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**Developments in Eating Disorder Research: Treatment
Approaches and Men's Experiences**

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**The thesis is submitted in partial requirement for the award of Doctorate In
Clinical Psychology (DclinPsy)**

**Coventry University, Faculty of Health and Life Sciences
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List of Abbreviations

APA	American Psychiatric Association
AN	Anorexia Nervosa
BED	Binge Eating Disorder
BN	Bulimia Nervosa
BMI	Body Mass Index
CBT	Cognitive Behavioural Therapy
CBT-E	Enhanced Cognitive Behavioural Therapy for Eating Disorders
CBT-Eb	Enhanced Cognitive Behavioural Therapy for Eating Disorders – Broad form
CBT-Ef	Enhanced Cognitive Behavioural Therapy for Eating Disorders – Focused form
DSM	Diagnostic and Statistical Manual of Mental Disorders
EDNOS	Eating Disorder Not Otherwise Specified
FPT	Focal Psychodynamic Therapy
ICAT	Integrative Cognitive Affective Therapy
IPA	Interpretative Phenomenological Analysis
IPT	Interpersonal Psychotherapy
MFT	Motivation Focused Therapy
NHS	National Health Service
NICE	National Institute of Clinical Excellence
OSFED	Other Specified Feeding or Eating Disorder
RCT	Randomised Controlled Trial
SD	Standard Deviation

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Declaration

This thesis has not been submitted for any other degree or to any other institution. The thesis was carried out under the clinical and academic supervision of Dr Kate Herbert (Clinical Psychologist, Coventry and Warwickshire NHS Partnership Trust), Ms Jacky Knibbs (Clinical Psychologist, Coventry University) and Dr Sarah Simmonds (Clinical Psychologist, Coventry University). All were involved in the initial discussions of ideas and development of the project. Dr Ken Goss (Consultant Clinical Psychologist, Coventry and Warwickshire NHS Partnership Trust) was also part of initial discussions regarding the development of the project and interview schedule. In addition to previously noted collaborations all material in this thesis is my own work. The literature review paper was written for submission to the European Journal of Eating Disorders. The empirical paper was written for submission to the British Journal of Psychology.

Summary

The thesis explores developments in the treatment of eating disorders (EDs) and the experiences of men living with an ED. The first chapter is a systematic review of a transdiagnostic cognitive behavioural model of treatment for EDs (CBT-E). Following database searches 15 studies were included for review. Results highlight that CBT-E appears to be an effective treatment option, with an indication that results transfer to clinical settings. Strengths and limitations of the included studies are discussed and implications for practice are considered. Areas for further study are recommended.

The second chapter is a qualitative study investigating men's experiences of developing and living with an ED. Interpretative Phenomenological Analysis (IPA) was employed to facilitate an in-depth exploration into participants' experiences. The ED taking control; the ED consuming their life; the conflict between letting go and holding onto the ED; and questioning of masculine identity were themes which emerged from participants lived experiences. Implications for clinical practice and directions for future research are highlighted.

The third chapter presents a reflective account of undertaking the research project. Parallels between the experiences of participants and the researchers own experiences as a man are considered.

Overall Word Count: 19198

Chapter 1: Literature Review

A Systematic Review of the Effectiveness of Transdiagnostic Cognitive Behavioural Therapy (CBT – E) in the Treatment of Eating Disorders

In preparation for submission to the European Journal of Eating Disorders (See
Appendix A for author instructions for submission)

Overall chapter word count (excluding tables, figures and references): 7995

1.1. Abstract

Eating disorders (EDs) are serious mental health conditions. It is therefore important that psychological treatment is effective. Cognitive Behavioural Therapy (CBT) is an evidence-based treatment for bulimia, but there is a need for treatment for all EDs. In line with this, there has been a move to consider a transdiagnostic cognitive behavioural model of treatment (CBT-E), which can be used, with a range of EDs. The aim of this systematic review was to gather relevant studies in order to assess the effectiveness of CBT-E in the treatment of EDs. A systematic search of the literature was carried out between August 2015 and November 2015. 15 studies were included within the systematic review. Results highlight that CBT-E appears to be an effective treatment option, with an indication that results transfer to clinical settings. Strengths and limitations of the included studies are discussed and implications for practice considered. The review also highlights gaps within research and areas for further study are recommended.

Keywords: Eating Disorders, Transdiagnostic, Enhanced Cognitive Behavioural Therapy, CBT-E.

