ORIGINAL RESEARCH

Open Pilot Trial of a Single-Session Consultation Service for Clients on Psychotherapy Wait-Lists

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THE DEMAND FOR MENTAL HEALTH services dramatically exceeds the number of available providers, rendering months-long waits for therapy the rule, rather than the exception, facing treatment-seeking individuals. In the United States, wait-times for outpatient psychotherapy often span weeks to several months (Blech et al., 2017; Steinman et al., 2015), and waiting for care can itself may cause harm. Longer wait-times are linked to worsening mental health symptoms (Steinert et al., 2017), even when compared to "no treatment" conditions (where individuals do not expect to receive future care (Furukawa et al., 2014), along with smaller symptom improvements and greater odds of premature dropout once treatment is accessed (Reitzel et al., 2006; Swift et al., 2012). Thus, there is a need for efficient, sustainable service-delivery models that enable quick access to treatment for as many patients as possible. Offering interim, low-intensity supports to treatment seekers may help mitigate adverse effects of waiting for longer-term care. To explore this possibility, we tested the acceptability, feasibility, and short-term effects of a solution-focused single-session consultation service, offered to individuals waiting for therapy at two outpatient clinics with mean wait-times of 2 to 6 months.

What Are Single-Session Interventions and Why Deliver Them?

Single-session interventions (SSIs) are defined as "specific, structured programs that intentionally involve just one visit or encounter with a clinic, provider, or program" (Schleider et al., 2020). SSIs may serve as stand-alone programs (e.g., where no other treatment is accessible, as is true for many individuals with mental health needs; Kazdin, 2019) or as adjunctive supports within existing care systems (see Hoyt et al., 2018, for examples of both application types). Evidence supports both applications. SSIs have reduced anxiety, depression, self-harm, and interpersonal challenges, among other psychosocial concerns (Cartwright-Hatton et al., 2018; Davis et al., 2012; Hymmen et al., 2013; Ranney et al., 2017; Schleider et al., 2019). A meta-analysis of 50 randomized trials found a significant, positive effect of SSIs on mental health problems, versus control conditions, at post-intervention (g = .32; Schleider & Weisz, 2017)—an effect comparable to that observed for longer-term therapies lasting 16 weeks on average (g = .46; Weisz et al.). SSIs may also improve treatment expectancies, which predict subsequent engagement and response (Swift et al., 2012; Thiruchselvam et al., 2019; Wu et al., 2020). For instance, relative to a placebo control, a 15-minute, online SSI teaching that emotions are malleable strengthened adults' beliefs that therapy could be effective (Schleider & Weisz, 2018).

Because SSIs may improve both symptoms and treatment expectancies, delivering an SSI *when individuals initially seek therapy* might augment expectancies for change, capitalize on motivation, and prevent symptom increases while waiting for longer-term care. Hoyt and colleagues (2018) note that SSIs may confer at least three structural benefits if integrated into traditional outpatient clinics: (a) SSIs increase access to immediate support, providing patients with meaningful therapeutic interactions at just the right moment (when they are first compelled to seek support); (b) SSIs may reduce risks of delayed treatment (or prevent overtreatment, as an SSI may be sufficient to address certain patients' needs); and (c) SSI services could provide a valuable clinical training opportunity to trainees, given that weekly therapy is infeasible in many clinical settings (e.g., inpatient clinics, schools, primary care). As such, it is important to identify SSIs best-suited for flexible, broad use across diverse clinical settings—especially SSIs that are easy to implement, requiring minimal training to deliver.

SSIs for Individuals Waiting for Therapy: A Solution-Focused Approach

Although many existing SSIs might be usefully integrated into existing clinical settings, we opted to test a novel "single-session consultation" service (Schleider, 2020; full intervention protocol accessible at osf.io/xnz2t/ and draws heavily from principles of Solution-Focused Brief Therapy; SFBT; Bannink, 2007; De Shazer, 1985). SFBT is focused on identifying and mobilizing a patient's present goals, hopes, and strengths (i.e., a strengths-based, patient-centered approach as opposed to a deficits-focused, therapist-driven approach). Interventions based on SFBT have guided single-session clinical services internationally, though few such services exist in the United States (several exist in Canada, New Zealand, and Australia; see Hoyt et al, 2018, for case examples). Given its emphasis on *present hopes, patient strengths*, and *concrete strategies*, SFBT fits naturally into a single-session format. Therapists help patients identify the tools and capacities they already possess to solve a problem at hand, and to take steps, however small, toward a future in which that problem is less influential. SFBT asserts that all people possess inner resources to solve life's challenges; that one does not need to know what caused a problem (e.g., via comprehensive clinical assessment) to begin solving it; and that the client is expert in their life and best positioned to address their problems (de Shazer, 1985).

