Single Session Therapy as a framework for post disaster practice in low and middle income countries

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In response to a disaster in high income countries, disaster mental health professionals typically have, at most, one encounter with a survivor of the event. After providing the initial psychosocial interventions, the individual is either referred to follow-up mental health resources or has access to the mental health delivery system. When disasters occur in low and middle income countries, access to follow-up and treatment for mental health issues may be unavailable or limited in capacity. Underdeveloped and poorly resourced primary and secondary care services, a deteriorating health care infrastructure and the limited availability of health care professionals are all barriers that contribute to limiting access to mental health care for survivors of a disaster. This paper will discuss implementing Single Session Therapy as a framework of practice for providing mental health interventions, post disaster, when it is not possible to provide either continuity of mental health treatment or follow-up for survivors.

Keywords: Single SessionTherapy, disaster mental health, global mental health

Introduction

Disasters can appear to be omnipresent within the 21st century global community that is instantly connected by social media and through the internet. Whether it is a natural disaster, or other catastrophic event, both witnesses and survivors can experience a sense of fear and anxiety about the future (U.S. Department of Veterans Affairs, 2011). As an outcome of evolving research on the mental health effects of disasters (Galea, Nandi, & Vlahov, 2005; Green, 1998; Norris, Friedman, & Watson, 2002a; Norris,

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Key implications for practice
- Single Session Therapy (SST) provides a viable, post disaster, mental health intervention when no continuity or access to mental health treatment exists
- SST promotes existing clinical and psychotherapeutic skills of professionals
- The SST framework ensures that the client leaves the single session with a specific plan of action

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Friedman, Watson, Byrne, Diaz, & Kanisty, 2002; North, 2007; Rubonis & Bickman, 1991) researchers emphasise that all individuals impacted by disaster experience psychological distress at some level. There is a consensus in disaster research that mental health services should be integrated into the emergency and medical response to ensure the identification of mental health needs, triage, referral to appropriate services and direct intervention (North & Pfefferbaum, 2013; Pfefferbaum et al., 2012).

In the aftermath of disaster, survivors are faced with the task of rebuilding their lives and their communities. Many individuals would have experienced a threat to their own lives and the lives of their loved ones, and many would have experienced the death of family members and significant people in their lives. Many communities in the disaster zone would be experiencing severe destruction of infrastructure and a

disruption to services that support the essentials of life, food distribution, water and shelter. The adverse physical and mental health effects can range from mild and transient to severe and chronic, increasing primary health care use for 12 months or more after the event. Long term psychological effects can result in some individuals experiencing serious mental health problems, ranging from posttraumatic stress disorder (PTSD), to depression and anxiety.

Usually, in high income countries, disaster response planning promotes a coordinated response by government agencies at the national, civic and community level to mobilise disaster management plans to provide the necessary life support, medical and mental health assistance to those impacted by disaster. First responders rely on a system of disaster preparedness and response that has access to the public health care system, including the mental health care system, and that provides the necessary follow-up services and treatment for those individuals who continue to struggle with physical injuries, stress and mental health issues long after the disaster has ended.

Many low and middle income countries (LMIC) have an underdeveloped mental health care system with limited capacity, before disaster. In a 2007 report on global mental health in LMIC, Saraceno et al. (2007, p.1171) identify a number of barriers that inhibit the development of sustainable mental health services. These include:

> '...insufficient funding for mental health services, mental health resources that are centralized in and near big cities and in large institutions, complexities of integrating mental health care effectively into primary-care services, low numbers and limited types of health workers trained and supervised in mental health care and mental health leaders often deficient in public-health skills and experience.'

In LMIC, where the existing mental health system has limited capacity to cope with the overwhelming demand for psychological treatment post disaster, a single session providing mental health and psychosocial support may be the only alternative available to many individuals.

