SINGLE SESSION THERAPIES

Why and How One-at-a-Time Mindsets Are Effective

EDITED BY
FLAVIO CANNISTRÀ AND MICHAEL F. HOYT

ROUTLEDGE

Single Session Therapies

This volume presents the latest information from international leaders as well as emerging experts on how to make Single Session Therapy (SST) efficient and effective.

Key topics involve different productive mindsets and multi-theoretical clinical methods with different problems and populations (including individuals, families, adolescents, children, and couples), as well as walk-in and by-appointment access, digital services, implementation and training, the structure and aesthetics of a single session, and connections to sports coaching.

It is an essential book for practicing professionals, such as psychologists, social workers, psychiatrists, counselors, case workers, and behavioral healthcare specialists, as well as graduate students and healthcare administrators and policymakers.

Flavio Cannistrà, Psy. D, is the Co-Director of the Italian Center for Single Session Therapy, the author/editor of *Single Session Therapy: Principles and Practice* and *Brief Therapy Conversations*, and was the co-organizer of the 4th International Symposium on SST, held in Rome in November 2023.

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To my mother, who taught me thinking.
To my father, who taught me goodness.
—F.C.

To my dear friend, Clem, who lived every moment.
"Hey, amigo!"
—M.F.H.

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- To one another, for friendship, learning, and love.

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—Flavio Cannistrà, Rome, Italy

—Michael F. Hoyt, Mill Valley, California, USA

Part I

Opening

Chapter 1

Editors' Introduction

Flavio Cannistrà and Michael F. Hoyt

The 4th International Single Session Therapy Symposium, titled *Single Session Therapies: What, How, and Why Single Session Mindsets and Practices are Effective, Efficient, and Excellent*, was held in Rome on November 10–12, 2023. Hosted by the Italian Center for Single Session Therapy under the co-directorship of Flavio Cannistrà and Valeria Campinoti, it brought together experts from around the world to describe and discuss the latest information. This book is based on those presentations, plus others that expand understanding of SST ideas, implementations, mindset, and methods. It is intended to give an updated overview of the state of SST, with special attention to three particular aspects:

1. theory and epistemology, recognizing that a single session mindset is one of the most important factors for this way of helping people;
2. implementation and findings, enlarging knowledge and visions about what we know that can be achieved in one session and in which fields; and
3. practices and techniques, continuing to offer therapists skills that enhance their ability to maximize every single session.

We recognize that this book cannot give expression to all who are involved in "Single Session Thinking and Practice" (as Hoyt, Young, & Rycroft, 2021 have called it), but we hope this contribution will share many of those voices and help to inform further SST developments.

What Is Single Session Therapy?

Single Session Therapy (SST) is therapy that is approached one session at a time (OAAT). Although the general term *single session therapy* had appeared previously (e.g., Sproel, 1975; Bloom, 1981; Rockwell & Pinkerton, 1982), in his watershed book *Single Session Therapy: Maximizing the Effect of the First (and Often Only) Therapeutic Encounter*, Moshe

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Talmon (1990, p. xv) gave it a specific and somewhat arbitrary definition for research purposes:

> Single-session therapy is defined here as one face-to-face meeting between a therapist and a patient with no previous or subsequent sessions within one year.

In the *Encyclopedia of Psychotherapy*, Brett Steenbarger (2002, p. 669) wrote:

> Single-session therapy is a general term that is used to describe any form of psychotherapy that seeks to address the presenting problems of clients within a single visit.

The *APA Dictionary* (https://dictionary.apa.org/single-session-therapy; retrieved September 11, 2020) gives the following definition:

> *Single Session Therapy (SST)*: Therapy that ends after one session, usually by choice of the client but also as indicated by the type of treatment (e.g., Ericksonian psychotherapy, solution-focused brief therapy). Some clients claim enough success with one hour of therapy to stop treatment, although some therapists believe that this claim represents a flight into health or temporary relief from symptoms. Preparation for the session (e.g., by telephone) increases the likelihood of the single-session therapy being successful.

