centers (Littrell et al, 1995), humanitarian settings (Paul & van Ommeren, 2013), and hospitals (Gibbons & Plath, 2012). The most common setting for SST research has been walk-in therapy centers, with one third of the studies included in the current review conducted within this context. With increased demand for accessibility to mental health services, accompanied more often by budgetary constraints, growing popularity in walk-in therapy as a model of service delivery has emerged (Slive et al., 2008). The unique “one stop” nature of this form of therapy make it ideally suited to SST. Clients receive therapy without being placed on a waiting list, with the aim that they leave with a clear outcome (Slive et al., 1995). Thus, this form of therapy meets the demands of what Slive et al. (1995) described as the “fast food” culture of modern society. Similarly, these approaches may suit the fast paced context in which some sport psychologists operate where minimal contact with the athlete is sometimes the norm. For example, head quarters psychologists at Olympic and Paralympic Games have reported the constraints associated with this role, such as trying to solve problems with athletes they are meeting for the first time (e.g., Katz, 2009).

Single Session Therapy Suitability

SST appeared to be suitable for a wide range of clients and presenting problems. Client groups within the research papers sampled comprised individuals, couples, and families of all ages who presented a variety of problems. When reported, the most frequent type of presenting problems included behavioral issues (Hampson et al., 1999; Miller, 2008; O'Neill & Rottem, 2012), relationship issues (Harper-Jaques et al., 2008; Miller, 2008; O'Neill & Rottem, 2012), anxiety or stress related issues (Hampson et al., 1999; Harper-Jaques et al., 2008), mental health issues (Harper-Jaques et al., 2008; O'Neill & Rottem, 2012), parenting issues (Hampson et al., 1999), post-traumatic issues (Hampson et al., 1999), communication issues (O'Neill & Rottem, 2012), and academic or career issues (Littrell et al., 1995). In contrast, some studies excluded clients presenting certain problems, these included sexual abuse, brain injury, serious mental illness, HIV/AIDS (Boyhan, 1996), high risk of immediate harm to self or others (Campbell, 1999; Littrell et al., 1995; Perkins, 2006), psychosis, family violence, or ongoing abuse (Campbell, 1999; Fry, 2012), acute crisis, and autism (Fry, 2012).

These findings generally reflect Talmon's (1990) original assertion on the types of presenting problems for which SST is suitable or unsuitable. Talmon identified the ideal SST candidates to be clients who seek therapy to solve a specific problem; clients who seek therapy to confirm if they or significant others are 'normal'; clients who can identify exceptions to their problem; clients who have a particularly 'stuck' feeling in relation to their past and actively seek change; clients with a good support network (e.g., family, friends); or clients with a truly unsolvable problem. However, Talmon considered SST unsuitable for clients who request a long-term therapeutic approach, for clients who are psychotic, or for clients who suffer from conditions with biological or neurological components (e.g., Alzheimer's disease, dementia).

Single Session Therapists' Guiding Model of Practice

SST is not simply a condensed form of longer-term models of psychotherapy (Bloom,

2001), nor one particular intervention in itself, but rather it is a different outlook on what therapy is (Campbell, 2012). As a result, a range of theoretical models guided SST therapists' practices. These included solution-focused therapy (Perkins, 2006), MRI strategic therapy (Littrell et al., 1995), narrative therapy (Slive & Bobele, 2012), the Milan systemic model (Miller, 2008), cognitive behavioral therapy (Young et al., 2008), the neuro-associative conditioning model (Stanton, 1995), crisis intervention theory, the empowerment model, grief and loss theory, the feminist model, and the eclectic model (Gibbons & Plath, 2005). As Rosenbaum (1994) commented, "…the phenomenon of single session therapies seems to cross theoretical lines" (p.234). Thus, as long as therapists are "…willing to regard single visits as potentially self-contained psychotherapies, single session therapies can offer a special opportunity for therapists interested in psychotherapy integration" (Rosenbaum, 1994, p.234).

The most frequently cited model of practice guiding SST was solution-focused therapy. Other systemic based models of practice (e.g., MRI strategic therapy, narrative therapy, Milan model) were also relatively common during SST. These already brief models of practice perhaps lend themselves well to working in a single session way, and support recent calls for brief solution-focused methods to be adopted in sport psychology (e.g., Birrer et al., 2012; Høigaard & Johansen, 2004). The common feature of these approaches being their systemic underpinning, stemming from the original Bateson research project and the MRI's interactional conceptualization of behavior (Watzlawick & Weakland, 1977).