There is minimal reference in the literature to the treatment of post disaster trauma utilising Single Session Therapy (SST) in either high income countries or LMIC. There is, however, an emerging discussion (Paul & van Ommeren, 2013; WHO, UN Action & UNFPA, 2012) of the application of SST in acute emergency settings. Paul and van Ommeren (2013) discussed the potential adaptation of SST to acute emergency settings in LMIC where offering just the one session may be the only option. They identified the two existing studies that utilised SST post disaster (Miller 2011; Urrego, Abaakouk, Roman, & Contreras, 2009). Miller (2011) provided an anecdotal narrative of his experience as a mental health professional responding to Hurricane Katrina, 23 August, 2005 and Urrego, Abaakouk, Roman & Contreras (2009) reported on a study by Médecins Sans Sans Frontières utilising SST in the provision of mental health services during the ongoing armed conflict in Columbia.

This paper builds on the ongoing discussion of adaption of SST to acute emergency settings and proposes that SST could be a viable treatment response post disaster in LMIC given that psychological distress for some individuals continues long after the acute emergency stage. The process of providing SST will be discussed via a case presentation. The case presentation is based on the author's experience as a mental health trauma therapist on a medical mission team in Cité-Soleil, Haiti, in February 2012, two years post earthquake (12 January 2010). In addition, the paper will discuss how implementing SST post disaster can provide a framework of practice when it is not possible to provide continuity in case management,

follow-up and referral to mental health treatment services.

Single Session Therapy: theory and practice

SST is an established mental health intervention and has been used by mental health professionals for more than 40 years (Johnson, Whitaker & Porter, 1980; Walk-in Counseling Center, Minneapolis, MN, 1977) as a treatment of choice when the understanding between the therapist and the client is that a single session may be the only session feasible. SST is not considered a therapeutic model in itself (Talmon, 1990) and has been adapted by therapists from different theoretical orientations as a framework of practice to provide planned single session interventions. The theoretical premise of SST is to ensure that the client leaves the single session with a specific plan of action to address the presenting problem. SST reinforces the individual's personal resources and skills that enhance resiliency and promotes problem solving (Campbell, 2012). Although part of the mainstream mental health treatment in high income countries, there have been limited reports of utilising SST in disaster emergency situations, in both high income countries and LMIC.

The overarching theoretical premise of SST is that change is inevitable and an inherent process of living. SST therapists believe that clients need only the support and assistance of therapists for brief periods to enable them to utilise their own resources to solve their problems (Talmon, 1990, Watzlawick, Weakland, & Fisch, 1974). SST emerged from the theoretical model of planned short term psychotherapy and is grounded in the same theoretical principles (Bloom, 2001; Messner & Gurman, 2011; Wells, 2010) that (a) improvement is most rapid at the beginning and then slows; (b) the therapist plans each contact as a self contained episode aimed at providing rapid help; (c) the therapist assumes an active role in the session in establishing goals, determining interventions and in bringing the session to an agreed conclusion; and (d) clients are encouraged to continue therapeutic work related to the problem in their own time following the session. That is, each session is whole and complete within itself (Slive & Bobele, 2011) and is designed to provide a significant therapeutic impact within that single session.

The rationale for SST is supported by research that has identified the most frequent or modal number of psychotherapy sessions is one (Slive & Bobele, 2011; Bloom, 1992; Talmon, 1990) and the average number of sessions as three (Gelso & Johnson, 1983). Talmon (1990), based on a study of 200 single session cases, found that between 30% and 55% of clients are likely to attend only one therapy session and that 78% of clients reported improvement in their presenting problems.

According to Miller (2011), therapists who conduct SST are working toward two main objectives. The first objective is that therapists provide clients with a specific reframing of their presenting problem with the goal of enabling clients to view the problem as more manageable. (Reframing is a technique, frequently employed by therapists, to present clients with different ways of understanding their current situation and thereby providing clients with ideas about possible and potential paths to a solution.) The second objective is to assist clients in identifying existing resources they can use to resolve their presenting problems. SST is effectively accomplished when therapists present observations that commend their clients' existing strengths, restores autonomy and confidence, and offers solutions that their clients can begin implementing immediately (Miller and Slive, 2004 Miller & Slive, 2004; Slive & Bobele, 2011; Talmon, 1990).