More generally, as Hymmen, Stalker, and Cait (2013, p. 61) put it:

> SST refers to a conscious approach to make the most of the first session knowing it may be the only session the client decides to attend—not to the situation where there is an expectation that the client will attend multiple sessions but chooses to attend just one.

SST is a deliberate approach to "capture the moment" (Young & Rycroft, 1997; Hoyt & Talmon, 2014), to make the most of the first (and often only) session. Whether sixty minutes (or more, or less), it is one session by intention (Bloom, 1992), "by design not by default" (Budman & Gurman, 1988), the one session being what Hurn (2005) calls "planned success" rather than "unplanned failure."

Thus, along similar lines, Hoyt et al. (2021, p. 3) articulated:

> The essence of single session thinking is to approach the first session as if it will be the only session, while creating opportunities for further work if it is requested by the client. What emerges is a collaborative,

direct, and transparent approach to providing services that puts the client in a very active role in determining the focus and length of the work.

As Young (2018; Chapter 6 this volume) has noted, Single Session Therapy/One-at-a-Time (SST/OAAT) is a service delivery approach that capitalizes on the natural help-seeking pattern of many clients. Thus, it is important to recognize that it was clients/patients—not therapists—who really "invented" Single Session Therapy! Subsequent investigations have endeavored to identify which clients find one session helpful and sufficient and what happens in sessions to enhance the likelihood of benefit—so that effective SST methods can be developed for more people. Schleider (Chapter 10) describes how the single session mindset has been usefully applied to digital client self-directed interventions.

Approaching each session one at a time (OAAT) is first of all a mindset and a service delivery. Indeed, from Talmon's (1990) original research and through the years to the present book, we see different ways to apply this kind of mindset: in clinical practice and for school, career, and human services counseling; by appointment and walk-in/drop-in; in person and online (even through digital services and software). Jay Haley's cover endorsement of Talmon's (1993) *Single Session Solutions: A Guide to Practical, Effective, and Affordable Therapy* seems more prophetic than ever: "We once assumed that long-term therapy was the base from which all therapy was to be judged. Now it appears that therapy of a single interview could become the standard for estimating how long and how successful therapy should be."

A Short History of SST

Occasional reports of successful one session therapies began with Sigmund Freud and are scattered through the psychotherapy literature (see Cannistrà & Piccirilli, 2021/2018; Hoyt, 2025). In the mid-1980s, Moshe Talmon, an Israeli psychologist then working at a large health maintenance organization (HMO: Kaiser Permanente) in Northern California, noticed that many patients came to the clinic and were seen only one time, regardless of the patient's diagnosis, the therapist's theoretical orientation (psychodynamic, cognitive-behavioral, family systems, etc.), or whether the patient was seen by the Adult Team, the Child & Family Team, or the Chemical Dependency Team. Although initially concerned that these cases were failures or "drop-outs," Talmon took the important step of contacting many patients to see what had actually happened and found that the great majority were satisfied with what they had accomplished in their one visit and didn't feel the need for more sessions. They had, in effect, achieved their therapy goal(s) and had "graduated" rather than "prematurely terminated" or "dropped out." Talmon then invited colleagues Robert Rosenbaum and Michael F.

Hoyt to collaborate on a prospective study of what might be accomplished in one deliberate visit. The books *Single Session Therapy* (Talmon, 1990) and *Single Session Solutions* (Talmon, 1993) were published, along with several chapters (Hoyt, 1994; Hoyt, Rosenbaum, & Talmon, 1992; Rosenbaum, 1990, 1993; Rosenbaum, Hoyt, & Talmon, 1990) and a training video (Talmon, Rosenbaum, Hoyt, & Short, 1990).

At approximately the same time, the Eastside Family Center (now called the Eastside Community Mental Health Service) in Calgary, Canada, began to offer no-appointment-needed walk-in therapy sessions—most of which were for a single session. They also reported considerable success in terms of client-reported outcomes and satisfaction (Slive, MacLaurin, Oaklander, & Amundson, 1995; Miller & Slive, 2004; Miller, 2008; Slive & Bobele, 2011; McElheran, 2021; Stewart et al., 2018; also see this volume, Bobele & Slive, Chapter 8, and McElheran, Chapter 14.