1.2. Introduction

Eating disorders (EDs) are serious mental health conditions, which have been shown to have a significant physical and psychological impact (BEAT, 2015). They have the highest mortality rate for any psychiatric disorder, with 20% of those with anorexia dying prematurely (Crow et al., 2009). Additionally, those with a chronic ED may need an extended period of intensive treatment. As such, the estimated costs of treatment have been predicted at between 3.9 and 4.6 billion pounds, with a predicted loss of income to the economy of between 6.8 and 8 billion pounds (BEAT, 2015).

It is therefore important that psychological treatment is both timely and effective. The National Institute of Clinical Excellence (NICE) recommends Cognitive Behavioural Therapy (CBT) as the treatment of choice (NICE, 2004), particularly for bulimia nervosa. While there is evidence of the effectiveness of this intervention, a need for an improvement in psychological therapies for treatment of all EDs is highlighted (NICE, 2004). In light of this, a move to a transdiagnostic CBT model of treatment (CBT-E), which can be used, with a range of EDs has been considered (Fairburn, 2008; Fairburn, Parson, Cooper & Shafran, 2003). The aim of this systematic review is to gather relevant studies in order to assess the effectiveness of CBT-E in the treatment of EDs. In addition, the review will discuss the findings in terms of their impact on practice and consider recommendations for future research.

1.2.1. Defining Eating Disorders

With the publication of the DSM-5 (American Psychiatric Association, 2013), EDs are now divided into four diagnostic categories: ‘Anorexia Nervosa’, ‘Bulimia Nervosa’, ‘Binge Eating Disorder’ and ‘Other Specified Feeding or Eating Disorder’.

Anorexia (AN) is characterised by lack of maintenance of a healthy weight, a fear or refusal of weight gain, and non-recognition or unrealistic perception of the seriousness of low weight (APA, 2013). Bulimia (BN) is characterised by recurrent binge eating, followed by compensatory behaviours such as purging (self-induced vomiting, use of laxatives), fasting and over-exercising (APA, 2013).

Within the DSM-5, Binge Eating Disorder (BED) is now a separate category. It is characterised by recurring binge eating at least once a week, over three months, while experiencing lack of control and guilt after overeating (APA, 2013). Other Specified Feeding or Eating Disorder (OSFED) is an ED that does not meet the full DSM-5 criteria for AN, BN, or BED. Examples include atypical anorexia (patients meet criteria for AN, but despite significant weight loss are not underweight), atypical bulimia (patients meet criteria for BN, but behaviours are less frequent) and night eating syndrome (APA, 2013).

For the purpose of the review, it is important to note that BED formed part of a category called eating disorder not otherwise specified (EDNOS) in previous editions of the DSM (DSM-IV, APA, 2000). As such, studies which were carried out before the change to diagnostic labels will use the term EDNOS, rather than BED or OSFED.

1.2.2. Prevalence

Within the UK it is estimated that between 725,000 and 1.6 million are affected by an ED (BEAT, 2015; NICE, 2004). Additionally there has been a 34% increase in inpatient admissions since 2005/6 (BEAT, 2015). While EDs are more common in the female population, men are estimated to comprise 10% to 25% of those affected (Health and Social Care Information Centre, 2013; Hudson, Hiripe & Pope, 2007).

Before the latest change to the DSM, it was estimated that 10% of patients were diagnosed with anorexia, 40% with bulimia and the remainder with EDNOS (included BED) (BEAT, 2015). Fairburn and Bohn (2005) also highlight that EDNOS are the most common presentation in outpatient settings, followed by bulimia and then anorexia. Within inpatient settings, anorexia or underweight types of EDNOS are the most common presentation (Dalle & Calugi, 2007).

1.2.3. Treatment of Eating Disorders

Treating EDs is difficult and relapse rates are high (Groff, 2015). They often occur co-morbidly with additional mental health diagnoses such as obsessive compulsive disorder (OCD), anxiety, depression, post-traumatic stress disorder (PTSD) and personality disorders (BEAT, 2015; Stuhldreher et al., 2012), which can further complicate treatment (Groff, 2015).

1.2.3.1. Bulimia Nervosa

Evidence from systematic reviews indicates for the treatment of bulimia CBT is the leading approach (Hay, Bacaltchuk & Stefano, 2009; Shapiro, Berkman, Brownley, Sedaway, Lohr & Bulik, 2007). It is also the NICE (2004) recommended treatment.

Evidence suggests it is effective in long-term reduction of binge and purging behaviours and psychological symptoms (Hay et al., 2009; Shapiro et al., 2007). However, treatment is not always successful. For example, remission rates were low, with 20 to 40% of patients reporting recovery that was maintained (Brown & Keel, 2012; Shapiro et al., 2007; Wilson, Grillo & Vitrussek, 2007).