We designed the Single-Session Consultation (SSC) as a flexible, SBFT-based program for use with adolescents and adults, regardless of problem type or severity. Using the SSC, therapists help clients identify (1) a specific, modifiable problem (and associated "hope" for their SSC session); (2) the "smallest-possible step" they can take toward overcoming their problem; and (3) a personalized Action Plan, drawing on their inner abilities and external resources to help them enact this smallest-possible step. This process aims to empower the client, helping them realize and mobilize their existing resources to cope more effectively. Notably, the SSC is designed to be delivered by therapists with *any level* of clinical training, from trainees to seasoned professionals, and training is approximately 90 minutes in length (Schleider, 2020). Thus, the SSC is designed

for immediate scalability across diverse settings.

Present Study

This open pilot trial examined the feasibility, perceived acceptability, and short-term effects of the SSC service, which was offered to clients on waiting-lists at two outpatient clinics at Stony Brook University across a 6-month period. At both of these clinics, wait-times for psychotherapy average 2 to 6 months. Preregistered hypotheses were as follows (see https://clinicaltrials.gov/ct2/show/NCT04069832):

1. Clinically relevant constructs of hopelessness and perceived agency (primary outcomes) will significantly improve from pre-SSC to immediately post-SSC.
2. SSC participants will view the program as acceptable and useful in addressing their clinical needs, indexed by mean ratings of at least 3.5 out of 5 across the five items (each rated on 1–5 Likert scales) on the "Consultation Feedback Form" developed for this study (available at osf.io/zwphv).
3. The SSC will show feasibility as a service provision model based on patient attendance (i.e., >50% of patients offered the SSC service will elect to receive it, and >75% of clients who schedule an SSC will attend, which would reflect a substantially lower "no-show" rate than average for community-based mental health clinics, where 40-60% of scheduled sessions are attended (Lefforge et al., 2007; Oldham et al., 2012).
4. Clients' overall psychological distress will significantly decrease from baseline to 2 weeks after their SSC.

Last, to explore whether SSC might provide sufficient clinical care for some subset of clients, we documented patients' choices about whether to remain on (or remove themselves from) clinic wait lists 2 weeks after their SSC.

Method

Procedure

All clients 13 years or older who inquired about outpatient therapy services at two outpatient clinics (described below) from September 2019 to February 2020 were offered an SSC. Prospective clients completed a brief phone screen to collect contact information, a brief summary of their primary reason for seeking services, and an abbreviated risk assessment to determine appropriateness for outpatient therapy (versus emergency services if imminent risk is present). If emergency services are not required, clients were placed on clinic wait-lists (estimated at 2–6 months). Clients were then informed of the SSC service and invited to take part in a one-time, face-to-face consultation with a trained clinician while waiting for treatment. Clients expressing interest in the SSC were scheduled for a session within 2 weeks of this invitation, choosing among 6 to 8 preexisting SSC appointment times (1–2 session options per weekday). Clients received confirmation emails shortly after scheduling and 24 hours before their session. Prior to scheduling, clients were informed that the cost of an SSC is identical to the cost for a single session of psychotherapy (between $20 and $65, per the clinics' sliding fee schedules).

Participants were asked to arrive 30 minutes prior to their SSC to complete

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baseline questionnaires. Upon arrival, after providing informed consent to take part in the SSC trial, participants self-reported overall psychological distress, levels of hopelessness, and levels of perceived agency at baseline. Participants then took part in their 1-hour SSC with a trained clinician. Immediately after the SSC, participants again self-reported levels of hopelessness and perceived agency, along with feedback on the session's acceptability. Participants were then contacted via phone for a two-week follow-up assessment, wherein they again self-reported overall psychological distress and received the option of *remaining on* or *removing themselves from* the clinic waitlist for therapy. Clinic staff attempted to contact SSC recipients up to 3 times for their follow-up call. If no response was received, clients were considered unresponsive and were automatically removed from the clinic waitlist, per both clinics' standard policies.