Explicitly Stated Assumptions of Single Session Therapy

While various theoretical models of practice have guided SST, there appears to be a number of shared assumptions that are common within systemic approaches, which are in stark contrast to many of the traditional therapies (see Becvar & Becvar, 1999). Indeed, SST authors have noted that these assumptions may contradict those associated with traditional long-term psychotherapeutic approaches (Campbell, 1999; Fry, 2012). Hence, Fry (2012) and Perkins (2006) commented that the implementation of a SST framework could challenge

therapists' assumptions about behavior change and the role of therapy. Therapists practicing SST often assumed that rapid change is not only possible, but also common in human experience (Bobele et al., 2008; Fry, 2012; Slive & Bobele, 2012). As such, the history of the complaint is not relevant (Bobele et al., 2008; Littrell et al., 1995) and no direct link between duration or severity of complaint and length of treatment is assumed (Bobele et al., 2008; Slive & Bobele, 2012). When clients are stuck with a problem, it is assumed that they are limited by their current understanding of their situation (Young et al., 2008). In line with this, clients know when they need help and so it is assumed that the greatest opportunity for change comes in the early stages of therapy (Bobele et al., 2008; Miller & Slive, 2004; Young et al., 2008). When working this way, therapists assumed that their role was to find out what the client wants and to provide them with a framework to resolve their problems using their own resources (Harper-Jaques et al., 2008; Littrell et al., 1995; Miller & Slive, 2004; Slive et al., 1995; 2008; Young et al., 2008); an idea recently echoed by sport psychologists in the value of recognizing the client's expertise in the development of their own solutions (Collins et al., 2013; Lindsay et al., 2007). Single session work is ultimately made possible as it is assumed that a small therapeutic change may be all that is necessary and can also lead to more meaningful changes (Littrell et al., 1995; Slive et al., 2008).

Pre-Session Questionnaires

The majority of SST studies reviewed used pre-session questionnaires. Clients were asked to complete questionnaires in the waiting room (Miller, 2008; Slive et al., 2008), prior to arrival (Fry, 2012), or over the phone prior to attending the session (Jevne et al., 1995; Paul & van Ommeren, 2013). Harper-Jaques et al. (2008) described the purpose of using pre-session questionnaires was to gain information on "…the issues that bring [clients] to walk-in [therapy], their perceived strengths and resources, level of distress, attempted solutions to date, and what they want from the session" (p.45). Example questionnaires provided by Boyhan (1996), Fry (2012), and Young et al. (2008) demonstrated the types of questions used to generate potential solutions (e.g., if this consultation was successful what would you and

your family be doing differently?), to distinguish important issues (e.g., what is the one problem that seems most important to work on now?), to gather strengths and resources (e.g., what would someone else like and respect most about you if they had a lot of time to get to know you?), and to gain a good contextual understanding of the problem (e.g., what made you decide NOW is the right time to seek help?).

The questions included within pre-session questionnaires typically communicated the therapist's assumptions and structured the client's expectations regarding the forthcoming therapy. For example, asking "what do you need to get from the session today?" (Miller, 2008, p.81) prior to the session is congruent with the assumption that the therapist's role is to find out what the client wants and to give it them (Harper-Jaques et al., 2008; Miller & Slive, 2004; Slive et al., 1995; 2008). Miller (2008) also noted that these pre-session questionnaires helped gain a solvable framing of problems from clients and thus stimulated them towards solution-focused thinking, rather than focusing on the history of the problem. The use of pre-session questionnaires in SST appears to be useful for gathering important information for the therapist regarding the requirements of clients, as well as an opportunity to prime solution-focused thinking in clients.

Consultancy Teams

A common feature of SST approaches, in stark contrast to the one-to-one approach of traditional psychotherapeutic methods, was the use of consultancy teams. Fifteen of the 24 studies where such detail was provided reported using a consultancy team, ranging in size from two therapists (Denner & Reeves, 1997; O'Neill & Rottem, 2012) to as many as seven (Bobele et al., 2008). Typically, this involved the use of a primary therapist who would lead the session with the client, while a team of therapists would observe behind a one-way mirror or screen with access to a telephone or another means of communicating with the primary therapist (e.g., Harper-Jaques et al., 2008; Jevne et al., 1995; Slive et al., 1995; Slive et al., 2008). On occasion, studies reported the use of two therapists (co-therapists) in the consultancy room with the client (e.g., Denner & Reeves, 1997; O'Neill & Rottem, 2012).