In light of this, alternative evidence-based interventions such as Interpersonal Psychotherapy (IPT) have been considered (Murphy, Straebl, Cooper & Fairburn, 2010). Although IPT takes between 8 to 10 months longer to complete, studies have shown a comparable effect to CBT (Argus, Walsh, Fairburn, Wilson & Kraemer, 2000; Fairburn, Jones & Reveler, 1993). Additionally, Shapiro et al. (2007) highlight evidence for pharmaceutical interventions such as fluoxetine as effective in decreasing symptomology. However, the impact is short-term.

1.2.3.2. Anorexia Nervosa

There is less published research on treatment of anorexia and Murphy et al. (2010) highlight that studies are often hindered by high dropout rates and small sample sizes. However, there is indication that CBT can be effective in reducing risk of relapse following weight restoration (Bulik, Berkman, Brownley, Sedaway & Lohr, 2007). It is less clear if CBT is effective in patients with a long-standing presentation who are significantly underweight (Bulik et al., 2007).

There has been more substantial research in adolescents with anorexia, but this has focused mainly on family therapy. Research has shown that family therapy with

adolescents and younger children with anorexia is more effective in those with healthy family dynamics (Brown & Keel, 2012).

In terms of pharmaceutical interventions, results appear mixed. For example, Brown and Keel (2012) highlight that antidepressants are not effective in improving weight restoration and limited evidence they impact on secondary outcomes (Brown & Keel, 2012). However, antipsychotic medication was found to be moderately effective in restoring weight (Brown & Keel, 2012) and had a positive effect on depression (Lebow, Sim, Erwin & Morad, 2013).

1.2.3.3. Binge Eating Disorder

Murphy et al (2010) highlight that research on the treatment of BED is growing. Reviews (Brownley, Berkman & Sedway, 2007; Mitchell, Devlin & De Zwaan, 2008; Sysko & Walsh, 2008) highlight effectiveness of CBT-BED, a CBT intervention similar to that used for bulimia. This treatment is reported to have an effect on binge eating behaviour, but limited impact on body weight.

1.2.4. A Transdiagnostic Model of Eating Disorders

The classification of EDs suggests they are distinct and require separate interventions. However, this is questioned, with Fairburn et al (2003) arguing that all EDs share similar features such as a core psychopathology in their over-evaluation of shape and weight. Fairburn and Cooper (2007) also highlight how patients can shift from one ED diagnosis to another over time. It is therefore suggested that there is limited use in distinguishing among disorders (Fairburn, 2008; Fairburn et al., 2003).

This led to the development of a transdiagnostic model of the factors which maintain an ED (Fairburn et al, 2003). As highlighted, a central aspect to the model is that over-evaluation of shape and weight and their control maintains all EDs, and other clinical characteristics are an outcome of this. For example, restriction of diet; preoccupied thinking that is focused on food and eating; being preoccupied with shape and weight; checking or avoidance of body shape and weight; and using extreme weight control strategies (Fairburn et al., 2008).

The exception is binge eating, which is not viewed as an outcome of over-evaluating shape and weight. The model proposes that attempts to keep strict dietary rules are inevitably broken, and when this happens it provides evidence of perceived poor self-control. This then maintains the core psychopathology by increasing concern about ability to control eating, shape and weight. Binges act as a maintenance factor, as they may improve mood and act as a distraction from problems. They also support beliefs that purging is an effective weight control strategy (Fairburn, 2008) (Figure 1.1 highlights the model).

