Retiring, Rethinking, and Reconstructing the Norm of Once-Weekly Psychotherapy

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Retiring, Rethinking, and Reconstructing the Norm of Once-Weekly Psychotherapy

Evidence-based psychotherapies hold clear potential to alleviate mental health problems (Cuijpers et al., 2020; Weisz et al., 2017), yet there is no scientifically-driven consensus for how *long* treatment should last (treatment *duration*, including total numbers of *hours* or *weeks* a treatment might last) or how *often* sessions should occur (treatment *frequency*). In practice, once-weekly therapy is the dominant outpatient service available to youths and adults alike, largely due to long-held beliefs and insurance companies' limiting reimbursable treatment-time to 50-minute, weekly sessions. But ubiquity cannot be mistaken for clinical or practical superiority. Indeed, weekly hour-long therapy sessions are among numerous treatment structures that can help patients achieve clinical gains, with recent trials supporting the utility of brief, intensive, and concentrated treatments for widely-varying problem types (Dobias, Schleider, & Ollendick, 2020). Further, existing psychological services—dominated by weekly, outpatient options—fall short of meeting population-level mental health needs. Most youths and adults with psychiatric disorders never access care due to financial and logistical constraints, and among those who do, premature drop-out is common (Abel et al., 2020; Burns et al., 1999; McKay & Bannon, 2004). Among those who do access psychological support, receipt of evidence-based intervention remains rare, often taking the form of unstructured, brief interactions with physicians (e.g., in primary care settings) or healthcare workers with limited mental health training (Kazdin, 2019). Despite repeated calls to diversify treatment options, and to ensure that these diverse options are backed by scientific evidence (Kazdin, 2019; Schleider, Dobias, Sung, & Mullarkey, 2020), the “weekly therapy hour”—in many cases, absent of any quality assessment ensuring reliance of evidence-based approaches—remains the practical default.

Given limited accessibility of, and significant dropout from, weekly outpatient therapy (suggesting that many are unable to access treatment as it is routinely provided), and the established efficacy of alternative treatment formats (suggesting that treatment may be redesigned to improve accessibility without sacrificing clinical utility), we assert that it is our field's ethical obligation to retire

and rebuild the longstanding “default” to once-weekly outpatient services.¹ To be clear, we do *not* endorse eliminating weekly psychotherapy as an option for patients; many once-weekly, evidence-based treatments, if delivered as intended, may benefit patients greatly. However, repositioning evidence-based weekly therapy as one of *many* treatment options, and improving the availability of additional, diverse evidence-based service types, may strengthen the accessibility, flexibility, and potentially the effectiveness of mental health treatment overall.

Treatment need not occur once-weekly.

Psychotherapies need not be delivered in a once-weekly format to effect clinical improvement. One intensive outpatient treatment, involving four consecutive days of exposure and response prevention treatment, has substantially reduced OCD symptoms for adults up to four years later (Hansen et al., 2019; Kvale et al., 2018) and adolescents up to six months later (Riise et al., 2016, 2018). Other trials indicate that an 8-day, 20-hour treatment involving cognitive-behavioral techniques—including interoceptive exposures and psycho-education—can reduce symptoms of specific phobia, social phobia, and GAD (Gallo et al., 2012). Written-exposure therapy, an exposure-based treatment involving recalling, processing, and making meaning of past traumatic experiences via timed sessions of expressive personal writing, has produced clinically-significant reductions in PTSD after just *3-4 hours* of intervention—and is non-inferior, and carries lower dropout-rates (6% vs. 39%) than lengthier, evidence-based alternatives (e.g., Cognitive Processing Therapy; Thompson-Hollands et al., 2019). Clearly, cookie-cutter treatment formats are unnecessary for meaningful therapeutic change. Indeed, large-scale trials and systematic reviews of treatments for anxiety disorders, depression, and behavior problems indicate that non-weekly interventions—from self-guided supports to brief, one-session treatments to concentrated, week-long interventions—can yield benefits approximately equivalent to once-weekly evidence-based

¹ In the present article, we focus our discussion on *outpatient* mental health services, given the numerous structural and practical differences between inpatient and outpatient mental health treatment options for individuals. As such, our discussion is centered on outpatient psychotherapy options, which collectively represent the majority of mental health services that individuals receive in their lifetimes.

psychotherapy, both for youths and adults (Beevers et al., 2017; Öst & Ollendick, 2017; Schleider, Dobias, Sung, & Mullarkey, 2020; Stoll et al., 2020; Thompson-Hollands et al., 2019).