Clinical Settings

This trial took place at two mental health clinics affiliated with Stony Brook University, the Leonard Krasner Psychological Center (KPC) and the Mind-Body Clinical Research Center (MBCRC). The KPC is the training facility for students in Stony Brook University's clinical psychology doctoral program. Student clinicians provide a variety of evidence-based assessments and therapies, including outpatient services for children, adolescents, and adults under the supervision of licensed psychologists. The MBCRC, housed in the Department of Psychiatry at Stony Brook Hospital, provides evidence-based adult outpatient mental health services and is staffed by predoctoral and postdoctoral trainees, social workers, and clinical psychologists.[1]

Inclusion Criteria

All English-speaking adolescents (age 13+) and adults on waitlists for outpatient therapy services at the KPC and MBCRC received invitations to take part in this study. Child clients < age 13 were not eligible to take part in this study, as the SSC was designed for use with adolescents and adults. Due to unusually low rates of service inquiries from prospective adolescent clients during the recruitment period, all participants in this study were adults (> 18 years). Informed consent was obtained prior to study initiation with each participant.

Therapist Training, Supervision, and Fidelity

Six advanced doctoral student clinicians from the KPC and three postdoctoral clinicians from the MBCRC attended a 90-minute SSC training, led by the first author (JLS). This training provided background information on single-session and solution-focused therapeutic techniques; a step-by-step walkthrough of the SSC program protocol; an overview of potential challenges (and recommended solutions) faced by SSC providers; and guidelines for addressing imminent risk during an SSC session. Clinicians in this study were advised to utilize standard clinic procedures to assess risk in participants reporting non-zero suicidal ideation at pre-intervention. If risk to the client was deemed imminent, clinicians were instructed to prioritize risk management and triage over SSC completion. Although several participants in this study (26.67%) reported passive suicidal ideation at pre-intervention, risk was assessed and deemed imminent in none of these cases, and all of these clients engaged successfully in the SSC.

To promote clinician fidelity, therapists received a step-by-step guide to delivering the SSC in its intended format (available here: https://osf.io/r5gk3/) and an "Action Plan" worksheet to be completed jointly with clients during the SSC (available here: https://osf.io/7jt6m/). The Action Plan is designed to impose a uniform, linear structure onto each SSC while generating a personal coping plan for each client. Action plans were successfully (at least 80%) completed for all SSC sessions in this study, suggesting fidelity to the intended format. Additionally, all SSC sessions delivered at the KPC (23 of 30 in this study) were video-recorded for supervision purposes and viewed in full by the first author (JLS). Consistent with the successfully completed Action Plans, recordings suggested therapists' fidelity to the SSC structure.

Single-Session Consultation Overview

The SSC is designed to last approximately 1 hour, although a session may last 30–90 minutes, depending on clinical setting, client needs, and therapist availability. Below we summarize the key tasks within an SSC. A more comprehensive description of the SSC and its delivery, including example responses to client concerns, strategies for incorporating strengths-based language throughout the intervention, and solutions to common problems, is available in the open-access SSC manual: https://osf.io/tua4h/.

After briefly assessing readiness to engage in the SSC (i.e., assessing imminent risk, which takes precedence over the SSC if present), the SSC therapist briefly introduces the purpose and parameters of the SSC; sets client expectations (i.e., this session will not become a long-term therapeutic relationship; it is simply a means of providing short-term support while you are waiting for services); praises the client for taking initiative to engage in the SSC; and introduces the Action Plan, which will guide the session's structure and will be completed jointly over the upcoming hour. Next, the client is asked to identify their top problem in the present moment (which led them to seek services), along with their top hope for today's session (framed as a discrete, tangible step they would like to take towards a future where their top problem is more manageable). If needed, the therapist redirects the client to identify a top problem and commensurate top hope that is modifiable—i.e., changeable via personal effort. Examples for ways to reframe "external" top problems to relatively "internal" alternatives are noted in the SSC manual.

