

Fulfilling the promise: Commentary on Schleider et al. (2023) Zafra Cooper DPhil<sup>1,2</sup>  | Roz Shafran PhD<sup>3</sup><sup>1</sup>Yale School of Medicine, New Haven, Connecticut, USA<sup>2</sup>Department of Psychiatry, Oxford University, Oxford, UK<sup>3</sup>Great Ormond Street Institute of Child Health, University College London, London, UK**Correspondence**

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Email: [zafra.cooper@yale.edu](mailto:zafra.cooper@yale.edu)**Action Editor:** Ruth Striegel Weissman**Abstract**

In their paper on “Realizing the Untapped Promise of Single-Session Interventions for Eating Disorders” Schleider and colleagues suggest an innovative approach to addressing a much-discussed critical issue in the treatment of eating disorders—how we help more people quickly and with greater efficiency. While building on the feasibility and success of program-led approaches, they make a potentially transformative proposal for the use of single-session, “one-at-a-time” interventions freely accessible to those in need. We suggest that not only does this proposal have the potential to narrow the treatment gap, but its ability to generate informative data at scale may also contribute to improving treatment outcomes overall. We also note the need for further independent support for the claim that single sessions produce meaningful benefit especially in the field of the prevention and treatment of eating disorders. While Schleider and colleagues’ proposal is potentially transformative and has heuristic value, some caution needs to be exercised. In our view, single-session interventions should not be regarded as displacing existing treatment provision. Rather they should be seen as complementary and a potential way of improving provision overall.

**KEYWORDS**

accessible treatment, eating disorders, self-guided interventions, single-session interventions, program-led interventions, treatment gap

In their paper on “Realizing the Untapped Promise of Single-Session Interventions for Eating Disorders” Schleider and colleagues (Schleider et al., 2023) suggest a bold and innovative approach to addressing two inter-related and well-known critical needs regarding the treatment of eating disorders. First, they identify the *treatment gap*. Despite the existence of empirically supported and effective treatments, most of those in need do not have access to these treatments. Eating disorders are undetected and untreated, or not effectively treated due to a wide variety of barriers including stigma, trained provider shortages, geography, and cost. While this treatment gap exists for virtually all mental health conditions, as so clearly highlighted by Thomas Insel (2022) in his recent book, *Healing*, it has been well-documented that the problem is particularly acute for the treatment

of eating disorders. Second, Schleider and colleagues draw attention to research findings that demonstrate that even for the few who do receive evidence-supported treatments (carried out with fidelity), a *significant proportion either do not benefit or do not benefit sufficiently*, with 40%–50% people continuing to experience a range of problems. This has led to frequent calls and, indeed, efforts to improve treatments to obtain better outcomes.

Schleider and colleagues build on previous initiatives but make potentially transformative suggestions. Initiatives to address the treatment gap in eating disorders have fallen under two broad headings, those that are essentially therapist-led and so adhere to the still dominant model of psychological treatment provision and those that are program-led (i.e., based primarily on the content of the materials such as self-help guides). In the former, modifications are made to treatment content, mode of delivery or method of therapist training

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(e.g., web-based) to reduce therapist input and make treatment more widely available, while in the latter, treatment content is conveyed directly to individuals and may or may not be accompanied by additional guidance. Such program-led approaches, especially when self-guided, offer the greatest potential for widening access. Brief “low intensity” interventions, delivered in guided form, have gained empirical support at least for adults and are recommended by national guidelines as first line interventions for some forms of eating disorders. As Schleider and colleagues note, however, these guidelines are often inconsistently followed and there may still be barriers to access. Interventions are usually only accessed through traditional clinical services and still require a trained mental health practitioner to provide guidance, albeit a less specialist one. A variety of digital interventions, usually commercially produced apps, are more widely accessible, but most are not clearly evidence based and attrition from, and low adherence to, such programs remain major problems.

In response, Schleider and colleagues propose single-session interventions that target core mechanisms linked to eating disorder onset and maintenance that are easy to access and complete and are optimized for effectiveness. The key features of these sessions are that they are designed for a “one-at-a-time” approach to intervention, they can be self-guided or an adjunct to therapy, and they are empirically informed. So, although in practice, such sessions may be completed on multiple occasions or possibly combined with other such sessions or other interventions, sessions are explicitly designed such that any one session will target a particular problem or issue in a theory driven way to achieve meaningful change. Because such interventions can be delivered as self-guided digital programs free at the point of use, they can be available to anyone with the ability to access the internet. They do not require referral to health services, any interaction with traditional treatment providers or treatment facilitators or even parental consent. Such interventions have the potential to be delivered *directly to the user* avoiding the barriers of stigma, cost, and geography and are likely more accessible to traditionally underserved and marginalized populations. Viewed along a continuum of increasing accessibility, these interventions fare extremely well. Given their targeted nature, they can potentially be accessed just in time as a need is perceived. Furthermore, they do not require effortful persistence over time but still produce meaningful benefit, making them likely to be highly acceptable. Finally, even if one session does not convey sufficient benefit, as seems likely in some, or even many cases, this approach opens the possibility that these single sessions could be combined to provide beneficial and accessible treatment.

Building on the program-led approach to accessibility Schleider and colleagues' proposal for single-session interventions is potentially transformative. Freely accessible self-guided interventions available to those in need have circumvented issues of intellectual property that have historically been one of the barriers to evidence-based treatments being translated from research into practice. This approach also avoids the commercialization of mental health treatment via digital apps. Cutting out intervening barriers to deliver interventions directly to users is likely to significantly narrow both the research-practice gap and the treatment gap. Of course, the question of the future and sustainability of such freely available digital interventions is critical. For these interventions to be updated and evolve, resources are required,

and these need to be sustainable. It should also be noted that barriers are still likely to remain for those who may have a need for such interventions, but who do not have easy or reliable access to the internet. This may be more likely to be the case in some countries or for some groups, even though they might otherwise greatly benefit.