Breaking away from traditional delivery models may even carry advantages over once-weekly options. A metaregression including 70 psychotherapy trials found session *frequency*—rather than *number* of sessions or *duration* of therapy—was strongly associated with treatment efficacy for depression (Cuijpers et al., 2013). Controlling for total number of sessions, treatment effect size was notably higher among *twice-weekly* treatments, versus once-weekly treatments (increase of $g = .45$). Higher session frequency in the first 3 months of treatment is associated with faster improvement and recovery (Tiemens et al., 2019). Further, patients randomized to receive twice-weekly sessions experienced greater depression reductions than those offered once-weekly therapy (Bruijnicks et al., 2020). Thus, defaulting to once-weekly treatment may fail to optimize patients' clinical progress.

More treatment—in hours, days, or weeks—is not always better.

Brief, evidence-based treatments, including some lasting just a few hours or a few days, can benefit many populations and problem types. Meta-analytic evidence suggests a single session intervention (SSI) can significantly improve anxiety, conduct problems, and substance use in youth (Schleider & Weisz, 2017), and recent trials indicate that SSIs can reduce youth depression (Schleider & Weisz, 2018; Schleider et al., 2019). Evidence across 58 studies indicates interventions lasting <5 minutes can have similar effects on young adults' problem drinking, versus multi-session interventions (Tanner-Smith & Lipsey, 2015). Single-session, walk-in therapy is associated with symptom improvement in adults ages 18-80 and can reduce clinic wait-list length (Harper-Jaques & Foucault, 2014).

Still, even if patients can benefit from brief treatments, wouldn't *more* treatment be better? Some correlational work suggests receiving more sessions relates to greater symptom improvement (Hansen et al., 2002), but this evidence is mixed (King, 2015). Indeed, correlational analyses cannot establish whether more treatment *causes* greater improvement. RCTs where patients are randomized to receive more versus fewer sessions for specific phobia (Öst et al., 1997), panic disorder (Roberge et al., 2008), insomnia (Edinger et al., 2007), PTSD (Deblinger et al., 2011), and substance abuse (Covi et al., 2002)

consistently find *no evidence* for longer treatments' clinical superiority. The assumption that "more treatment is better" is unsupported by gold-standard evidence.

Brief and personalized?

"Personalized" treatment refers to therapies that are tailored to an individual's specific presenting needs. A course of treatment may be "personalized" in multiple ways, including through *matching* individuals with particular therapies most likely to benefit them based on pre-treatment characteristics (e.g., symptom severity), or *altering the course of treatment* based on changing needs, problems, or preferences as therapy progresses. One concern around brief treatments and SSIs is that their brevity might preclude personalization to individual patients' needs. This concern is misguided for at least two reasons. First, many brief treatments are "problem-agnostic" by necessity (e.g., walk-in single session therapy): They are inherently designed to adapt to the patient's presenting problem *as they understand it*—not to a particular clinical diagnosis, which many therapy protocols are designed to target (Harper-Jaques & Foucault, 2014; Schleider et al., 2020). Thus, many brief treatments may be *easier* to personalize than traditional, manualized treatments centering diagnostic-criteria.