Effectiveness of SST

There is a growing body of efficacy research on SST (Bloom, 2001; Cameron, 2007; Hurn,

2005; Hymmen, Stalker & Cait, 2013; Talmon, 1990) In his meta-analysis, Bloom (2001) reported that the controlled studies he reviewed identified no strong difference between the efficacy of single and multiple sessions of therapy. In an earlier review of SST studies, Bloom (1992) found that the outcomes of planned short-term psychotherapy and time unlimited therapy were generally the same. Research investigating the outcome of traditional psychotherapy (time unlimited therapy) reports that it is common for clients to make significant improvements during the beginning of a therapy experience, and that the rate of subsequent improvement declines as the number of psychotherapy sessions increase (Bloom, 2001; Howard, Kopta, Krause & Orlinsky, 1986; Seligman, 1995).

Hymmen et al., (2013) conducted the most recent empirical review of SST and concluded that the majority of SST clients found it sufficient and helpful. In addition, their study reiterated the findings of earlier studies; that participation in SST results in clients reporting improvement in their presenting problem. The review also reinforced the caveat and caution expressed by earlier researchers Bloom (2001), Hurn (2005) and Campbell (2012), that many of the studies have methodological limitations, as standard measures were not employed to measure outcome, and few studies incorporated control groups into their design. Hurn (2005, p33), concluded that there is '*no conclusive evidence that SST is better than long term therapy or that it is preferable to other mainstream paradigms*'. He did, however, propose that since the uncontrolled studies reported between 70% and 80% success rates, SST may be of benefit being integrated into the mental health system triage stage in order to provide a therapeutic context when this may be the only contact the individual has with the system.

Cameron (2007) also identified methodological limitations of the efficacy studies on SST and reiterated that the studies lacked sufficient scientific rigor to support the generalisability of findings that SST is any more effective than other forms of psychotherapy. He did, however, acknowledge that given the apparent effectiveness of SST (as reported by clients and the positive outcomes reported through qualitative studies) provides an effective solution for a wide range of client problems within the context of limited resources.

Disaster mental health interventions: similarities and differences to SST

Disaster mental health interventions are determined as an outcome of a mental health psychosocial assessment that identifies any mental health disorders and psychosocial stressors that have affected the victim or survivor of a disaster. Norris et al. (2002) reported that a minority of individuals who experience distress from living through a disaster will develop a psychiatric disorder. The outcome of their study indicated that the majority of individuals will experience varying degrees of stress related symptoms and recover with access to strength and resilience based psychosocial interventions, most often provided by first responders to the disaster. Disaster mental health response could include psychological first aid (PFA), psychological debriefings in the form of critical incident stress debriefing (CISD), and crisis intervention (CI). These interventions are intended to provide early intervention to address emotional distress, provide emotional support and reassurance of recovery, and to connect individuals to services to address their immediate needs.

Psychological first aid (PFA) is considered an important component of the psychosocial response to the needs of those who are experiencing acute stress due to a disaster or emergency situation (Everly & Flynn, 2006; Parker, Everly, Barnett & Links, 2006; Schafer, Snider & van Ommeren, 2010). Developed from expert consensus (Bisson & Lewis, 2009), this practice has not yet been empirically tested (Dieltjens,

Moonens, Van Praet, De Budk & Vander-kerckhove, 2014). The National Center for PTSD and the National Child Trauma Stress Network define PFA as '*an evidence informed modular approach for assisting people in the immediate aftermath of a disaster and terrorism: to reduce initial distress, and to foster short-term and long-term adaptive functioning*' (National Center for PTSDNational Center for PTSD, nd). PFA, employed within hours or sometimes days in the aftermath of a disaster, provides support for basic physical and psychological needs, ensures safety, provides comfort and communicates information to the survivor to direct them to appropriate levels of care. The *IASC Guidelines on MHPSS in Emergency Settings* (IASC, 2007) recommend PFA as an appropriate support for individuals experiencing acute mental distress, following exposure to extremely stressful events.