Next, the clinician poses the "miracle question," a common SFBT technique: *Imagine that a miracle occurs overnight; while you are sleeping, your reason for seeking services has completely disappeared. When you wake up, how will you know that there has been a miracle? What will you do, think, or feel differently?* The therapist supports their client in crafting as vivid a description as possible of their "miracle day" wherein their top problem is absent. Next, the therapist asks the client to rate, on a 1-to-10 scale, "how close they are to [their] miracle day" at the present moment, with "10" representing their problem having disappeared entirely, and "1" representing their problem being at its worst (completely incapacitating). The remainder of the session is dedicated to crafting a personalized Action Plan, geared towards

[1]There were no significant differences across clinics in uptake of the SSC when offered, but a larger number of clients at the KPC (versus the SSC) were offered the SSC, as there were more staff members available at the KPC to assist with recruitment calls for this study. We were unable to examine differences in outcome by clinic, as only 7 individuals completed the SSC at the MBCRC; thus, results of statistical tests would have been uninterpretable.

helping the client "move up by just one point on your Miracle Day scale"—for instance, if a client rates themselves at a "4 out of 10" in terms of closeness to their miracle day, their plan is geared towards supporting them in reaching a "5 out of 10." The Action Plan includes up to three concrete things that the client can do (including where and when they will do those things) to increase their miracle day scale rating by a single point. Therapists encourage the client to choose Action Plan strategies reflecting small steps they have taken before (e.g., based on times when their miracle day scale rating was slightly higher than today's rating), drawing on the client's existing strengths, habits, connections, and coping skills as heavily as possible. Clients are also guided to identify two people or community resources that can help them implement their plan. Once the Action Plan is constructed, the client is asked to identify an inner obstacle that may keep them from following through with their plan: a "thought, feeling, or bad habit that could get in the way" of carrying out the Action Plan as intended. Upon identifying an inner obstacle, the client is asked to generate a "phrase, thought, or action to help them overcome their inner obstacle." The therapist works with the client to help them generate an inner obstacle that feels personally important, and to craft a way to overcome it that "rings true" to them.

Upon ending the SSC, the therapist takes a few moments to write a personalized note to their client at the bottom of the Action Plan worksheet. This note is written in the second person (using "you" pronouns) and identifies two specific reasons why the clinician personally believes that the client is capable of following-through on their action plan, based on their own observations during the SSC. The client receives a copy of their action plan, including the note from their clinician, at the SSC's conclusion. Clients are also provided with a list of referrals to local emergency services and crisis hotlines and textlines, should they require immediate support before beginning psychotherapy.

Measures

State Hope Scale
(SHS; Snyder et al., 1996)

The SHS is a 6-item self-report measure of agentic, goal-directed thinking. Respondents rate 6 items on a Likert scale from 1 (*definitely false*) to 8 (*definitely true*). Higher mean scores reflect a greater sense of personal agency (i.e., personal capacity to pursue and sense of having attained goals). Scores range from 1–8, with higher scores reflecting greater perceived agency. The SHS was administered at pre-SSC and immediately post-SSC. Internal consistency was α= 0.86 and 0.92 at pre-and post-SSC, respectively.

Beck Hopelessness Scale-4
(Perczel Forintos et al., 2013)

The brief, 4-item BHS asks respondents to report agreement with 4 items on a 0–3 scale. Higher scores reflect greater hopelessness; scores range from 0–12. The BHS-4 was administered at pre- and immediately post-SSC. Internal consistency was α= 0.87 at both pre- and post-SSC.

Brief Symptom Inventory-18
(BSI-18; Derogatis, 2001)

The BSI-18 assesses self-reported psychopathology and distress. It was selected as the primary outcome measure for this study because it is brief, normed on a national U.S. sample of adults, and inclusive of multiple domains of psychopathology (depressive symptoms, anxiety symptoms, somatic symptoms). Respondents rate endorsement of 18 physical and emotional complaints on a 0–4 Likert scale. The total sum score yields an additional total distress score (range: 0–72). Higher scores indicate higher levels of overall psychological distress. The BSI-18 was administered pre-SSC and at 2-week follow up. Internal consistency was α= 0.85 and 0.90 at pre- and post-SSC, respectively.

Consultation Feedback Form

The consultation feedback form, designed for this trial and administered at post-SSC, contains 5 items rated on a 1 (*Not at all*) to 5 (*Very much*) Likert scale, reflecting endorsement of a series of statements about the SSC (e.g., "Did you find the consultation helpful in addressing your concerns?" and "How hopeful are you that the action plan will be useful?" Higher scores indicate greater perceived usefulness of the SSC. Internal consistency was α= 0.86.