Since these early reports of the benefits of SST (by appointment or walk-in), numerous studies have been conducted and have consistently documented the value of SST—as will be seen in the References included with each chapter. Books in English, Italian, Swedish, Spanish, German, Japanese, and Dutch have appeared—including many by authors who contributed to this volume.[1]

There has been rapidly growing interest in SST, and there have been three previous international symposia, each resulting in a co-edited volume:

1. March 2012, on Phillip Island (near Melbourne, Australia)—see Hoyt and Talmon (2014)
2. September 2015, in Banff, Canada—see Hoyt, Bobele, Slive, Young, and Talmon (2018)
3. October 2019, again in Melbourne—see Hoyt et al. (2021)

The present volume, based on the international symposium held in Rome during November 2023, is the fourth.

What Is Mindset?

The term *mindset* refers to those beliefs, attitudes, and principles that underlie and guide one's perceptions, feelings, and actions. Concerning "The Vital Role of the Therapist's Mindset," Flavio Cannistrà (2021, p. 77) wrote:

> How we look—which is directed by our mindset—influences what we see, and what we see influences how we proceed. This [. . .] is about mindset, but also about epistemological and trans-theoretical matters. My meta-intention is that the reader becomes more aware of how our

> mindset shapes clinical reasoning processes, the logic within how we listen and how we speak, the choice and clarification of the words we use, and thus, how we work with our clients—and how we may help them in a single session.

He notes that different theories predict (foretell in advance) different lengths of treatment, that different theories operate from different observations and opinions, and that "a choice must be made. Actually, a choice is always made. Here, I present my choices to be briefer in therapy" (p. 85) and then enumerates choices to be pragmatic, to be efficient, to avoid theory reification, and to adopt a multi-theoretical mindset. In a subsequent paper, "The Single Session Therapy Mindset: Fourteen Principles Gained through an Analysis of the Literature," Cannistrà (2022, p. 2) notes that it is essential to take mindset into account because "the organized series of ways in which we think and practice acts as a guide to a number of key points of the therapy itself."

Windy Dryden (2024, p. 3, emphases in original) distinguishes between three types of thinking that comprise the SST mindset:

> SST 'orientation' thinking is the general thinking the SST therapist engages in when they are reflecting on the work and describes their orientation *to* the work. Such thinking is neither directly concerned with the active preparation the therapist makes before doing SST, nor is it concerned with how the therapist works with a particular client. On the other hand, SST 'pre-session thinking' is the thinking in which the therapist engages as they *actively prepare* to do the work and 'in-session' thinking is the thinking in which the SST therapist engages *in* during the session. It is more specific and directly concerned with how to help the client the therapist is working with.

The fundamental SST mindset is that each session—indeed, every chance to encounter a person—is approached (a) as though it may be the only one, a complete-unto-itself one-at-a-time (OAAT) event with a beginning, middle, and end; and (b) with the belief that the client is capable of making changes now. As will be seen in the chapters that follow, there are many variations of these SST/OAAT basic themes and how they can be put into practice in a wide range of contexts with an assortment of persons and problems.

The Book in Hand

The present volume explicates the continued exciting expansion of SST. In addition to some of the original investigators, a number of additional authors discuss new topics. The book is divided into five parts.

Part I. Opening. Editors' Introduction. This opening chapter welcomes readers, provides a brief overview of SST, its history and underlying mindset, and sets the stage for the chapters that follow.

Part II. What—Mindset, Theories, and Epistemologies Behind SST comprises six chapters in which various authors offer different perspectives on the essentials of single session thinking and practice. SST is not portrayed as a panacea, but the various authors emphasize how a flexible, here-and-now focus often yields positive outcomes.