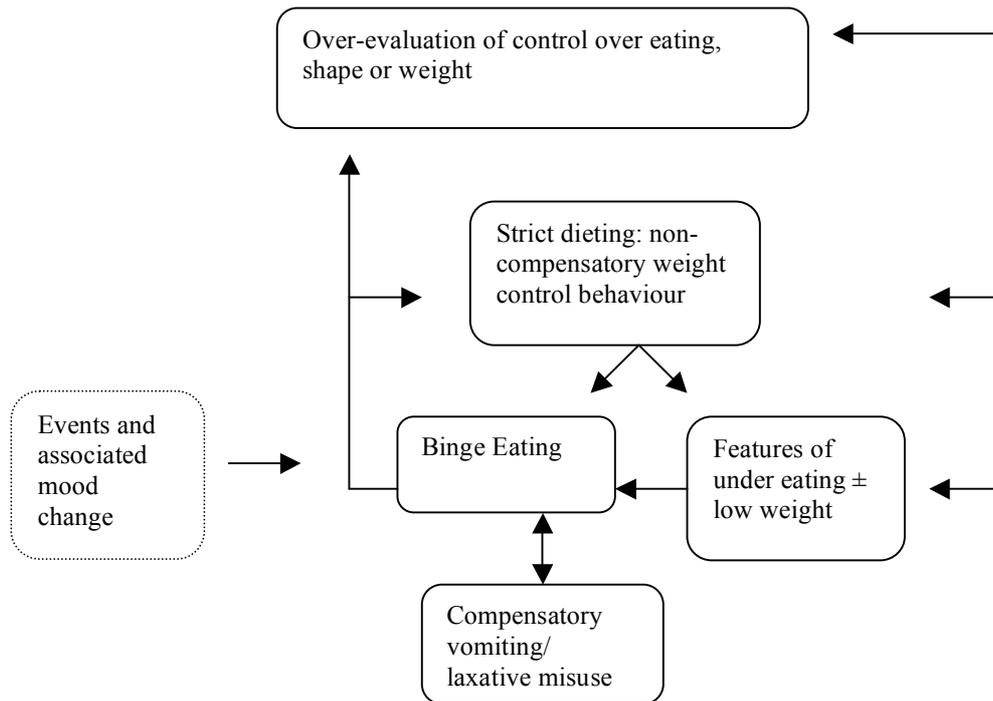


Figure. 1.1 The “Transdiagnostic” Cognitive Behavioral Formulation of Eating Disorder Psychopathology (Fairburn, 2008)

The transdiagnostic model proposes the core processes maintain all EDs. It is suggested for some clients all the processes occur, but for others only a few may be present (Fairburn, 2008).

1.2.5. Enhanced CBT for Eating Disorders (CBT-E)

CBT-E is based on the transdiagnostic theory and is designed to treat the individual psychopathology of an ED. CBT-E is delivered individually to adults and is enhanced to target barriers to change. For example, it focuses on elements within ED presentations such as perfectionism, low self-esteem and interpersonal difficulties (Fairburn, 2008).

There are two forms of treatment. The first is focused (CBT-Ef), which addresses the psychopathology. The second is broad (CBT-Eb), which targets both the psychopathology and additional external barriers to change. There are two intensities of treatment. The first is for those with a body mass index (BMI¹) of 17.5 and above and comprises 20 sessions over 20 weeks. The second is for those with a BMI below 17.5 and comprises 40 sessions over 40 weeks. The additional time is to target low motivation and being underweight (Fairburn, 2008). CBT-E has also been adapted for adolescents and inpatients (Murphy et al., 2010).

¹ Body Mass Index (BMI) – The World Health Organisation (WHO) (2016) explains that BMI is an index of weight to height used to classify underweight, overweight and obesity in adults. Weight in kilograms is divided by the square of the height in metres (kg/m²). Underweight is classified as 18.5 and below, normal weight is 18.5 – 25, overweight is 25 – 30 and obese is 30 and above.

1.2.6. Stages of Treatment in CBT-E

The broad and focused versions of treatment have the same stages. These are outlined in Table 1.1.

Table 1.1. A summary of the stages of treatment in CBT – E (Fairburn, 2008).

Stage	Content
Stage 1	8 sessions. 2 per week over four weeks. Focusing on engagement, personal formulation, and psycho-education. Introduction of weekly weighing and regular eating.
Stage 2	2 sessions. To review progress, identify problems to be addressed and barriers to change. To revise formulation.
Stage 3	8 weekly sessions. The main body of treatment. Addresses processes that maintain the ED.
Stage 4	3 sessions two weeks apart. The ending of treatment. Identifying potential setbacks and planning until post treatment review (after 20 weeks).

1.2.7. Rationale for the Systematic Literature Review

As EDs are difficult to treat and relapse rates are high, it is important to continue to develop and evaluate the effectiveness of treatments. While there is evidence for using CBT to treat bulimia and BED, there is less evidence for its use with anorexia. A transdiagnostic model that proposes treatment across a range of EDs has the potential to impact on practice and policy. It is therefore important to evaluate the effectiveness of this form of intervention.

It is noted that there was a recently published review by Groff (2015) regarding the effectiveness of CBT–E. However the review was a description of the individual

papers. Additionally, only six studies were included, which is arguably too limited a number from which to draw any meaningful analysis. Since the cut off for inclusion in the review by Groff (2015) of January 2013, there have been a number of new studies published. Therefore an additional aim is to add weight to the recent review by incorporating the previous studies with newly published material.

1.2.8. Aims of the Review

The purpose of this review is to critically consider the literature in relation to the impact of transdiagnostic CBT in the treatment of EDs. CBT-E aims to address different aspects in treatment including behavioural change, weight restoration (in patients who are underweight) and reduction in psychological symptoms. Therefore in order to assess effectiveness, the review will focus on these aspects by identifying the following:

1. The impact of CBT-E on behavioural change.
2. The impact of CBT-E on weight.
3. The impact of CBT-E on psychological symptoms.
4. The maintenance of any changes to the above factors over time.