Sample Size Justification

We were interested in obtaining precise estimates of feasibility and acceptability outcomes; client satisfaction ratings; and changes in proximal intervention outcomes to aid in the planning of a larger-scale efficacy trial. A sample of 30 participants was sufficient for these objectives, per guidelines for pilot study-planning proposed by Joulius (2005) and Whitehead et al (2016).

Analytic Plan

Per preregistered analyses, we ran two 2-tailed paired samples *t*-tests to assess whether participants' hopelessness and perceived agency significantly improved from pre- to post-SSC. A pre-post difference with $p < .05$ indexed a significant change, in either case. We next examined Consultation Feedback Form scores; mean scores of >3.5/5 on each item indicated that

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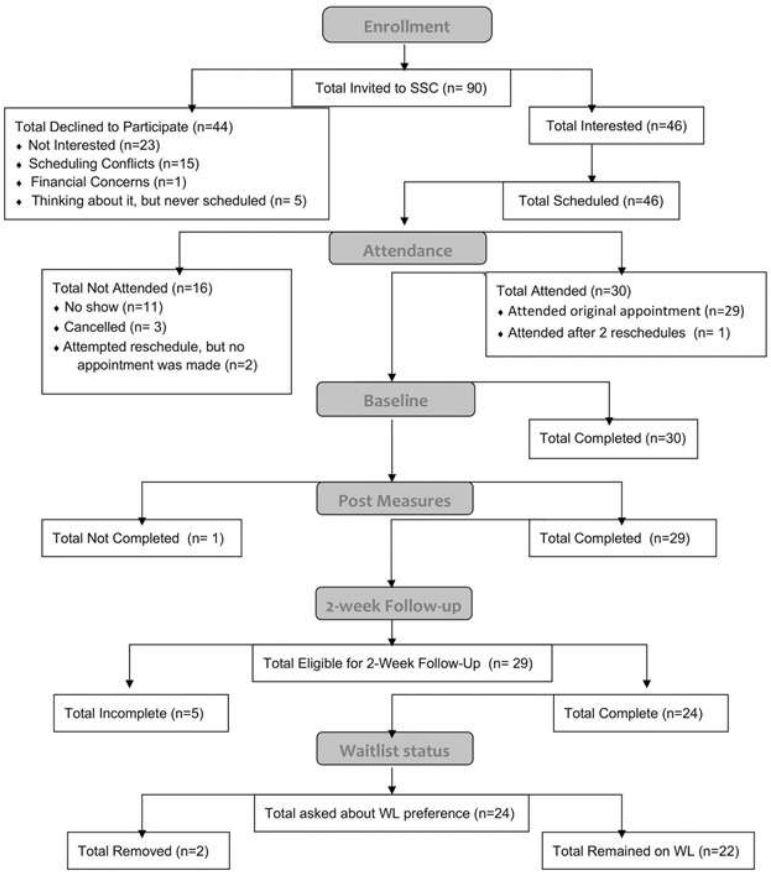

Figure 1. Modified CONSORT diagram illustrating participant enrollment, attendance, and retention patterns

participants found the SSC *more than somewhat acceptable* along all dimensions examined. To gauge service model feasibility, we first divided the number of waitlisted individuals who accepted the SSC invitation by the number of people who received SSC invitations; we then divided the number of people who attended their scheduled SSC by the total number of who scheduled an SSC. An "accepted SSC invitation" rate of >50% and an "attended scheduled SSC" rate of >75% suggested the SSC's feasibility as a service delivery model in these clinics. Last, we ran a 2-tailed paired samples *t*-test to test whether participants' psychological distress (BSI-18 scores) significantly ($p < .05$) reduced from pre-SSC to follow-up.

For paired-samples *t*-tests, the false discovery rate (FDR) was applied to identify potential false-positive results. *Q*-values were computed for *p*-values from *t* tests using an online calculator applying Benjamini and Hochberg's (1995) approach (www.sdmproject.com/utilities/?show=FDR). Results were considered significant if FDR corrected $q < 0.05$.