Second, psychotherapy may be personalized not just *during* the treatment, but *prior* to treatment, as well. Indeed, many treatment personalization attempts have involved "matching" particular patients with best-fit interventions *before services begin* (Cohen & DeRubeis, 2018). This personalization approach may be especially important with respect to the effectiveness and accessibility of mental health services, as patients routinely see 10+ outpatient providers before accessing treatment they perceive as helpful (Harris et al., 2020). Given sufficiently-large samples, artificial intelligence could help identify precision treatment "rules" indicating which treatment is most likely to benefit particular patients (Bickman, 2020). Most traditional RCTs have too few participants to reliably identify precision treatment rules (Kessler et al., 2019), but online SSI research may overcome this obstacle. In the previous year, our group has recruited over 900 youths for an open-label trial of SSIs (Schleider, Dobias, Sung, Mumper, et al., 2020); 302 participants for an online RCT testing an SSI targeting parents experiencing anxiety (NLM, NCT04453865); and >500 adolescents for another online SSI RCT (NLM, NCT04498143). Large

datasets aggregated across affordable, online SSI trials could be leveraged to develop precision-treatment “rules” with great statistical precision, and at a long-impossible rate, thus rapidly forwarding efforts to reduce psychopathology’s public health burden (Kazdin, 2019).

Recommendations & Conclusions

Clearly, diverse cost- and time-efficient treatment structures—not just once-weekly psychotherapy—can yield meaningful clinical benefits for youths and adults. Treatment utilization patterns suggest that many clients cannot consistently access or complete weekly treatment involving months-long commitments; likewise, it is unrealistic to think this model would be *preferable* to individuals seeking high-quality care. However, major structural changes to our mental healthcare ecosystem are needed to broaden access to and awareness of diverse treatments. We offer the following recommendations as first-steps:

Therapist Training. Therapists should be trained to deliver treatment in varying formats and structures, and once weekly therapy should be identified as just one of many evidence-based treatment approaches. This will require a major revolution in training programs in clinical psychology and allied disciplines. Indeed, it may involve overhauling how we are willing to define “treatment” for psychological distress, and acknowledging that “treatment” can occur in a wide variety of settings, with or without a trained provider present, over an hour or many months, and within or beyond brick-and-mortar clinic. This expanded understanding of “treatment” may create new roles and opportunities for mental healthcare providers, including flexible utilization of widely-varying forms of therapeutic client supports both in and out of traditional “sessions.” It will also require sustained commitment to questioning longstanding assumptions about when, where, and how clinical progress may be achieved.

Research Priorities. The vast majority of treatment trials focus on weekly therapy sessions. However, a robust and growing body of literature has revealed that other brief, intensive and concentrated approaches can work equally well. It will be important that we personalize these approaches and determine for whom they are most effective.

Insurance Reimbursement. Insurance companies must provide flexible structures for supporting non-weekly psychotherapy—for instance, reimbursing by *time spent in treatment* regardless of frequency, intensity, or duration. It is most cost-effective to cover treatment that is efficient *and* that “works.” There must be flexibility such that, if weekly therapy is needed for certain people—which it naturally will be—that will be coverable, too. The key is making therapy sufficiently accessible and flexible to meet *all* individuals’ clinical needs.

Treatment Quality Assessment. Just as with any mental health treatment, it is critically important to ensure that brief treatments and SSIs are monitored for quality—including their adherence to evidence-based models and practices. Without ensuring high-quality treatment *content*, diversifying the *structure* of available interventions will fail to reduce mental illness on a large scale. Brief, digital and self-help interventions are relatively straightforward to monitor for quality, as they are often standardized by design; quality assessment of therapist-delivered brief interventions must be supported via continued promotion of measurement-based approaches to treatment across disciplines (see Bickman, 1996, & Garland, Bickman, & Chorpita, 2010, for further discussion on this topic).

In sum, we do not endorse *abandoning* weekly therapy; rather we submit that it *cannot* ethically remain the “norm” or the sole format for the delivery of evidence-based treatments. Evidence supports the use of brief, intensive and concentrated treatments; they can be more efficient than longer treatments, more cost-effective, and more accessible (Ollendick, Öst, & Farrell, 2018; Ollendick, Ryan, et al., 2018). To some extent, psychological treatment provision is *already* being overhauled by the COVID-19 pandemic, including rapid normalization and expansion of telehealth and digital interventions. This moment presents a prime opportunity for our field to reconsider how psychological services can and should be structured—both regarding *session frequency* and *what a “session” looks like*, and deployment of brief, concentrated therapies without sacrificing personalization potential. Doing so could create more accessible, ethical, and effective treatment options for clients.

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