1.3. Method

1.3.1. Search Process

A systematic search of the literature investigating the use of a transdiagnostic model of CBT in the treatment of EDs (including anorexia, bulimia, BED and other specified eating disorders) was carried out between August 2015 and November 2015. Relevant databases covering literature from psychology were used and

included PSYCHINFO, Medline and Web of Science. Additionally, searches for online materials were undertaken using Google Scholar. The reference lists of extracted articles were examined by hand for additional relevant articles. Grey literature searches using Locate were undertaken to identify any relevant unpublished work.

1.3.2. Search Terms

Search terms were used based on their relevance to the research question. Synonyms were identified to ensure all aspects of the term relevant to the review were covered. Table 1.2 highlights the key search terms used.

Table 1.2. Systematic Review Search Terms

Concept	Variation	Location of Keyword
Eating Disorder*	Anorexia Bulimia Binge Eating Disorder Eating disorder not otherwise specified	Title
Transdiagnostic	Enhanced Cognitive Behavioural therapy CBT-E	Title, abstract, article
Effect*	Impact Outcome	Title, abstract, article

1.3.3. Search Strategy

Keywords were truncated (using the symbol*) to ensure all variations of the term were captured. Concept and variation were linked with the Boolean operator ‘OR’.

The concepts were combined with the Boolean operator ‘AND’.

1.3.4. Inclusion and Exclusion Criteria

1.3.4.1. General Initial Screening

Article titles and abstracts were initially screened and retained if they were:

1. Written in the English language
2. Peer reviewed
3. An outcome study evaluating treatment
4. Accessible in full

Following initial screening, full text articles were obtained and assessed for eligibility for review according to specific inclusion and exclusion criteria (see Table 1.3).

1.3.4.2. Specific Inclusion and Exclusion Criteria

Table 1.3. Specific inclusion and exclusion criteria for journal articles

Specific Inclusion Criteria	Specific Exclusion Criteria
<ol style="list-style-type: none">1. Studies which had used a transdiagnostic model of CBT.2. Participants were receiving treatment for an eating disorder.3. Studies which reported outcome of treatment.	<ol style="list-style-type: none">1. While studies which investigated a comparison between the use of transdiagnostic model of CBT and another therapy model were included, research that only investigated a different model of therapy were excluded.2. Single case studies were excluded due to small sample size.

1.3.5. Classification of Studies

The process of study selection was recorded on a ‘Preferred Reporting Items for Systematic Reviews and Meta-analyses’ (PRISMA) flow diagram (Figure 1.2).

341 records were identified through searches of PSYCHINFO, medline and Web of Science. After duplicates were removed, 205 records remained for screening. After viewing the titles and abstracts, 188 were excluded as either they were not relevant to the research question or they were not written in the English language. This left a remainder of 17 studies for which the full text articles were obtained. At this stage three single case studies were excluded as they did not meet the inclusion criteria. 14 studies met the inclusion criteria. Examining the reference lists for each study identified one additional article which met the inclusion criteria. Searches of grey

literature did not identify any additional studies. Therefore following a search of the literature, a total of 15 papers met the inclusion criteria and were retained for the systematic review.