Psychological debriefings, the most common of which is Critical Incident Stress Debriefing (CISD), is a single session employed within 2 to 14 days of a disaster and involves group debriefings of the experience of the event. Most psychological debriefings involve a single session and focus on emotional processing/catharsis by facilitating the recollection, ventilation and reworking of the traumatic event. Psychological debriefing as an early intervention after trauma has been criticised as likely ineffective and some evidence suggests that some forms of debriefing may be counterproductive by slowing down natural recovery (van Emmerik, Kmphuis, Hulsbosch & Emmelkamp, 2002; Rose, Bisson, Churchill, & Wessely, 2002; National Institute of Mental Health, 2002).

CI is defined as the provision of emergency psychological care to survivors to assist those impacted by the crises to return to an adaptive level of functioning and to prevent or mitigate the potential negative impact of psychological trauma (Everly & Mitchell, 1999). It aims to reduce the intensity of an individual's emotional, mental, physical and behavioural reactions to a crisis. CI provides immediate short term help to individuals and can range from one session to several weeks, with the average duration being four weeks.

PFA, CI and SST are all interventions that assist individuals who experience an event that produces emotional, mental, physical, and behavioural distress or problems. PFA and CI assess an individual's needs, level of distress and impairment, encourages positive ways of coping and provides links with other mental health services and support, which could include SST. The difference between PFA, CI and SST is that PFA is not intended to provide psychosocial intervention by psychotherapy. PFA is provided during and post disaster by first responders who may be either trained lay counsellors or professional mental health professionals. Both SST and CI are models of psychotherapy employed by mental health professionals to apply psychotherapeutic techniques to the situations where people are suffering and need support. CI responds to the immediate crises, while SST is intended to be provided as follow-up treatment for mental health issues related to being a survivor of the disaster in the subsequent days, weeks and months.

Haiti earthquake and mental health

The 12 January 2010 earthquake in Haiti caused widespread damage to an already limited water and sewage system, exposing survivors to even greater risk of contamination and disease. It was estimated that more than 300,000 people died as a result of the 7.0 magnitude earthquake and some 300,000 were injured. The Haitian government estimated that 250,000 residences, 30,000 commercial buildings and 80% of schools were destroyed or severely damaged by the earthquake. Approximately 1.5 million people found themselves living in 1,555 temporary camps (Disaster Emergency Committee, 2014).

Data from the Caribbean Country Management Unit (2006) reported that, prior to the earthquake, approximately half of the population did not have access to formal health care services, and access to mental health services was considered significantly lower. The Pan American Health Organization/WHO (2010) reported that the mental health system was supported by an estimated 23 psychiatrists and nine psychiatric nurses. Cité Soleil, on the outskirts of the capital Port au Prince, was the location of the medial clinic where SST was provided. It is one of the largest slums in the northern hemisphere. About 300,000 people live in extreme poverty on less than $2 a day. Most residents of Cité Soleil do not have running water, toilets or access to a doctor and 70% of the workforce is unemployed. The shanty town has been called a *'microcosm of all the ills in Haitian society: endemic unemployment, illiteracy, non-existent public services, unsanitary conditions, rampant crime and armed violence'* (Revol, 2006. para. 1).

Culturally in Haiti, mental health problems are often attributed to supernatural forces, with problems in daily functioning often viewed as the consequence of a spell, a hex or a curse transmitted by a jealous person. Specific to this, mental illness is also attributed to the failure to please spirits including those of deceased family members. As a result, Haitians often rely on their inner spiritual and religious conviction to deal with mental health problems. Shame may also be associated with the decline of functioning in severe mental illness with family potentially reluctant to acknowledge that a family member is ill (Nicolas, Jean-Jacques & Wheatley, 2012; WHO, 2010).

It is important as a western psychotherapist to be aware of the importance of not imposing a Western etiological perspective of mental health in a non western cultural context. Sue and Sue (1999) state that treatment that fails to integrate the cultural background of the client will not lead to positive behaviour change by the client. Nicolas et al., (2007) recommend that, *'by taking culture into consideration, mental health clinicians and health care providers will be able to treat and relate to their patients more effectively, ultimately leading to more successful interventions'* (p 96).