However, regardless of the size of consultancy team employed, most studies described the use of a consultancy break towards the end of therapy session. These short breaks (usually 10-15mins) allowed all members of the team to meet together and compare observations and plan an intervention, while the client(s) wait for the return of the primary therapist in the consultancy room. O'Neill and Rottem (2012) reported that SST clients appreciated having several minds trying to collectively solve their problem, while therapists found working with colleagues enabled them to simultaneously remain reflective and client focused.

Goal Directed Consultancy

Fifteen studies described SST consultations as being goal directed. These goals determined what therapists and their clients intended to achieve as a result of therapy. This approach was described as "consumer-driven" (Miller & Slive, 2004; Slive et al., 1995; 2008), in the sense that the therapist sought out the client's perception of what they wanted from the session and strove to provide a service that aligned with that agenda. The development of these consultancy goals coincided with the negotiation of a well-defined, clearly understood and articulated solvable problem between the therapist and client. Bobele and colleagues (2008) noted that SST therapists "…negotiate problem definitions with clients in a way that they can be appreciated from a single-session perspective. For example, low self-esteem, depression, poor communication skills, or DSM-IV diagnoses are inappropriate for us" (p.81). Instead, Bobele et al. ensured that the language and labels used to define problems and consultancy goals were specific, behavioral, and observable. For example, rather than the therapist using the concept laden descriptions highlighted above, the language used to provide consultancy goals for these problems could have included statements such as, "…making a confident presentation on job interviews (low self-esteem), getting up and working on household chores by 7 a.m. (depression), spending 10 minutes with my spouse talking about household budget (poor communication skills)" (p.81). Explicit consideration of language used when defining and solving problems with athletes and coaches has received some attention within recent sport psychology settings (Lindsay, Pitt, & Thomas, 2014).

Careful consideration of the language used to describe a problem may play a valuable role in ensuring consultancies remain goal directed from a single session perspective (Bobele et al., 2008; Lindsay et al., 2014).

Utilization of Strengths and Resources

Reflecting on 25 years of SST experience, Talmon (2012) outlined what he believed were the "DNA" of SST practice. These included establishing a positive therapeutic relationship, mutually identifying a new understanding of problems, and utilizing clients' underlying strengths and resources (Talmon, 2012). Indeed, utilizing strengths and existing resources within the intervention was explicitly referred to by 16 of the 27 studies included in this review. Slive and colleagues (2008) noted that single session therapists "…adhere strongly to the notion that only clients can solve their problems, and all clients have resources that can be directed toward problem solving" (p.13). The role of the therapist was to discover the client's strengths and resources through their questions and to direct these toward solving the client's problem. One study commented that the consultancy team assisted this process. Jevne et al. (1995) noted that the observing therapists in their consultancy team would be trained to identify strengths and resources that may be utilized in the intervention.

Key Findings

In this section, we review the studies that provided an *outcome* measure of SST's effectiveness. In line with Hymmen et al. (2013), these findings can be divided into three categories relating to *problem improvement, single session sufficiency,* and *client satisfaction.*

Problem improvement. The degree to which SST resulted in a change in the clients' presenting problems was measured in a variety of ways. Studies by Denner and Reeves (1997) and Stalker et al. (2012) measured the effects of SST using a standardized instrument that assessed levels of psychological distress. Both studies reported a statistically significant improvement on the General Health Questionnaire (GHQ-12) after receiving SST. Denner and Reeves also found a significant reduction in anxiety and depression scores at a 6 weeks post SST. Three studies demonstrated significant problem improvements based on scaling

questions relating to the client's perception of their problem (Campbell, 1999; Littrell et al., 1995; Perkins, 2006). In the only study that compared the effects of SST to a control group (who did not receive SST), Perkins (2006) found a significant reduction in problem severity and frequency in the experimental group in comparison to the control group. Furthermore, Perkins' follow up study of her 2006 work revealed that these effects were maintained 18 months post SST (Perkins & Scarlett, 2008). Campbell (1999) reported a significant reduction in an inclusive score measuring problem frequency, intensity, disruption, and distress and a significant increase in coping ability following SST. Finally, Littrell et al. (1995) found that SST significantly alleviated students' concerns regarding their problems, reduced the intensity of undesired feelings, and resulted in a significant increase in motivation towards achieving their goals.