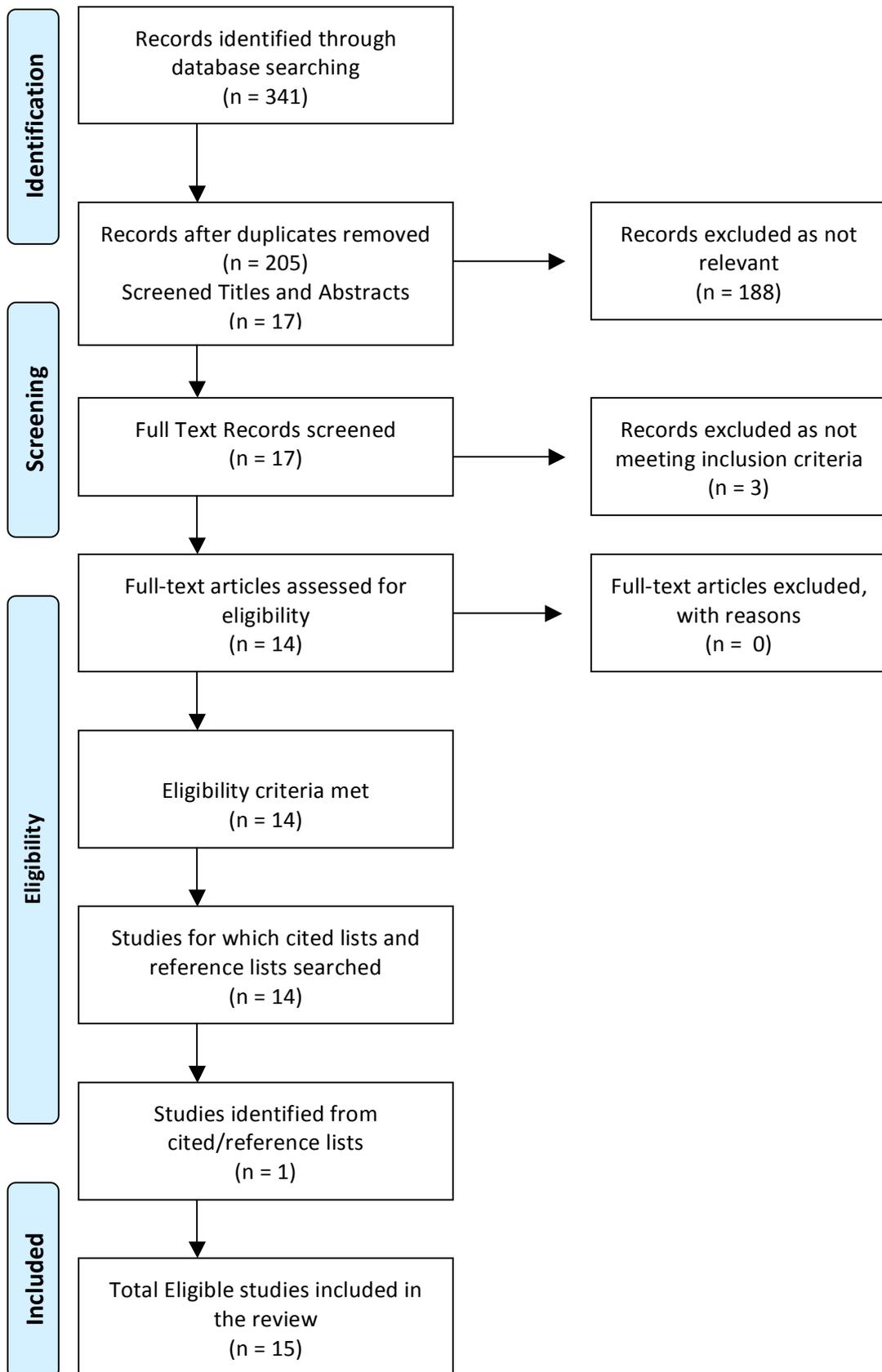


Figure 1.2. PRISMA flow diagram of study selection procedure

1.3.6. Assessment of Quality

The assessment framework developed by Caldwell, Henshaw and Taylor (2005; 2011) (see Appendix B) was used to assess the quality of the 15 studies. This framework was considered suitable for the current review because it can be applied to quantitative research methodologies.

All studies were scored against 18 quality criteria and for each criterion studies were rated as 0 if the criterion was not met, 1 if the criterion was partially met and 2 if the criterion was fully met. The rating for each article was calculated by adding the scores for all 18 criteria, so that each article would receive a score between 0 and 36. It was proposed that papers which scored below the midpoint of 18 would be excluded as not reaching a satisfactory level of rigour.

To enhance reliability of the quality assessment, another researcher rated three articles independently against the same criteria. An inter-rater reliability analysis using the Kappa statistic was performed. The results (Kappa = .63, $p < .001$) suggest moderate to strong inter-rater reliability.

All 15 papers resulted in an above average score on the quality assessment framework and consequently no papers were excluded.

1.3.7. Characteristics of Studies

A summary of the key characteristics of the 15 studies included in this review is found in Table 1.4. Of the 15 studies, a number were carried out by the same group of researchers. For example, five were carried out by Dalle and colleagues, and three by Fairburn and colleagues. Studies used sample populations from Italy (6), Denmark (1), Germany (1), the United Kingdom (4) Australia (3) and the United States (1). Three studies focused solely on bulimia, 6 studies focused solely on anorexia and the remainder investigated a mixed sample. In the main, studies included a female population, with a mean age range of between 16 and 28 years. Participants reported the duration of their eating disorder between 0.86 years to 12 years. All the studies were quantitative and there were a mixture of randomised control trials (RCTs) and trials in routine clinical settings. Across studies, variables included ED psychopathology, weight, behaviour, general mood and two studies also investigated quality of life.

