RUNNING HEAD: SINGLE-SESSION INTERVENTIONS

Single-Session Interventions: Complementing and Extending Evidence-Based Practice

Jenna Y. Sung, Mallory L. Dobias, & Jessica L. Schleider

Department of Psychology, Stony Brook University

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In a time of increasing demand and limited resources, diverse approaches to disseminating evidence-based mental health services are imperative to reduce the overall burden of psychopathology. Unmet treatment needs are especially notable for youth; up to 80% of U.S. youth with mental health needs receive no treatment at all (Kataoka et al., 2002; Kazdin & Rabbitt, 2013), and few who successfully connect with services receive evidence-supported care (Kazdin, 2019). Even among those who *do* receive quality care, the modal number of sessions clients attend is one (Hoyt, Bobele, Slive, Talmon, et al., 2018), raising the concern that clients may discontinue treatment before engaging in the therapeutic mechanisms that make them effective. Thus, the field of psychotherapy is in a dire need of innovative shifts in intervention research to disrupt the continuously increasing prevalence, incidence, and burden of mental illness.

Defining “Single-Session Interventions”

Single session interventions (SSIs), defined as “specific, structured programs that intentionally involve just one visit or encounter with a clinic, provider, or program” (Schleider et al., 2020), offer a promising avenue to create such shifts in the field’s conceptualization of psychotherapy. In this sense, SSIs may be viewed as a particular variety of evidence-based “kernel” (Embry & Biglan, 2008), strategically fragmented to help maximize scalability and ensure that clients receive a full dose of the intended treatment every time.

SSIs Help Overcome Treatment Access Barriers

Inherent in their structure and flexibility, SSIs confer many practical and logistical benefits. While most trials testing SSI effectiveness involve therapist-delivered interventions, SSIs powered through technological platforms (e.g. web-based, virtual reality) may alleviate many traditionally cited barriers to treatment. Self-administered SSIs allow individuals to access therapeutic tools anywhere at any time, overcoming geographic limitations and the short supply of highly trained clinicians. Given the brevity and low cost of the treatment, adding SSIs into the ecosystem of mental health care options may offer a more feasible treatment option for overburdened or financially limited families. In fact, a recent

open trial evaluating three open-access, free-of-charge SSIs for youth recruited participants who are defined as “hard-to-reach populations” (53.75% non-white; 43.23% sexual minorities; Schleider et al., 2020).

SSIs Can Work

Literature has supported SSIs’ capacity to reduce psychopathology in youths and adults (Calvete et al., 2019; Cartwright-Hatton et al., 2018; Davis et al., 2012; Hoyt, Bobele, Slive, Young, et al., 2018; Hymmen et al., 2013; Ranney et al., 2017; Schleider et al., 2019; Schleider & Weisz, 2016; Slive et al., 2008). More specifically, a meta analysis of 50 randomized controlled trials reported a small-to-medium overall effect ($g = .32$) for SSIs targeting youth psychological problems (Schleider & Weisz, 2017); notably, the overall effects of SSIs, including self-administered SSIs, were only slightly smaller than traditional forms of psychotherapy ($g = .46$) that typically span across several months.

Notably, SSIs are not “silver bullets” in ameliorating youth psychopathology or the mental health treatment gap. Further studies will help us realize SSIs’ full promise and limitations. However, SSIs offer a path toward diversifying treatment options available to families with varying needs—especially when the alternative is no treatment at all.

Our approach to SSI design

Our team follows the “B.E.S.T.” elements when designing SSIs (see Schleider et al., 2020 for a detailed description of this approach), derived from principles of social-psychological research (Aronson, 1999; Lewin, 1944). In each SSI we design, we use *brain science* to normalize concepts in the program (e.g. using neuroplasticity to explain how and why personal traits are malleable). Second, we *empower* youths to a “helper” or “expert” role by framing the participants as active contributors to the improvement of our SSIs and asking them to provide advice to peers. Third, we embed *saying-is-believing* exercises to solidify learning; these exercises promote the internalization of the SSIs’ message by asking the youth to problem solve a hypothetical situation based on what they learned. Finally, we include *testimonials* and evidence from valued others; the testimonials include stories from older peers and other experts that reflect the program’s core message.

How to incorporate SSIs in your practice

The flexible nature of SSIs allow them to easily integrate into existing systems; SSIs can be designed to target any specific problem (e.g. self-esteem, academic performance, treatment expectancies, etc.) and the delivery format are adjustable to fit the needs of virtually any environment (e.g. self-administered vs. clinician-guided; online vs. in-person). Such flexibility renders SSIs ideal for limited-resource settings like schools and pediatric practices, where they may reach large populations of youths.

SSIs carry practical applications beyond therapeutic benefits. An SSI may serve as first-line, low-intensity intervention within stepped-care treatment approaches, or as a motivating stepping-stone for individuals who are ambivalent about treatment. In either case, individuals who subjectively benefit from an SSI may be primed to engage more effectively with subsequent, longer-term CBT. As waitlists grow longer at mental health clinics across the United States, standalone SSIs might also facilitate more rapid access to low-intensity care. For example, offering one-time, solution-focused consultations (Schleider 2020; Schleider et al., 2020) as a walk-in service, or soon after clients inquire about treatment, may capitalize on client motivation, prevent clinical deterioration while waiting for treatment, and perhaps reduce waitlist lengths overall (e.g., if a subset of clients finds an SSI sufficient for their needs).

SSI Resource List

Self-administered SSIs. Youth ages 11-17 are welcome to participate in Project YES (Youth Empowerment and Support; www.schleiderlab.com/YES), the Lab for Scalable Mental Health's anonymous, online program evaluation project. Although these online SSIs were designed for youth, people of any age can take part in Project YES. Materials for all SSIs in Project YES are publicly available on Open Science Framework (Project Personality: <https://osf.io/a9uv2/>; The A.B.C. Project: <https://osf.io/ch2tg/>; Project C.A.R.E.: <https://osf.io/57b3k/>).

Clinician guided SSIs. Several SSI protocols are available via Open Science Framework. A few examples are: Single Session Consultation (SSC; <https://osf.io/tua4h/>), Short-term Transdiagnostic Anxiety Treatment (STAT; <https://osf.io/2v8k3/>—may be delivered in 1-3 sessions) and CBT-based One Session Distress tolerance for Emergency responders (CODE; <https://osf.io/hzs9m/>).

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