Mocun-Aydin (2000), in his work with Turkish women, detailed the consequences of imposing western psychological theory when working in another cultural context. He stated:

> *'Helping clients achieve insight, self-awareness, and personal growth may be the counsellor's goals; however, unless these goals are owned by the client, no positive outcome will be achieved. It is quite common that the client may want solutions to practical problems without any reference to internal change. In a situation such as this, it is important to recognise that the therapeutic relationship should contain shared and appropriate goals if it is to be effective. In practice, this means that the therapist will find out from the client what are his or her desired goals. The therapist, then, may explain the way counselling works and both parties may negotiate a common purpose'* (p. 292).

SST as a framework of intervention is congruent with the recommendations of integrating culture into the treatment process with the client. In SST, therapist and clients formulate shared goals that enable their clients to find or create answers that work within their lived experience, while making the most of their innate abilities to heal themselves. SST focuses on problems as they are occurring in the present and resulting from aspects of human interaction (Slive, McElheran & Lawson, 2008) in the context of the client's lived experience, relationships and cultural community. These principles and premises of SST promote the validation of the cultural experience of the client and the collaborative problem solving relationship with the client.

In addition to integrating culture into the treatment process the *IASC Guidelines on*

Mental Health and Psychosocial Support in Emergency Settings (Inter-Agency Standing Committee, 2007) recommend that mental health and psychosocial support in emergency settings focus on using local resources, social networks and social support systems. Following the *IASC guidelines*, Rose, Hughes, Ali and Jones (2011) identified a number of dilemmas that they experienced in integrating mental health into primary care settings after the Haiti earthquake:

> '. . .the sustainability of the integrated mental health/primary care model, post emergency in a country with poorly developed primary health infrastructure, and no history of community psychiatry; the possibility of unintended bad consequences; and whether it was wise to invest in community mental health services, rather than reinforcing already established central ones' (p. 220).

They recommended that,'*in future disasters, we should pay greater attention to the setting up of carefully situated integrated clinics operating as referral hubs, serving clusters of emergency primary care clinics*' (p. 222).

Case presentation

The following case study is one of a number individuals referred for mental health treatment by physicians of the medical mission team. All of these individuals connected the onset of their symptoms to their experience of surviving the earthquake and the persistence of their symptoms to the daily struggle for survival. The case is anecdotal and not intended as evidence of the effectiveness of SST. It does, however, serve the purpose of reporting on the process of implementing SST as a mental health intervention in a post disaster LMIC. In addition, the case example demonstrates the process of acknowledging and validating the client's lived experience within their cultural context. Specifically, as emphasised by Mocun-Aydin (2000), the author engaged the clients in a therapeutic relationship that contained shared and appropriate goals, that is, as the therapist it was my responsibility to find out from the client what are his or her desired goals.

The process of SST from referral to intervention to termination

Referral information A 75 year-old female was referred for a mental health consult following a medical evaluation where she presented as frail and malnourished, complaining of headaches, muscle pain, decreasing weight (90lbs from 200lbs) and problems sleeping. The physician reported that the symptoms, although related to malnutrition, may also be the result of depression. She was accompanied by two women neighbours who had been looking out for her since she lost her family in the earthquake. They reported that her symptoms emerged shortly after the earthquake and they were concerned that her symptoms were becoming more prevalent, as a result they brought her to the clinic to see the doctor.

Engagement The author, as therapist, was active and present with the client. That is, the nature of the session was explained as a single session, that it would focus on what she identified as important from her lived experience. I ensured that the therapeutic process was within an understanding of culturally constructed experiences and responses to trauma that are unique to particular cultural groups (in this case, Haitian populations). Given the stigma of mental health and the possible consequences of being identified as having a mental illness, problems were discussed within the context of somatic symptoms and physiological complaints prior to the exploration of emotional reactions to stress. Specifically important, keeping in mind that religious beliefs are an important aspect of Haitian life and that religious beliefs help to see beyond tragedy

and instil hope for improved circumstances (WHO, 2010).

Client narrative As she relayed the history of her physiological symptoms she clearly reported a significant increase in the severity of the symptoms since the earthquake, and since she has been on her own. She reported that her entire family had been killed in the earthquake. She began to weep quietly as she recounted holding her son as he died from injuries sustained in the collapse of the family home. She emphasised the joy she had felt in life before the earthquake and her sense of pride as a mother. She also spoke of being strong before the earthquake and emphasised her physical wellbeing, *'I was 200 lbs. Now I'm nothing'*, referring to her current weight of 90 pounds.