Table 1.4. Characteristics of Studies

<i>Study(author, location)</i>	<i>Participants (age, gender, ED)</i>	<i>Design</i>	<i>Main Outcome measures</i>	<i>Main findings</i>	<i>Quality Assessment Rating</i>
Fairburn, Cooper, Doll, O'Connor, Bohn, Hawker, Wales & Palmer at al. (2009)	154 (147 female) Mixed sample of diagnoses (57 BN, EDNOS 92, BED 7)	RCT comparing the broad and focused forms of CBT-E	Eating Disorder Examination Questionnaire (EDE-Q) Binge/purging episodes	Waiting list little change in severity 77.8% completion	88.0%
United Kingdom	Mean age: 26.1 Mean Lowest BMI: 18.7 Mean Highest BMI: 26.4 Duration of ED: 8.6 years		BMI Brief Symptom Inventory	Significant reduction in bingeing and purging No significant change in weight End of treatment 51.4% EDE-Q score of 1.74 or less At follow-up 50% EDE-Q score of 1.74 or less No difference between the broad and focused forms of treatment	

Fairburn, Bailey-Staebler, Basden, Doll, Jones, Murphy, O'Connor & Cooper (2015) United Kingdom	130 (127 female) Mixed sample of diagnoses (53 BN, 8 BED, 69 Other) Mean age: 25.9 years Mean BMI: 22.8 Duration of ED: 9.9 years	RCT comparing CBT-E (N=65) and Interpersonal psychotherapy (N=65) No significant differences between groups at baseline	EDE – Q Binge/purging episodes BMI Brief Symptom Inventory	74.8% completion for CBT-E 86.0% 81.5% Completion for IPT Significant reduction in bingeing and purging, but greater in CBT-E group No significant differences in weight End of treatment 33.3% of IPT group EDE-Q score of 1.74 or less compared to 65.5% of CBT-E group At follow-up 49% of IPT group had an EDE-Q score of 1.74 or less compared to 69.4%of CBT-E group	
Allen, Fursland, Raykos, Steele, Watson & Byrne (2012) Australia	95 (No information on gender) Mixed sample of diagnoses (19 AN, 31 BN, 45 EDNOS) Mean age: 26.52 (MFT + CBT-E group), 26.44 (CBT-E only group) Mean BMI: 19.18 (MFT + CBT-E group), 20.32 (CBT-E only group)	Trial comparing CBT – E only (N=43) and MFT followed by CBT – E (N=52) No significant differences between groups at baseline	EDE – Q BMI Readiness and Motivation Interview	Completion for BN was between 55-59%. Completion for AN was between 33-36%. No significant differences in weight Comparable reduction in ED symptoms over time. At end of treatment 44% in MFT group had an EDE-Q score of 1.74 or below compared to 55% in CBT-E only group MFT increased readiness to change	75.0%

Byrne, Fursland, Allen & Watson (2011)	<p>125 (122 female)</p> <p>Mixed sample of diagnoses (34 AN, 40 BN, 51 EDNOS)</p> <p>Mean age: 26.03 years</p> <p>Mean BMI: 19.8</p> <p>Duration of ED: 7.79 years</p>	Open trial of CBT – E within a clinical setting	<p>EDE – Q</p> <p>BMI</p> <p>Rosenberg Self-Esteem Scale</p> <p>Perfectionism Subscale of the Eating Disorder Inventory</p> <p>Distress Tolerance Scale</p> <p>Inventory of interpersonal problems</p> <p>Depression Anxiety and Stress Scales</p> <p>Quality of Life and Enjoyment and Satisfaction Questionnaire</p>	<p>52.8% completion</p> <p>No significant change in weight</p> <p>At end of treatment 32% had an EDE-Q score of 1.74 or less</p> <p>Significant improvements in quality of life</p>	89.0%
Turner, Marshall, Stopa & Waller (2012)	<p>203 (190 female)</p> <p>Mixed sample of diagnoses (56 AN, 58 BN, 89 EDNOS)</p> <p>Mean age: 27.6</p> <p>Mean BMI: 21.0</p> <p>31 participants with a BMI below 17.5 (mean 15.68)</p>	Trial of CBT – E in clinical setting	<p>EDE – Q</p> <p>BMI</p> <p>Clinical Impairment Assessment Questionnaire</p> <p>Hospital Anxiety and Depression Scale</p> <p>The CORE Outcome Measure</p>	<p>44.1% completion</p> <p>Significant increase in weight in those who were underweight</p> <p>At end of treatment 31% had an EDE-Q score of 1.74 or less</p>	75%