Several other studies measured problem improvements using less controlled methods. Using self-report methods related to improvements in their problem at follow-up, three studies revealed that 67.5% (Miller & Slive, 2004), 71% (Hampson et al., 1999), and 78% (Boyhan, 1996) of clients reported a decrease in problem severity following SST. Two studies that assessed how helpful the intervention had been to the client's situation found that SST was helpful for 84% (Young et al., 2008) to 88% (Hampson et al., 1999) of clients.

Single session sufficiency. A common measure reported within SST intervention studies was sufficiency (i.e., was a single session of therapy enough to resolve the client's problem). In walk-in therapy settings, single session sufficiency ranged between 44.3% (Miller & Slive, 2004) and 60% (Slive et al., 1995), as measured by client self-report. Alternatively, Harper-Jaques and colleagues (2008) measured sufficiency by recording the number of clients returning for walk-in therapy at two therapeutic centers, and found that very few clients returned for further therapy within the same year.

The length of time between therapy and follow-up varied amongst studies measuring single session sufficiency. For example, Denner and Reeves (1997) found that three-quarters of clients reported that SST was sufficient at a 6 week follow-up, while Boyhan (1996)

reported that SST was sufficient for just over half of individuals at a 2 month follow-up. Research measuring single session sufficiency 3-5 months post session found that 60% of clients reported SST to be sufficient (Jevne et al., 1995). From a longitudinal perspective, Perkins and Scarlett (2008) revealed that 60.5% of parents who had received SST with their children had not required any further therapy at an 18 month follow-up. Finally, annual reviews of single session family therapy conducted by Fry (2012) and O'Neill and Rottem (2012) revealed that SST was sufficient for around half of clients. To summarize, the average of the nine studies that measured single session sufficiency would suggest that SST is sufficient for around 62.4% of clients. This finding is comparable to the 60.9% reported in the review of SST by Hymmen et al. (2013).

Client satisfaction. Six studies measured client satisfaction with SST via a self-reported multiple-choice question. The proportion of clients that reported they were satisfied with the session ranged between 74.4% (Miller & Slive, 2004) and 96% (Hampson et al., 1999). Client satisfaction was often maintained for a significant amount of time following SST. For example, Perkins and Scarlett (2008) revealed that immediate satisfaction with the service was maintained at an 18 month follow-up. Collectively, the average satisfaction scores from these studies suggested that the majority (87.6%) of clients were satisfied with SST.

Summary of Single-Session Therapy Findings

As a method, SST appeared to be guided by a range of theoretical models, yet was more often underpinned by a solution-focused model with a number of systemic based assumptions relating to behavior and the role of therapy. During the therapy process, it was commonplace for SST studies to employ pre-session questionnaires and consultancy teams. SST consultations were typically goal directed and therapists' often incorporated the client's strengths and existing resources within their interventions.

In terms of effectiveness, the evidence tended to suggest that SST can lead to significant problem improvements and is sufficient for improving client's situations.

However, there were a number of methodological limitations associated with the majority of SST studies in relation to the measurement of effectiveness. These limitations, which are discussed in greater detail by Hymmen and colleagues (2013), included: a lack of control conditions, inconsistent or invalid measures of effectiveness, small sample sizes, and data collection issues (relating to the therapist collecting the data). Furthermore, although experimental evidence does offer support for SST as a model of problem solving (e.g., Perkins, 2006), evidence of this type remains limited. However, Campbell (2012) argued that although "…there may not be 'experimental evidence' that such single sessions are effective…this has to be taken less seriously than some might propose because there is obviously considerable organizational and experiential evidence that these services work" (p.23). Indeed, there are an increasing number of applied organizations adopting SST models (Hymmen et al., 2013), many of which have provided evaluative research included in this review (e.g., Boyhan, 1996; Fry, 2012; O'Neill & Rottem, 2012; Young et al., 2012).

In his seminal article, Seligman (1995) asserted that controlled experiments are not the only way of determining whether psychotherapy works. In doing so, he distinguished the difference between efficacy methods (i.e., standardized therapy treatments in controlled environments) and effectiveness methods (i.e., investigating the outcome of therapy in clinical settings). Seligman noted that both methods of study are important, although efficacy studies are often considered the "gold standard" for measuring if a treatment works. SST studies have tended to measure effectiveness, providing a valuable evaluation of practice (Anderson, Miles, Mahoney, & Robinson, 2003; Seligman, 1995). The lack of experimental studies of SST may be explained in part by the individualized nature of the methods associated with single session approaches being less suited to the efficacy paradigm (Seligman, 1995). For example, problems are described in very individual and specific terms for each client, and interventions often utilize unique resources to each individual client. Due to the individualized nature that is inherent within SST approaches, any future research in this

area in sport settings may need to rely upon single-case research methods (see Barker, McCarthy, Jones, & Moran, 2011).