Part III. Why, Where, and for Whom—Implementations, Applications, and Research offers ten chapters, with authors describing ways these ideas can be put into practice in various contexts with different populations and problems. Reports involving access systems, online SST and single session interventions (SSI), children and adolescents, adults, couples, and families come from the US, Canada, Italy, Australia, the UK, Holland, Japan, Israel, and Sweden. An update is also provided of recent supporting research.

Part IV: SST Techniques and Practices contains nine chapters describing additional specific SST techniques and methods drawn from different theoretical orientations. Reports come from around the globe. Goal setting, alliance building, and evoking client resources are emphasized; strategic, solution-focused, hypnotic, and narrative therapy methods are highlighted.

Part V. Closing . . . Until the Next Time—Editors' Conclusion: Themes, Lessons, and the Future garners key ideas and considers future possibilities.

References are gathered at the end of each chapter, and there is an overall Index at the end of the book.

One Size Does Not Fit All: Many Roads Lead to Rome

SST is not a particular psychotherapy theoretical orientation (such as psychodynamic, cognitive-behavioral, solution-focused). Much like the famous saying "All roads lead to Rome" ("*Tutte le strade portano a Roma*" in Italian), there are many ideas and methods that can inform SST. It was advantageous that when Talmon and his colleagues at Kaiser conducted their original study, they were of varying theoretical orientations. As Talmon (2014, p. 31) wrote:

> When we started our SST project, Rosenbaum had trained in brief psychodynamic therapy and was then fascinated with non-directive hypnosis *à la* Milton Erickson. Hoyt had done an internship with Carl Whitaker, trained in brief psychodynamic therapy, and was then taken by

the work of Goulding and Goulding (1979), which combined Transactional Analysis (TA) and Gestalt into what they called Redecision Therapy, a very directive form of treatment. I was primarily a systemic therapist working with the Child and Family Team while Hoyt and Rosenbaum worked with the Adult Team. When we started the project I was quite intrigued by the simple elegance of solution-focused therapy developed by de Shazer, Berg, et al. (de Shazer, 1985, 1988) in Milwaukee. I met them shortly before our project started and they were a main force in spreading the word about our initial findings long before we published anything.

Rather than narrowly conceiving of SST as a particular form of strategic, psychodynamic, solution-focused, or family systems therapy, this multi-theoretical perspective helped promote the more capacious idea that SST is essentially a delivery format ("OAAT") and that SST could be successfully conducted in various ways. One size doesn't fit all.

Figure 1.1 There are many ways to get to the light.

Source: (photo: Michael F. Hoyt © 2023. Used by agreement.)

Thus, as Cannistrà (2024, p. 105) recently commented:

> When it comes to SST there is no one specific theoretical corpus to refer to. In our view, this illustrates one of the great strengths of SST, i.e., the fact that [it] is seen as a transtheoretical method, something that occurs and is located beyond the theoretical reference points of the practitioner. [. . .] The expression "Single Session Thinking" [. . .] highlights a way of thinking rather than a method of intervention: [. . .] it seeks to prioritize a mindset that accepts that a single session is possible (and from this, different ways of achieving it will then arise).

Perhaps it is fortuitous that Rome, the site of the 4th International SST Symposium, is also the home of one of the world's most revered ancient buildings, the Pantheon. The word *pantheon* comes from ancient Greek and means "all the gods." When one walks into the Pantheon and looks up, one sees (Figure 1.1) the Oculus surrounded by many coffers (panels).

In the chapters that follow, there are many ways that can lead to a successful SST. First we will consider some of the thinking and mindsets that inform SST; then we will look at a variety of implementation and practice contexts, examining closer some specific methods and techniques; and then will see what lessons can be learned and what likely trends can be predicted.

Note

1 See Cannistrà and Piccirilli (2018/2021), Cooper (2024), Dryden (2016, 2017, 2018, 2019a, 2019b, 2021), Hoyt (2024; Hoyt & Cannistrà, 2023), Schleider (2023), Slive and Bobele (2011; Bobele & Slive, in press), Söderquist (2023), and van Empel (2023).