As her narrative continued, she spoke of longing for her children and feeling overwhelmed by the loss with bouts of deep sadness during which she could not eat nor sleep. She described herself as being lonely and avoided people and places in the community, as she was reminded of her children.

Problem exploration From a western lens of psychopathology, the etiology of the symptoms defined her as frozen in mourning and presenting with the criterion for complicated grief reaction (Horowitz, Siegel, Holen, Bonanno, Milbrath & Stinson, 1997). In other words, she presented as unable to move through one or more of the normal stages of grief after a considerable amount of time. Complicated grief is considered to be an ongoing heightened state of morning the keeps one from healing. According to Horowitz et al., *'complicated grief disorders may include symptoms such as intrusive images, severe pangs of emotion, denial of implications of the loss of the self, and neglect of necessary adaptive activities at work and at home'* (p. 290). For this syndrome psychotropic medications and standard grief focused supportive therapies have not proven effective, therefore, the recommended treatment is complicated

grief treatment (CGT), which is a combination of cognitive behavioural techniques with aspects of interpersonal psychotherapy and motivational interviewing (Simon, Pollack & Fischmann, 2005). For this client and therapist, with limited resources and no access to ongoing psychiatric intervention, the diagnosis and recommended treatment became meaningless. What was meaningful was the knowledge that grief is a universal, sometimes debilitating, human experience and that individuals' experiences differ considerably in intensity and length among cultural groups and from person to person. Therefore, the task was to discover this client's unique lived experience with grief and to explore potential resources within her community and culture to assist her in navigating the grief process.

SST is not intended to treat an individual's diagnosis rather it treats the presenting. In this case, SST provided the framework to ask questions that were in the context of being inquisitive to elicit her lived experience and to open the possibility of alternative behaviour to promote returning to her pre crisis psychological state to the extent possible. I worked collaboratively with her to explore solutions and to ensure that I understood her experience and perception. The session focused on her current attempts at coping with the problem, her strengths and her formal and informal resources. Next, I asked what she hoped would be the outcome of our time together. Her goal was to be free of headaches, muscle pain and to be able to sleep.

Focus of therapy Congruent with the principles of SST, I engaged her in a process of redefining the problems into terms that are behavioural, observable and specific to her experience and under her control. The two primary interventions were commendation and reframing. Commendation is the practice of noticing, drawing forth, and highlighting previously unobserved, forgotten, or unspoken strengths, competencies, or

resources (Wright, Watson & Bell, 1996). Reframing is a technique employed in SST that offers the individual different ways of understanding their current situation. It is the ability to look at an issue or a problem from another perspective, especially a perspective that is more accurate, more complete, or more positive (Flaskas, 1992).

Solution exploration I first commended her for the love she had for her children and the importance of keeping their memory alive in the face of great physical and emotional hardship. I asked her how she had survived with such unbearable loss and how she had remained alive, living alone when there was limited food and shelter. Her explanation for her having survived was that it was the will of God and that her neighbours were caring for her. My hope was to tap into her existing strength, restore a sense of autonomy and confidence, and to offer potential solutions that she could immediately begin to implement.

The first step was to normalise her symptoms within the context of the stress of survival, post earthquake, and a mother's grief over the death of her children. A standard intervention for individuals experiencing trauma as an outcome of a disaster is to normalise the physical and psychological issues experienced as a result of a disaster as normal reactions to an abnormal event. I said that it makes sense that she would be feeling the way she was feeling, having survived the earthquake and now she is alone and grieving the loss of all her children. I wondered out loud about how difficult it would be to accept the loss of one child, and could not imagine how painful it would be to lose all of one's children. Lastly, I commended her on her strength in being a survivor of the earthquake, and that the stress of being a survivor often shows up as physical symptoms, such as headaches and trouble sleeping and that these are normal for many people who have been through what she has experienced.