Discussion, Implications, and Future Directions for Sport Psychology

The purpose of this article was to review the extant SST research and discuss its potential relevance to the discipline of sport psychology, and provide a rationale for an exploration of SST use within sport psychology. To borrow a phrase from walk-in therapists Slive et al. (1995), SST is well suited to the "fast food" culture of modern elite sport. In the demanding environment of elite sport, SST approaches could provide practitioners with an efficient and effective means to solve problems. Furthermore, individual athletes or teams may not have the luxury of being able to employ a full-time sport psychologist and single session strategies may therefore assist practitioners who have infrequent meetings with athletes due to time or budgetary constraints (see, Van Raalte, 1998). Although it is important to recognize that psychotherapy, mental health services, and sport psychology function within distinct and very different contexts, SST methods have previously been adapted and applied across a range of differing supportive and therapeutic contexts (e.g., social work, Gibbons & Plath, 2012; high school counseling, Littrell et al., 1995). Thus, there are a number of features relating to the practice of SST discussed in this review that might provide both implications for applied practice and avenues for future research in relation to single session methods of practice.

For several reasons, elite athletes and the problems they present to sport psychologists may be well suited to SST approaches. Indeed, the majority of elite athletes fall under the criteria of what Talmon (1990) described as the ideal candidates for SST. For example, athletes may have a good support network (e.g., coaches, support staff, teammates, family) surrounding them that can facilitate work done in a single session. Furthermore, the most frequent problems treated with SST were behavioral issues, relationship issues, and anxiety or stress related issues. Literature within the sport psychology domain has consistently demonstrated that behavioral issues (e.g., Luiselli, 2012), relationship issues (e.g., Rhind &

Jowett, 2008), anxiety (e.g., Hanton, Neil, Mellalieu, & Fletcher, 2008), and stress (e.g., Fletcher et al., 2012; Olusoga et al., 2012) are prevalent within the domain of elite sport.

Many of the studies featured in this review reported that therapists practiced SST guided by a solution-focused model. Although this was not typical to all SST studies presented here, it was the most frequent model of practice associated with SST (referenced by 12 out of the 27 studies) supporting Iveson's (2002) suggestion of the inherent fit between a solution-focused orientation and single session approaches. As Høigaard and Johansen (2004) commented, the application of solution-focused therapy could be particularly relevant for athletes given its focus on growth, results, and improvements. Furthermore, given the noted suggestion that sport psychologists' require briefer ways of effectively operating (Giges & Petitpas, 2000; Haberl & Peterson, 2006; Høigaard & Johansen, 2004; McCann, 2000), the use of these methods may extend beyond the boundaries of planned single session problem solving, and may be well suited to the requirements of a sport psychologist working at a competition (Birrer et al., 2012). At present, solution-focused methods are not typical to formal Western sport psychology qualifications, despite the importance of brief interventions to applied practitioners (Birrer et al., 2012; Giges & Petitpas, 2000; Haberl & Peterson, 2006). A comparison could be made with the findings of Gibbons and Plath's (2005) study of social workers use of SST techniques. Social workers recognized the importance of single session work in their roles, yet reported that these approaches were somewhat "invisible" within their professional training. Future researchers may wish to explore the suitability, viability, and market for solution-focused and single session problem solving methods within formal sport psychology qualifications.

There are a number of other aspects associated with SST that may be worth further exploration within sport psychology. As noted by Bloom (2001), Campbell (1999; 2012), Fry (2012), and Perkins (2006), the practice of SST questions many of the assumptions associated with traditional psychotherapeutic methods. For example, Fry reported that initial attempts to persuade a team of therapists to practice SST proved difficult because of beliefs that

included, "…'more is better'; 'real change happens slowly and gradually'; and 'change in therapy is built on the therapeutic relationship, which takes time to develop'" (p.56). However, incorporating alternative SST assumptions into practice appears to be an essential part of working in this way. This may prove difficult if these assumptions are incongruent with a practitioner's existing beliefs regarding human behavior (e.g., Fry, 2012) and may even require a fundamental shift in philosophy of practice. To adopt single session approaches into practice may be particularly challenging as their associated assumptions may question a practitioner's core beliefs and values (not necessarily their theoretical orientation or intervention methods) which, according to Poczwardowski, Sherman, and Ravizza (2004), are the most internal and stable factors of a sport psychologist's professional philosophy. Future researchers should explore the barriers, emotional challenges, and doubts faced by practitioners trying to shift their practice to briefer, single session approaches.