Results

Anonymized data and code for all analyses are available here: https://osf.io/xnz2t/

Descriptives and Feasibility

Of the 90 treatment-seeking individuals invited to take part in an SSC, 46 (51.11%) expressed interest in receiving one and scheduled an SSC appointment (see Figure 1). Among those who did not schedule an SSC, 23 (25.56%) noted they were not interested; 15 (16.67%) were interested but had conflicts with available SSC time-slots; 1 (1.11%) was interested but cited financial challenges; and 5 (5.56%) expressed possible interest but did not ultimately schedule an SSC. Among those who scheduled an SSC, thirty (65.21%) attended; 11 clients no-showed (with no additional clinic follow-up), 3 explicitly cancelled their SSC, and 1 failed to attend their scheduled session after rescheduling twice. These attendance patterns met our preregistered benchmark for feasibility in terms of interest (>50% scheduled an SSC among those invited) but not for attendance (>75% attendance among those scheduled). Rates of SSC session attendance were within-range of previously reported rates of outpatient therapy attendance in U.S. mental health clinics, where portions of scheduled sessions missed by clients ranges from 40 to 60% (Gopalan et al., 2010; Lefforge et al., 2007).

Table 1 displays demographic characteristics of SSC recipients, who were 31.2 years of age on average (range: 18 - 70) and 73.33% female. At baseline, 8 of 30 participants (26.67%) endorsed recent or current suicidal ideation (i.e., thoughts of suicide were present in the prior 2 weeks), and baseline BSI General Severity Index scores (M = 23.97) reflected mean t-scores > 63 — the established cut-off for "clinically-significant psychological distress" (Derogatis, 2001).

SSC participants presented with a diversity of "top problems." Most commonly, top problems involved interpersonal distress (e.g., loneliness; wanting to cope more effectively with a break-up; loneliness), uncontrollable or generalized worry, depressed mood, sleep disturbances, or academic stress.

Did SSC Recipients Report Improvements in Hopelessness, Agency, and Psychological Distress?

SSC recipients reported significant pre- to post-intervention increases in perceived agency, $d_z = 1.43$, $t(26) = 7.42$, $p < .001$, $q < .001$, and a significant decrease in hopelessness, $d_z = 1.11$, $t(26) = 5.75$, $p < .001$, $q < .001$, with large effect sizes for both primary outcomes. Per common language effect size estimates (Lakens, 2013), hopelessness showed a 86.59% chance of being lower at post- versus pre-intervention, and agency showed a 92.36% chance of being higher at post- versus pre-intervention.

Psychological distress from baseline to 2 weeks post-intervention significantly decreased, with a medium-to-large effect, $d_z = .72$, $t(23) = 3.52$, $p = .002$, $q = .002$. Psychological distress showed a 76.40% chance of being lower at follow-up relative to baseline. Additionally, two of the 24 participants who completed the 2-week follow-up assessment voluntarily removed themselves from their waiting-lists after receiving the SSC, citing reduced perceived need for treatment.

Did SSC Recipients Find It Acceptable?

Participants perceived their SSC sessions as highly acceptable. On a scale from 1 (*not at all*) to 5 (*very much*), participants rated their sessions as "helpful in addressing their concerns," *M*(*SD*) = 4.31(0.76) and as having "helped them develop an action plan to address their concerns," *M*(*SD*) = 4.55 (0.78). Participants generally rated themselves as "hopeful that the action plan will be useful," *M*(*SD*) = 4.07 (0.80), and "motivated to use their action plan," *M*(*SD*) = 4.24 (0.79). All but one of the participants (96.67%) reported that they would "mostly" or "very much" recommend the consultation service to others, *M*(*SD*) = 4.72(0.52). Additionally, several SSC recipients provided positive written feedback about their experience. As examples: "I didn't expect to feel this differently after a single consultation. It's a big relief"; "Great communication, the consultation didn't feel rushed. Everything was patient and led to a new revelation/idea/goal that was set"; "I feel very positive about my plan and I am excited to begin trying it out. Thank you." Other study participants provided either neutral written feedback (e.g., "thank you") or no written feedback. No participants provided negative written feedback on their SSC.