The next step was to help her get unstuck and begin a healthy grieving process. As she had presented as overwhelmed by ruminations about her children no longer being with her, the session focused on her beginning to experience how she might remember her children and not the loss of them. I asked her to tell me about her children and what she loved about each one. I asked her opinion about what her children would want her to do, and which memories they would hope she would keep close to her heart.

Termination She said her children would want her to be happy and to know that they are safe with God. At the end of our time together, she thanked me and said it was helpful to be heard and understood, and that she felt a burden had been lifted from her heart. As she prepared to leave she said she would talk to her (deceased) children through her prays and tell them about what we had talked about, and that she believed that God would provide and keep her strong.

Treatment plan In closing the session, I provided practical stress management techniques to address her presenting problem of insomnia and anxiety. I engaged her in simple relaxation response exercises that she could use when she became anxious and fearful or could not sleep. The formulation of a treatment plan was complicated by the lack of referral to, or follow-up by, a psychiatrist or mental health therapist for treatment of the diagnosis of complicated grief reaction. My task was to reframe the physical presenting problems as being associated with being a survivor of the earthquake, and her intense grief as a first step to enabling her to see the problems as more manageable.

Access to follow-up resources involved significant waiting times and complicated travel to hospital centres. She was encouraged to return to subsequent medical clinics offered in the area where she could receive follow-up from a physician, but may not have access to a mental health professional.

Single Session Therapy in LMIC: reflection on the process and practice

SST is defined as more of an approach to service delivery than a specific therapeutic model and is intended to be an adjunct to a therapist's theoretical model of choice. Young, Weir and Rycroft (2012) describe the implementation of SST by therapists as the process of *'embracing good practice basics'* (p. 86) and not as a replacement for their preferred therapeutic approach. They consider these good practice basics to be common across theoretical modalities and list them as; clarifying what the client wants from therapy (and from you, the clinician); checking in from time to time that you are on track during a session; providing direct feedback and responding to what the client has asked for; making the most of every encounter because you do not know if it will be your last; a more direct interview style (creating a context for mutual honesty and directness); follow- up after the face-to-face session to establish what the client wants in terms of ongoing support; and providing help during every contact, including any follow-ups. Training in SST involves adapting their therapeutic lens to the research underlying the practice and principles of SST. This author's therapeutic lens is cognitive behavioural therapy. In SST, therapists enable their clients to find or create answers that work, while making the most of their innate abilities to heal themselves. My role as a mental health trauma therapist is to acknowledge and validate the client's concern, help them prioritise their goals, provide the assistance asked for, and to emphasise their strengths and resiliency. As the mental health trauma therapist on this medial mission team to Haiti, for each case referred to me the process of treatment and intervention was formulated to be congruent with the following practice principles of SST (Hoyt, Rosenbaum & Talmon, 1992):

1) View each session as a whole, potentially complete in itself. Expect change.
2) The power is in the patient. Never underestimate your patient's strength.
3) This is it. All you have is now.
4) The therapeutic process starts before the first session and will continue long after it.
5) The natural process of life is the main force of change.
6) You do not have to know everything in order to be effective.
7) You do not have to rush or reinvent the wheel.
8) More is not necessarily better, better is better. A small step can make a difference.
9) Helping people as quickly as possible is practical and ethical. It will encourage patients to return for help if they have other problems and will also allow therapists to spend more time with patients who require longer treatment (p. 61 −62).

I followed the three primary assessment questions of SST: how is the client stuck, what does the client need to get unstuck, and how can I provide or facilitate what was needed. Within each SST session the focus of the therapist/client interaction was to reframe problems, so that the client's reasons for seeking treatment become less overwhelming and more manageable. The client was encouraged to identify small steps toward reaching their goals in order to promote a sense of progress and strengthen a sense of hope. In all cases, feedback was provided to the client that clarified the nature of the problem as well as what can be done to deal with the problem (Talmon, 1990). Clients' were assisted in redefining problems as behavioural, observable, specific and under the client's control. As an outcome of implementing SST in Haiti, I would add and emphasise an additional practice principle to SST, that is, to ensure that the individuals lived experience within their cultural context is integrated into treatment.