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Part II

What—Mindset, Theories, and Epistemologies Behind SST

Chapter 2

The Here and Now of Single Session Therapy

Questions That Need Answering

Flavio Cannistrà

What is Single Session Therapy (SST) for? The attempt to answer this question leads us to a multitude of further questions and possibilities. In this chapter we will look through the point of view of SST itself, discovering that the questions and possibilities raised can radically change our relationship with everything connected to our work as therapists.

A word of warning: there are many, many questions, but far fewer answers. The hope is that we can find them together.

Why Ask Ourselves What SST Is For?

When it comes to "therapy," we can't help but notice that we already have an enormous number of psychotherapies and intervention methods available (Norcross, 2005); it therefore seems reasonable to ask whether we really need another one. Indeed, adding to the list merely to satisfy a personal impulse to create something ("I want to invent my own way of doing therapy!") or to belong ("Nice to meet you, I'm a *Single Session Therapist*") makes no more sense than doing so in order to "fix" something that the other 500 approaches have inexplicably missed. However, it may be more helpful to take a different view. For example, we could begin with the observation that (1) albeit with some exceptions, there is widespread crisis in current mental health systems regarding service provision, cost-effectiveness, the usefulness of diagnoses, theoretical disputes, etc.[1], and (2) today's healthcare services are clearly not capable of solving this crisis. Are we asking the right questions?

At this point we should define the object in question ("What is a healthcare *system*?") and ask ourselves, "What does SST have to do with solving the crisis?" If we look at the definition of "system" in the Italian *Enciclopedia Treccani* we find that, in the scientific sphere, it is "any object of study that, although constituted by different *interconnected elements that interact* with each other and their environment, responds and evolves as a whole with its own general rules"[2] (*Sistema*, n.d.). In light of this definition,

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I see SST as an element of healthcare systems that is capable of *influencing* the crisis: I highlight "influence" rather than "solve" because it would be erroneous to think that such a complex matter could be solved by a single method, activity, person, etc. Nevertheless, what SST does differently from other approaches or methods of therapy is actually to present itself as a paradigm[3] change on several levels.

So we can reformulate the question: *How, and at what levels, can SST have a positive influence on the crisis in healthcare systems?*

To answer this, allow me to cite the definition of another word, "crisis," from Latin and Greek roots meaning "*choice, decision*, critical phase of an illness," which in turn are derived from words meaning "*distinguish, judge*" (*Crisi*, n.d., italics added). We can therefore think of SST as an element of current healthcare systems that can influence its processes and activities of *evaluation*, *judgment*, *decision*, and *choice*.

But which evaluations, judgments, decisions, and choices can SST influence?

And here we can turn to another definition, that of "Single Session Therapy." In his 1990 book, Talmon wrote (p. xv): "Single-session therapy is defined here as one face-to-face meeting between a therapist and a patient with no previous or subsequent sessions within a year." Since then, there have been several definitions offered, and they have led to new terms (such as *single session intervention*, *single session work*, and *one-at-a-time*—for a comprehensive overview, see Hoyt, 2025; Hoyt, Young, & Rycroft, 2021a, 2018; Hoyt & Talmon, 2014). Here I would like to draw the reader's attention to three:

1. SST as a *mindset*—thus Hoyt, Young, & Rycroft (2021b, p. 3) wrote: "The essence of single session thinking is to approach the first session as if it will be the only session, while creating opportunities for further work if it is requested by the client."[4]
2. SST as an *approach to service delivery*—thus Young (2018, p. 44) wrote:

> a fundamental definition of Single Session Therapy could be everything that derived attitudinally, clinically, and organizationally from accepting three findings [. . .] #1: that the most common number of service contacts that clients attend is one, followed by two, followed by three [. . .] irrespective of diagnosis, complexity, or the severity of their problem [. . .] #2: that the majority [. . .] of those people who attend only one session, across a range of therapies, report that the single session was adequate [. . .] #3: [. . .] that it seems impossible to accurately predict who will attend only one session and who will attend more, a proposition that had significant clinical and organizational ramifications.