The use of consultancy teams has often been associated with brief therapeutic approaches and has remained central to the practice of SST (e.g., de Shazer, 1985; Watzlawick et al., 1974). Recent evidence has emerged on how groups of sport psychologists, working within National sporting organizations, operate through a context of team orientated service delivery (e.g., Cogan, Flowers, Haberl, McCann, & Borlabi, 2012; Henriksen, Diment, & Hansen, 2011). These types of organizations, along with universities who have groups of sport psychologists employed within sport and/or psychology departments, may provide a suitable context to explore the application of consultancy teams in sport psychology. To this end, future research might include trying to understand factors such as when is most appropriate to use a consultancy team model (i.e., problem solving, organizational issues, individual issues); the best practice of this approach (i.e., number of observing practitioners, communication between therapists); the optimal make-up of the observation team (i.e., trainee/experienced practitioners, practitioners from other domains, practitioners with specialist areas); as well as its effectiveness and efficiency. In turn, future researchers may wish to explore any other benefits associated with consulting in this manner,

such as the training of neophyte practitioners (e.g., Bobele et al., 2008). While working as teams of therapists, many SST approaches used consultancy breaks to gather information from the observing team to then feedback to the client via an intervention message. As part of future research into consultancy teams in sport psychology, the value of these consultation breaks, how they best function, and their potential different uses could also be explored.

Another distinct characteristic of SST approaches was the utilization of strengths and existing resources in order to solve clients' problems. Positive psychology is a growing area of academic interest (Seligman & Csikszentmihalyi, 2000), with strengths based interventions (Gordon & Gucciardi, 2011) and positive psychology approaches (Wagstaff, Fletcher, & Hanton, 2012) beginning to filter into sport psychology. In pursuit of effective single session approaches, future researchers should explore these further. More specifically, research should consider how best to conduct strengths based interventions. Researchers should explore methods for unearthing client strengths and existing resources and, in turn, how to effectively utilize these in sporting contexts. Finally, in order to summarize the present review, we will finish by offering some concluding remarks.

Concluding Remarks

This article aimed to review relevant literature across a range of therapeutic settings with respect to SST, provide a rationale for the systematic exploration of SST within sport psychology, and discuss its potential application to elite sport. In order to contextualize the paper, a succinct history of SST approaches was provided. We subsequently reviewed 27 published SST articles to determine some of the distinguishing characteristics and the effectiveness of this method of problem solving. In the final section, we outlined the relevance of single session approaches to sport psychology and suggested a number of implications for both future research and applied practice. Despite the potential application of SST within sporting settings, it is worth acknowledging a level of caution regarding accepting this approach over others within our field. Indeed, our intention with the review is not to provide that perspective – merely to provide the sport psychology community with the

suggestion that SST may have the potential to act as a viable therapeutic method within our domain. As noted in other therapeutic settings that have utilized SST, further research related to the efficacy of SST through a larger number of controlled experimental research studies is required across a range of organizational settings (Bloom, 2001; Hymmen et al., 2013). However, despite this call for controlled research testing intervention efficacy, there remains a considerable amount of evidence in the field that has demonstrated the effectiveness of SST (Seligman, 1995). Perhaps the increasing number of applied organizations adopting SST approaches provides a significant opportunity for more controlled research to develop (Hymmen et al., 2013). We do not subscribe to the notion of the debate that the application of SST in sport should replace traditional problem solving methods, rather it is potentially worth exploring its application when problems need solving quickly and an alternative approach is worth considering. In sum, we hope that this article may spark further interest in single session problem solving and other novel brief and effective approaches of operating in the demanding arena of modern elite sport.

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Table 1. The characteristics and key findings of SST across the 27 studies reviewed.