The promising benefits of the single-session proposal are of course only likely to be realized if these interventions do produce meaningful benefit for those in need. Schleider and colleagues address this by highlighting their role in increasing uptake of mental health resources and in improving patient-level outcomes for young people in a variety of areas including for those with anxiety, substance use, and depression. Summarizing the literature, they claim that evidence from large randomized controlled trials and a meta-analysis indicate that singlesessions (one or more module but on one occasion) produce significant beneficial effects compared to control conditions. These effects are consistent across prevention and treatment trials, are obtained regardless of participants' diagnostic status, persist over time, and are present even when single-session interventions are digital and self-guided. They recognize that effects sizes are smaller than for evidence-based multi-session interventions for young people, but smaller effect sizes reliably achieved for a much wider population may produce major public health benefit (Kazdin & Blase, 2011).

While these findings are promising, especially if replicated by an independent group, some caution is needed. Generally, the reported effect sizes are greatest when comparisons are made with inactive as opposed to active control conditions and they diminish with longer follow up durations. Perhaps, most importantly, as Schleider and colleagues acknowledge, data supporting the use of single-session interventions for either the prevention or treatment of eating disorders are very limited. There is clearly work to be done to understand more about the conditions for which they work best, for whom they work and at what stage. Recognition of this early stage of the work is encapsulated in the authors' title referring to “untapped promise.”

It is also important to exercise some further caution and consider potential negative effects of self-guided interventions at scale. In the most accessible form of help, participants are necessarily anonymous, raising possible ethical issues such as how it might be possible to react, if at all, if someone is suicidal or in any other way in an extremely vulnerable position. There might also be a risk of pathologizing normal variations in eating experiences, which may, in turn, be self-fulfilling and potentially exacerbate symptoms (Foulkes & Andrews, 2023).

Despite these cautions, there are two additional broader positive consequences of the proposal to investigate the promise of single-session interventions for the prevention and treatment of eating disorders, beyond those particularly highlighted by Schleider and colleagues in this paper. The ability to recruit substantially larger and more diverse populations than is usually possible in eating disorder research and to learn how such groups react to single theory-driven targeted interventions, may provide valuable information for improving our understanding of what maintains these disorders, what the obstacles to progress in treatment are, and eventually how better to intervene to help those in need. Importantly, such benefits may accrue whatever form our improved interventions eventually take, whether they be data driven combinations of single targeted sessions to realize

the full potential of a “one-at-a-time” approach or refined mechanism-driven, traditional therapist-led treatment programs. Additionally, refining our ability to intervene helpfully for the large number of young people with body image concerns and a range of disordered eating behaviors, may contribute to the eventual prevention of full-scale eating disorder onset, but even if it does not, it will arguably contribute to relieving the considerable suffering and impairment of quality of life experienced by many young people.

Even if access to single-session interventions were to be widely available, clinical experience and research findings to date would suggest that there will be a proportion of people who do not benefit or do not gain sufficient benefit from available interventions. While those who do not benefit from brief, program-led treatments may not be the same individuals as those who do not benefit from evidence supported higher intensity interventions, it seems likely that these two groups overlap, with the former group being larger than the latter. Greater availability of single-session interventions may reduce waiting time for therapist-led treatment with consequent beneficial effects, but the concern about outcomes for those who do receive longer evidence-based treatments, raised by Schleider and colleagues, is still a major issue. Although not the main focus of their paper, this needs to be addressed.

Efforts to improve treatment outcome for eating disorders are likely to benefit from the same strategies developed to improve outcome for other psychological disorders, where the same need has arisen. One focus has been on making better use of existing treatments by developing more efficient methods of treatment selection or treatment matching (Cohen & Derubeis, 2018; Weisz et al., 2021), while another has been on developing novel treatment targets and interventions to improve outcomes. As identified earlier, Schleider and colleagues' approach with its ability to recruit large diverse groups of those with eating difficulties and the possibility of understanding how these groups react to single theory-driven interventions, may contribute to both these endeavors.

The approach outlined by Schleider and colleagues, has great advantages and flexibility to widen treatment access and potentially generate data that will improve interventions overall. We believe that it complements but does not supplant existing provision. There will always be a role and a need for more intensive, therapist-led interventions and for such interventions to achieve better outcomes. In attempting to improve outcomes, we may also perhaps learn from some past successes. Many of our current evidence-based treatments are based on models of the features or processes thought to maintain a particular disorder. These models are often based initially on detailed, astute clinical observation, which is subsequently modified and refined based on empirical research investigating hypothesized mechanisms and maintaining features. Intervention strategies and treatments derived from such models are then tested in clinical trials. Further refinements may also be made to the models based on observed non-response or obstacles encountered in treatment. This method has been successful in generating evidence supported treatments and may continue to have a complementary role alongside the new and exciting innovations suggested by Schleider and colleagues.

In conclusion, Schleider and colleagues' single-session approach is transformative in several ways. They have produced a thought-provoking paper addressing a fundamental question in our field—how

do we help more people quickly and efficiently? Their suggestions about radically widening access are innovative and deserve attention and further careful evaluation. Perhaps, most importantly, we should focus on their heuristic value in helping us think further about how to develop treatments to best widen access and more precisely match needs, as well as the ability of this approach to generate informative data that might contribute to improving outcomes overall.

#### AUTHOR CONTRIBUTIONS

**Zafra Cooper:** Conceptualization; writing – original draft; writing – review and editing. **Roz Shafran:** Conceptualization; writing – original draft; writing – review and editing.

#### CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

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#### DATA AVAILABILITY STATEMENT

Not applicable.

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