Table 1. Demographics, Individuals Attending an SSC Session

	Full Sample *M* (*SD*) or (%)	KPC Sample *M* (*SD*) or (%)	MBCRC Sample *M* (*SD*) or (%)
N	30	23	7
Age	31.2 (14.9)	26.3 (11.2)	47.0 (15.1)
Sex			
Male	8 (26.7%)	7 (30.4%)	1 (14.3%)
Female	22 (73.3%)	16 (69.6%)	6 (85.7%)

Note. KPC (Krasner Psychological Center); MBCRC (Mind Body Clinical Research Center). Due to the KPC's and MBCRC's transitions to telemental health services in April 2020, data on participants' race/ethnicity (stored on paper documents in both clinics) were inaccessible to the researchers at the time of data analysis for this manuscript.

Discussion

This open pilot trial tested the feasibility, perceived acceptability, and short-term effects of the Single-Session Consultation, a 1-hour solution-focused intervention for adults on waiting-lists for outpatient psychotherapy. Clients who completed the SSC reported significant pre- to post-intervention reductions in hopelessness (d_z = 1.43) and perceived agency (d_z = 1.11), along with significant reductions in psychological distress from pre-intervention to 2-week follow-up (d_z = 0.73). SSC recipients viewed the intervention as highly acceptable, per preregistered benchmarks. Regarding feasibility, attendance patterns met our preregistered benchmark with respect to client interest (51% of those offered an SSC elected to receive one, above our 50% benchmark) but not attendance (65% of those who scheduled an SSC attended one, below our 75% benchmark). Overall, results suggest the SSC's potential utility among high-symptom, treatment-seeking individuals.

Our study, though preliminary, suggests that a novel SSI may help fill gaps in existing services. Given the shortages of mental health providers and needs to expand service access across numerous settings, the SSC might prove helpful within and beyond outpatient mental health clinics. Providers in hospital and primary care settings, where time with patients is limited, may find the SSC's self-contained structure useful. Therapists in this study included both pre- and postdoctoral clinicians, suggesting the SSC's ease of delivery after a 90-minute training. Of course, these possibilities require further study in diverse contexts and populations. We have thus made SSC materials freely available, including SSC training slides, the intervention protocol, the Action Plan, and the Consultation Feedback Form used in this study (https://osf.io/xnz2t/), which we hope spur further tests of the program's potential.

Some aspects of our results warrant further consideration. For instance, due to logistical constraints, we were able to offer clients only a handful of time-slot options for SSC appointments, and those appointments were available in-person only. Walk-in clinics, teletherapy options, and other approaches conferring more flexible scheduling capacity could yield broader SSC interest and improved attendance. Although the SSC attendance rate in this trial (65%) compares favorably with session attendance rates in outpatient mental health clinics nationally (40–60%), alternative delivery models could further boost the SSC's accessibility and uptake—and in turn, its feasibility for clinics to provide.

Separately, most clients in this study chose to remain on their respective therapy waiting lists after completing an SSC. Notably, we do not view this as evidence that the SSC was ineffective. This sample was composed of treatment-seeking adults with no prior knowledge of the SSC, who contacted clinics specifically in pursuit of weekly therapy; thus, their continued interest in this type of treatment is unsurprising. Indeed, the fact that two participants perceived no need for therapy after their SSCs suggests its potential utility, for some, as a stand-alone intervention. As is discussed elsewhere (Schleider et al., 2020), most SSIs may operate as either stand-alone or adjunctive supports, depending on context, setting, and clinical need. This prospect should be explored in future, larger-scale trials of the SSC as a stand-alone support and as a means of enhancing client motivation and engagement once therapy begins.

This study has important limitations. Results of any nonrandomized pilot trial are preliminary. Further, this pilot trial had a relatively brief follow-up period compared the average waiting time for psychotherapy at the participating clinics, and

Table 2. Means, Standard Deviations, and Effect Sizes

	M (*SD*)
Agency	
Pre-SSC	26.30 (8.73)
Post-SSC	19.48 (8.04)
d_z [95% CI]	1.43 [0.88, 1.96]
Hopelessness	
Pre-SSC	5.37 (3.59)
Post-SSC	2.78 (2.50)
d_z [95% CI]	1.11 [0.62, 1.58]
Psychological Distress	
Pre-SSC	25.83 (11.24)
2-weeks	18.00 (11.83)
d_z [95% CI]	0.72 [0.26, 1.16]