3. SST as a *structured intervention method*—thus Cannistrà and Piccirilli (2021, p. 3) wrote:

> SST has progressively become a method for improving the utility of *every* session. Today especially, given the rapid changes to health and welfare which we are experiencing (whether we are public or private sector, health authorities or healthcare professionals), we must ask ourselves how we can make the therapeutic process more efficient (i.e., make every session prove useful and ideally, shorten the time needed for therapist and patient to achieve an agreed outcome) as well as more appropriate in terms of its response to people's needs and wants. [. . .] [T]he SST method is strongly resource-based, strength-oriented and person-centered.

These three definitions lead me to use the term "Single Session Therapy" and its variants with this meaning: *a series of heterogenous types of intervention with similar principles (mindset), which differ from other healthcare services primarily by their method of delivery and its implications.*

What I consider to have been the subject of the 4th International Symposium on Single Session Therapy, what emerges from this book, and the subject of reflection and discussion among all those involved in SST is *how to influence evaluations, judgments, decisions and choices made in the field of health and well-being in order to change the principles and practices of delivering healthcare services*. Or, to put it another way: by changing the principles and practices underlying the services we deliver, we seek to understand how we can influence the evaluations, judgments, decisions, and choices made in their inception and delivery.

In other words, what those working in SST are referring to is the *process* of change: change in psychotherapy, change in healthcare, change in how we think about change.

The Single Session Therapy Mindset (and Its Implications)

In actual fact, we're not only discussing these changes, we're already making them happen. For example, if we consider the fourteen principles of the single session mindset identified in "The Single Session Therapy Mindset: Fourteen Principles Gained Through an Analysis of the Literature" (Cannistrà, 2022), we find some interesting conclusions in our ways of conceiving therapy. Let's take a look at some of them.

- *Principle 1: A single session may be enough.*
- *Principle 6: Further sessions may be needed.*

Conclusion 1: Therapy, and change in general, might require one, a few, or many sessions, regardless of the diagnosis.

- *Principle 3: People have resources they can use to feel better.*
- *Principle 4: The client is the expert in their own life.*

Conclusion 2: The outcome of therapy, and change in general, can start with something the person already has and may be able to use in order to feel better.

- *Principle 2: The therapist can play an active role.*
- *Principle 5: Different methods may be used.*

Conclusion 3: To help people, we can draw on methods that are technically, theoretically, and epistemologically different from each other.

- *Principle 7: Single Session Therapy is suitable for different contexts and needs.*
- *Principle 8: It's fine to aim for small or simple goals and interventions.*

Conclusion 4: Therapy should not be considered as a "cure," and neither should its end necessarily coincide with a "global" change in the person or the problem.

- *Principle 4: The client is the expert in their own life.*
- *Principle 11: Results are mainly achieved outside the session.*

Conclusion 5: The power relation between the client and the therapist, the healthcare facility, the treatment process, and the approach to therapy is not one of subordination of the former to the latter.[5]

It does not follow that these conclusions are obvious and expected, particularly when it comes to their repercussions in clinical practice and, prior to that, in the organization of health services. But in any case, I believe they open the door to some questions that need answering.

A Few Questions and Reflections

(A) If therapy can require one, a few, or many sessions, regardless of the diagnosis (Conclusion 1), how do we decide the duration of therapy?

What is it that determines the length of a therapy? The diagnosis? The severity of the problem? Many studies do not appear to prove that these are the decisive factors. For example, in a review of the existing literature in the field, Cannistrà and Pietrabissa (2021) made an extensive list of studies—albeit not directly connected with SST practices—which

demonstrates the effectiveness of the single session in tackling problems such as anorexia nervosa, self-harm, PTSD, alcohol and substance abuse, etc. This seems to be an undisputed fact, even in fields totally unrelated to SST. To quote one of many examples, in their article tellingly titled "Severe and Enduring Anorexia Nervosa? Illness Severity and Duration Are Unrelated to Outcomes from Enhanced Cognitive Behavior Therapy," Raykos, Erceg-Hurn, McEvoy, Fursland, and Waller (2018) measure the change in body mass index (BMI) over the first five sessions in patients diagnosed with low, moderate, and high levels of anorexia nervosa (AN), showing improvements indicating that "trajectories are almost perfectly parallel, demonstrating that the severity of problematic eating disorder attitudes and cognitions at pre-treatment has no impact on the amount of change in BMI during the early phase of treatment," and adding that there is "a small association between illness duration and the probability of completing treatment. [. . .] For example, a patient with illness duration of two years had the same likelihood of completing treatment (64%) as a patient with illness duration of 18 years" (p. 704), ultimately claiming that use