Potential limitations of SST in LMIC Post Disaster

The potential disadvantage of SST post disaster would be the adoption of the model as a solution to the limited availability of mental health services in most LMIC. SST should not be a default position. Additionally, it should not be seen as a panacea in the context of no alternative for ongoing follow-up and treatment. It should, as in high income countries, be integrated into the existing mental health delivery system. Fernando (2012), in discussing challenges for mental health development in LMIC's, stated that:

'Developing mental health systems in LMI countries is not a simple matter of transferring established strategies commonly used in high income countries, irrespective of ground realities without taking on board what local people want. And mental health is not just a technical matter but is tied up with ways of life, values, and worldviews that vary significantly across cultures and societies. A basic principle of development is that we have to start by looking at what happens currently and work from there. This is important not just to ensure social and cultural relevance of services and ownership by the people responsible for sustaining them, but also for cost-effectiveness – using the least resources to achieve the greatest gain. In most LMI countries, a variety of services are accessed by people – but usually only if they can afford to do so' (p.10).

Similarly, as emphasised by Mocun-Aydin (2000), it is important not to transplant western mental health, in this case SST, embedded in a western conceptualisation of resiliency and recovery into the countries service delivery system. Therefore, western therapists need to be cautious of implementing a SST framework embedded with a specific western therapeutic lens, without consideration of the cultural context.

Potential benefits of SST in LMIC post disaster

Saraceno et al. (2007) identified the systemic barriers that inhibit the development and sustainability of mental health services in LMIC. As noted, these range from insufficient funding for mental health services, to the lack of mental health resources in rural areas, to the limited number of health care professionals trained and supervised in mental health care. If there is a disaster in LMIC, the fragile mental health delivery system can be completely overwhelmed and many individuals may not receive treatment for the mental health problems that emerge.

In relation to insufficient funding for mental health services and the limited number of health care professionals trained and supervised in mental health care, the SST framework may prove cost effective by providing additional capacity of psychotherapy services to the existing limited mental health services. In relation to the lack of mental health resources in rural areas, the provision of SST does not require the infrastructure of the larger institutions and can easily be implemented in rural areas. In addition, given that SST is a framework, it can be adapted by in-country mental health care professionals, as an adjunct to the specific theory of psychotherapy they have been trained in and from their cultural lens.

The potential benefit of SST as a planned, time limited, intervention resource in LMIC is that the therapeutic intervention is not contingent upon the number of sessions available, the number of therapists available, nor access to follow-up services. The SST framework of providing psychotherapy in one session, with the outcome of ensuring that the client leaves the single session with a specific plan of action to address the presenting problem, has the potential to positively impact the availability of mental health care. SST has the potential of providing mental health

intervention to more of the affected population and decreasing the demand on the existing mental health system for follow-up treatment. It has the potential to be an adjunct to the existing treatment resources available in LMIC in the same way that it is sanctioned as a valid mental health intervention in high income countries (Paul & van Ommeren, 2013).

Haiti, like many LMIC, has limited mental health resources, which results in the majority of survivors of the earthquake having no or limited access to follow-up mental health treatment. Providing SST, as detailed in the case study above, afforded an opportunity to engage a frail elderly woman in beginning the process of grieving, in saying goodbye to her children and in reconnecting to her faith community. By the nature of the medical mission being time-limited, there was no follow-up possible, and no outcome data was collected to provide evidence that she was able to work through the unbearable loss of her family and the incredible life struggle post earthquake. Without a planned evaluation as part of the process of determining effectiveness, this case example remains an anecdotal account of responding to human need and despair within the context of extremely limited resources. However, this experience of implementing SST to provide mental health intervention post disaster in Haiti demonstrated significant promise from the perspective of the therapist in treating the mental health needs of survivors of disasters when follow-up mental health care is inaccessible.

To further support the utilisation of SST as an additional resource in limited capacity mental health systems, and as an intervention strategy post disaster, a concerted focus will be required by practitioners, researchers and local mental health professionals to conduct methodologically sound empirical studies that will advance the knowledge and practice of SST as a viable treatment option post disaster.

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