Authors	Study Design	The Context of SST	SST Suitability (Clients/Participants, Frequent Problems)	Single Session Therapists' Guiding Model of Practice	Explicitly Stated Assumptions of SST	Pre-Session Questionnaires	Consultancy Team	Goal Directed Consultancy	Utilization of Strengths/Resources	Key Findings
Bobele, Lopez, Scamardo, & Solórzano (2008)	Overview and case examples	Walk-in therapy	Clients of all ages, majority Mexican-American	MRI strategic therapy, solution-focused therapy	Yes	Yes	Yes	Yes	Yes	-
Boyhan (1996)	Pre-post intervention outcome study	Family therapy	Families (n = 36)	Not explicit	Not explicit	Yes	Not explicit	Not explicit	Not explicit	53% reported single session sufficient. 56% rated problem improved, 22% a little improved
Campbell (1999)	Pre-post intervention outcome study	Family therapy	Families (n = 33)	Not explicit	Not explicit	Yes	Yes	Not explicit	Yes	Significant reduction in presenting problem ($p<.01$) Significant increase in coping ($p<.01$) Increased family pride led to greater positive effects.
Denner & Reeves (1997)	Pre-post intervention outcome study	Community mental health service	Individual clients (n = 13)	Cognitive-behavioural and solution-focused model	Not explicit	Yes	Yes	Not explicit	Not explicit	Significant reduction in anxiety ($p<.05$) and depression ($p<.01$) at 6 week follow-up Significant improvement on GHQ-12 ($p<.01$) at 6 week follow-up 75% reported single session sufficient
Fry (2012)	Overview, case examples, and post-intervention outcome study	Child and adolescent mental health services	Families (n = 144)	Solution-focussed therapy	Yes	Yes	Yes	Not explicit	Not explicit	56% reported single session sufficient
Gibbons & Plath (2005)	Qualitative study using focus groups	Hospital social work	Hospital social workers (n = 25)	Crisis intervention theory, empowerment model, grief and loss theory solution focused therapy, strengths perspective, systems theory, task centered casework	Not explicit	No	No	Yes	Yes	Social workers perceive setting clear goals, establishing quick rapport, and targeting problem solving to central issues important aspects of single-session work
Gibbons & Plath (2009)	Qualitative study using interviews	Hospital social work	Hospital patients (n = 12)	Not explicit	Not explicit	Not explicit	No	Not explicit	Not explicit	Clients perceive rapport building, empathy non-judgmentalism, practical assistance, and advocacy important aspects of single session work
Gibbons & Plath (2012)	Summary of previous work and survey	Hospital social work	Hospital patients	Crisis intervention theory, empowerment model, grief and loss theory solution-focused therapy, strengths perspective, systems theory, task centered casework	Not explicit	No	No	Yes	Yes	10% hospital social work is single session Practical guide for single session work provided
Hampson, O'Hanlon, Franklin, Pentony, Fridgant, & Heins (1999)	Post-intervention outcome study	Child and adolescent mental health services	Families (1994: n = 63; 1996: n = 70) 1994: 55% of problems (not exclusive) behavioral/emotional, 45% anxiety or stress, 9% parenting difficulties 1996: 69% of problems behavioral, 19% anxiety or depression, 10% post-traumatic related	Not explicit	Not explicit	Yes	Yes	Not explicit	Yes	1994: 84% satisfied with service, 80% reported SST helpful 71% rated problem improved 1996: 96% satisfied with service, 88% reported SST helpful