> of the term "severe and enduring" has the potential to result in even greater stigma than is currently experienced by individuals with eating disorders. [. . .] It can be used as a justification for clinicians to avoid applying effective treatment, as demonstrated by the finding that individuals with enduring AN are more likely to be offered non-evidence-supported treatments.
>
> (p. 706)

But why should we be concerned with Question A, i.e., what processes determine the duration of therapy? There may be a number of answers. Some insurance companies pay on the basis of duration, and some even ask mental health practitioners to sign an agreement with the client that specifies the length of treatment. As Jay Haley (1990, pp. 14–15) famously said: "The ideology and practice of therapy was largely determined when therapists chose to sit with a client and be paid for durations of time rather than by results." More generally, it is interesting to see how our mindset shifts when we see an insurance-reimbursable problem and not a person.

Added to this is the not at all obvious answer to what is meant by "diagnosis." As discussed in our book, *Brief Therapy Conversations* (Hoyt & Cannistrà, 2023), when we talk about *diagnosis* in the mental health sphere we almost take it for granted that we're referring to nosographic classifying diagnosis, a category-based system like the *DSM* or the *ICD*. But there are many ways to diagnose a problem attributable to a lack of well-being and mental health. To put it differently, there are many types of diagnosis, including systemic (Priest, 2023), operative

(Nardone & Watzlawick, 1990), hypnotic (Antonelli & Luchetti, 2011), psychodynamic (Lingiardi & McWilliams, 2017), and hierarchical taxonomic (Hopwood, Bagby, Gralnick, Ro, & Ruggero, 2019). And how do we respond to the success of therapies that do not feature diagnosis at all (e.g., Solution-Focused Brief Therapy—see Macdonald, 2007)?

(B) If the outcome of therapy, and change in general, can start with something the person already has and may be able to use in order to feel better (Conclusion 2), what is the role of the therapist?

In other words, what are the effective *whats* and *hows* of therapy? *What* should therapy do? What are its aims? What's the end result of successful therapy? The answers to these questions are not at all obvious. Let's consider a few examples, obtained by Googling "What's the aim of psychotherapy?":

- "to gain relief from symptoms, maintain or enhance daily functioning, and improve quality of life" (National Institute of Mental Health, NIMH, 2024)
- "not usually to give advice, but to provide a safe space to talk and to help you to find insight and understanding into your difficulties" (British Psychological Society, BPS, n.d.)
- psychotherapy "is considered the 'expert clinical response' to an illness. Over and above any possible definition, psychotherapy is an area of intervention for the purpose of curing" (Abbate, 2011, for the National Board of Italian Psychologists)
- "resolving problematic behaviours, beliefs, feelings and related physical symptoms. . . . Counselling is more likely to be on specific problems, changes in life adjustments and fostering the client's wellbeing. Psychotherapy is more concerned with the restructuring of the personality or self and the development of insight' (Psychotherapy and Counseling Federation of Australia, PACFA, n.d.)

Again, it's interesting to see how those definitions could lead to understandings of what are the aims of our therapeutic endeavors. Once we have established—if this is ever possible—the aims of psychotherapy and counseling, the next question is: *how* do we achieve them? Or rather, *how* do we achieve *what*? And even before that: what's the basis for our decisions about the *hows* and the *whats* of therapy? And once we've discovered that a single session may be all that's necessary, how will we alter our decisions? Might we even consider starting from this fact to decide the *whats* and the *hows*? Reflecting on the *what* and the *how* is anything