a subset of participants were lost to attrition (though no differences emerged in baseline psychological distress levels between participants who did versus did not complete the follow-up assessment). Nonetheless, it is notable that treatment-seeking individuals often report stable or worsening symptoms while waiting for therapy, yet participants in this trial reported symptom reductions 2 weeks post-SSC. Future randomized trials are needed to determine the longevity and robustness of effects observed in this study. Separately, due to the SSC's brief format (and its omission of a formal assessment, which might have lasted longer than the intervention itself), data on participants' diagnostic profiles were unavailable. We thus cannot comment on the SSC's utility as a function of problem type. Anecdotally, study authors (upon viewing video-recorded SSC sessions) and SSC therapists observed that some conditions rendered the program more challenging to deliver. Examples included traumatic brain injury (resulting in memory impairment) and an eating disorder (resulting in medical problems)—both noted spontaneously by SSC recipients during sessions (these two clients were referred to specialty services following their SSCs). At the same time, several clients reporting clinically elevated psychological distress and suicidal ideation engaged successfully in the SSC; thus, clinical severity alone does not appear to preclude acceptability, but formal investigation is needed as to whether the SSC's utility varies by clinical profile.

Overall, results support the Single-Session Consultation's acceptability in a high-symptom, treatment-seeking adult sample. SSC recipients reported improvements in hopelessness, perceived agency, and psychological distress while waiting for longer-term treatment. Both pre- and post-doctoral therapists successfully delivered the SSC following a brief, 90-minute training. Future studies will help gauge the SSC's best-fit applications and potential contraindications.

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LITERATURE REVIEW

Behavioral and Cognitive Therapies in Psychiatric Rehabilitation for the Schizophrenia Spectrum: Finding the Forgotten Stepchild

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ALAN BELLACK famously characterized schizophrenia as cognitive behavioral therapy's "forgotten stepchild" in his 1985 Association for Advancement of Behavior Therapy (later renamed the Association for Behavioral and Cognitive Therapies) presidential address, a characterization that largely rings true today (see Snyder et al., 2016). At ABCT's 52nd Annual Convention in 2019, the president of the ABCT Psychosis and Schizophrenia Spectrum Special Interest Group (PASS-SIG), Dr. Jerome Yoman, co-organized a panel discussion, including senior serious mental illness (SMI) expert panelists (i.e., Drs. Shirley Glynn, Kim Mueser, David Penn, Steven Silverstein, and Will Spaulding), and moderated by one of the authors of this article (Dr. Charlie Davidson). This panel commemorated 50 years of behavioral and cognitive therapies for schizophrenia spectrum disorders (SSDs). It was a lively panel discussion regarding the state of SMI/SSD treatment research (emphasizing effective SSD interventions) and concerns that mental health practitioners and trainees unfamiliar with SMI view SSD as too severe, too distinct, or even too risky to treat (see Combs et al., 2006, for an overview of SMI misconceptions and recommendations).

We pause here to address stigma and related factors that too often preclude an individual with SSD from receiving any type of care (Corrigan, 2004; Corrigan et al., 2014). Rates of institutionalization have rapidly declined since the 1950s, but rates of criminalization of mental illness and accompanying incarceration have increased (e.g., individuals with a mental illness are 50% more likely to receive a jail sentence for a misdemeanor conviction), as are rates of homelessness, and lack of insurance coverage in SSD (Davis et al., 2012; Hall et al., 2019). Individuals with SSD also experience stigma at alarming rates from the general population (Gerlinger et al., 2013) and from primary and mental health care providers (e.g., increased social distancing, stereotyping, and attribution of mental illness; Mittal et al., 2014). However, as our health care systems are increasingly pushed towards more efficient integrated care, clinicians and researchers are more likely than ever to encounter individuals with SSD, a history of psychosis, or psychosis secondary to another condition. A move towards inclusive care for individuals with SSD can decrease barriers to treatment, increase access to medications and effective psychosocial treatments, and combat stigma through increased interactions and visibility of recovery (i.e., if individuals have access to better treatment, providers see more individuals with SSD doing well and modify misconceptions that perpetuate stigma). The present article is a call for clinicians and researchers to reevaluate what they may have learned about SSD. Given the low prevalence rates of SSD, these misconceptions are perhaps not surprising and are likely the result of unfamiliarity rather than ill intentions. To this end, the present review provides a brief background on SSD, an overview of effective behavioral and cognitive treatments, and summarizes integrated services needed to provide truly integrated care for individuals with SSD.