Harper-Jaques, Mcelheran, Slive, & Leahey (2008)	Pre-post intervention outcome study	Walk-in therapy (at EFC and SCHC)	Clients of all ages (EFC, *n* = 1,455; SCHC, *n* = 240)	Not explicit	Yes	Yes	Yes	Yes	Yes	ECF: 86% satisfied with service Parental child conflict, mental health issues, relationship issues most frequent problems 37% returned for additional therapy SCHC: 94% satisfied with service Depression, relationship issues, anxiety most frequent problems 14.6% returned for additional therapy
Jevne, Zingle, Ryan, McDougall, & Mortemore (1995)	Qualitative study using interviews	Psychological support for rehabilitation from long-term disability	Teachers with a health disabling condition (*n* = 33)	Not explicit	Not explicit	Yes	Yes	Yes	Yes	60% reported singe session sufficient Respectful listening, supporting unique strengths, offering suggestions, and minimal personalized follow-up important aspects of single session work
Littrell, Malia, & Vanderwood (1995)	Pre-post intervention outcome study, comparison of three SST approaches	Student counselling	High school students (*n* = 61) 67% of problems were academic related, 18% personal, 10% relationship, 5% career	MRI strategic therapy, solution-focused therapy	Yes	No	No	Yes	Not explicit	Significant reduction in problem severity at 2 week and 6 week follow-up (p=.05) No difference among SST approaches, although solution-focused model took less time
Miller (2008)	Post-intervention satisfaction study	Walk-in therapy	Adults, couples, and families (*n* = 403) marital/couple conflict, depression, child behaviour problems most frequent	The Milan systemic model	Not explicit	Yes	Yes	Yes	Yes	81.9% satisfied with service Satisfaction highest for client presenting with sexual assault, self-esteem and child behavior issues and lowest for clients presenting with anxiety/stress.
Miller & Slive (2004)	Post-intervention outcome study	Walk-in therapy	Adult clients (*n* =43)	Cognitive, eclectic, feminist, Milan systemic, MRI, narrative, and solution-focussed models	Yes	Yes	Yes	Yes	Yes	74.4% satisfied with service 67.5% reported problem was improved or much improved 44.3% reported single session sufficient
O'Neill & Rottem (2012)	Mixed methods action research	Family therapy	Families (*n* = 139) and therapists (*n* = 12) 18% of problems were child's behaviour, 16% family relationship, 15% conflict, 15% communication, 15% mental health issues	Not explicit	Not explicit	Yes	Yes	Not explicit	Not explicit	43% reported single session sufficient The language of single session work, the follow-up telephone call, documentation and paperwork, working with a buddy, and being client focussed and keeping on track were perceived as important factors in single session work
Paul & van Ommeren (2013)	Overview	Humanitarian settings	Clients of all ages	Not explicit	Not explicit	Yes	Yes	Yes	Yes	-
Perkins (2006)	Randomized controlled trial	Child and adolescent mental health service	Clients aged 5-15 years (*n* = 216)	Solution-focused therapy	Not explicit	Yes	No	Not explicit	Not explicit	Significant reduction in problem severity (p<.01) and frequency (p<.01) following SST 95.2% satisfied immediately service after session, 87.6% satisfied at 1 month follow-up
Perkins & Scarlett (2008)	18 month follow-up study to randomised controlled trial	Child and adolescent mental health service	Clients aged 5-15 years (*n* = 152)	Solution-focused therapy	Not explicit	Yes	No	Not explicit	Not explicit	Benefits of SST maintained at18 month follow-up (no difference in problem severity, frequency, and client satisfaction) 60.5% of clients received no further help in the 18 months
Rosenbaum (1994)	Overview and case examples	Psychotherapy	Clients of all ages	Not explicit	Not explicit	Not explicit	No	Not explicit	Not explicit	-

Slive & Bobele (2012)	Overview and case examples	Walk-in therapy	Clients of all ages	Common factors, narrative therapy, solution-focussed therapy	Yes	Yes	Yes	Yes	Yes	-
Slive, MacLaurin, Oaklander, & Amundson (1995)	Overview, case-examples, and post-intervention outcome study	Walk-in therapy	Clients of all ages	Systemically based therapies	Yes	Yes	Yes	Yes	Yes	60% reported single session sufficient 89% satisfied with service
Slive, McElheran, & Lawson (2008)	Overview and case-examples	Walk-in therapy	Clients of all ages	MRI strategic therapy, narrative therapy, solution-focussed therapy,	Yes	Yes	Yes	Yes	Yes	-
Stalker, Horton, & Cait (2012)	Pre-post intervention outcome study	Walk-in therapy	Clients aged 16-61 years (n = 225)	Cognitive behavioural therapy, narrative therapy, solution-focussed therapy	Yes	Yes	Not explicit	Not explicit	Not explicit	Significant improvement on GHQ-12 at 1 month follow-up ($p<.01$) and improvement at 4 month follow-up ($p<.01$)
Stanton (1995)	Overview and case study	Psychotherapy	34 year old woman	Neuro-associative conditioning model	Not explicit	No	No	Not explicit	No	-
Talmon (2012)	Reflective discussion	Not explicit	Not explicit	Not explicit	Not explicit	Not explicit	Not explicit	Yes	Yes	-
Young, Dick, Herring, & Lee (2008)	Overview, case examples, and post-intervention outcome study	Walk-in therapy	Families	Cognitive behavioural therapy, narrative therapy, solution-focussed therapy	Yes	Yes	No	Yes	Yes	45-50% report single session sufficient each year 49% reported SST ”mostly, very much” helpful 35% reported SST “somewhat” helpful
Young, Weir, & Rycroft (2012)	Overview, organisational evaluation of implementing SST, and reflective discussion	Mental health services	Clients of all ages	Not explicit	Not explicit	Not explicit	Yes	Yes	Yes	71% of community heath services reported reduced waiting times following SST training 44% reported increased standard of service delivery 39% reported increased client satisfaction

Figure 1. A flow diagram of the critical review search process.