Watson, Allen, Fursland, Byrne & Nathan (2014)	196 (194 female) Mixed sample of diagnoses (87 BN, 74 EDNOS, 33 AN)	Trial investigating the impact of CBT – E on quality of life	Quality of Life Enjoyment and Satisfaction Questionnaire	36.1% completion	72%
Australia	Mean age: 26.05 Mean duration of ED: 8.58 years Mean BMI: 20.87 Mean AN BMI: 15.85		EDE – Q The Depression Anxiety Stress Scales Rosenberg Self-Esteem Scale BMI	At end of treatment 54% had an EDE-Q score of 1.74 or less 60% of those with BN had a score of 1.74 or less. This was 50% for EDNOS and 36% for AN Significant improvement in quality of life across diagnoses	
Fairburn, Cooper, Doll, O'Connor, Palmer, Dalle Grave (2013)	Anorexia specific study at two sites (Italy and UK)	RCT investigating impact of CBT – E across two sites	EDE - Q BMI	63% completion	86.0%
United Kingdom	99		Brief Symptom Inventory	Significant increase in weight 88% had an EDE – Q score of 1.74	
Italy	UK: 50 (48 female) Mean age: 23.4 Duration of ED: 3.0 years BMI: 16.5 Italy 49 (48 female) Mean age: 24.6 Duration: 3.0 years BMI: 15.7			Some deterioration at 60 week follow-up, but still significantly improved from baseline	
	No differences between groups				

Zipfel et al. (2014) Germany	Anorexia specific study Outpatients 242 (no information on gender) Focal Psychodynamic therapy Mean age: 28.7 Mean weight: 46.33kg CBT- E group Mean age: 27.4 Mean weight: 46.33kg Treatment as usual group Mean age: 27.7 Mean weight: 46.71	RCT comparing CBT-E (N=80) with Focal psychodynamic therapy (N=80) and optimised treatment as usual (psychotherapy and structured care from a family doctor, N=82) No significant differences between groups at baseline	EDE – Q Weight gain in KG The Structured Interview for Anorexic and Bulimic Disorders (SIAB-EX)	66.2% completion for FPT and 81.2% completion for CBT – E Weight increase in all treatments. Largest in CBT- E, but no significant differences between groups. At 12 months weight maintained and no difference between groups At end of treatment no differences between treatment modality for ED psychopathology (around 11% had achieved an EDE-Q score of 1.74 or below At follow up 35% of those in the FPT group had an EDE-Q score of 1.74 or less compared to 20% in the CBT – E group	75.0%
Dalle Grave, Calugi, Conti, Doll & Fairburn (2013) Italy	Anorexia specific study Inpatient 80 (78 female) Mean age: 23.4 Mean duration of ED: 5.0 years Mean weight: 37.4kg	RCT comparing CBT-Ef (N=42) and CBT- Eb (N=38)	EDE - Q Weight in KG Brief symptom inventory	90% completion No significant differences between the programmes Significant improvements in weight 46.8% had a global EDE-Q 1 standard deviation above the community mean Some deterioration at 6- month follow-up	69.4%

Poulson, Lunn, Daniel, Folke, Mathieson, Katznelson & Fairburn (2014) Denmark	Bulimic specific study	RCT with community population	BMI	77.8 completion for CBT-E and 70.6% completion for psychoanalytic psychotherapy	80.0%
	Total Sample: 70 (69 female)	N = 34 received 2 years weekly psychoanalytic therapy	Binge/purge episodes	No change in BMI	
	Mean age: 25.8	N = 36 received CBT-E	EDE – Q administered at baseline, 5 months, 24 months	At 5 months CBT-E: 42% ceased bingeing/purging psychoanalytic: 6%	
	Mean duration of ED: 12.3 years			At 24 months CBT-E: 44% ceased bingeing/purging psychoanalytic: 15%	
Mean BMI: 22.6			At 5 months CBT-E: 36.1% had a global EDE score below 1SD above community mean Psychoanalytic: 23%		
			At 24 months CBT-E: 47.2% had a global EDE score below 1SD above community mean Psychoanalytic: 50%		

Wonderlich, Peterson, Crosby, Smith, Klein, Mitchell & Crow (2013)	Bulimia specific study 80 (72 females)	RCT in a community sample comparing ICAT (N=40) to CBT-E (N=40)	BMI Binge/Purge episodes	75% completion for CBT-E and 85% completion for ICAT	78.0%
United States	Bulimia Nervosa Mean age: 27.3 Mean BMI: 23.9		EDE – Q administered at baseline, end of treatment and 4 month follow-up	No difference in BMI Significant improvements in binge/episodes Significant improvements in EDE-Q. 47.5% in the ICAT condition were 1 standard deviation above the community mean compared to 37.5% in CBT-E condition Continued improvements at 4 month follow up No significant difference between outcomes for each model	
Dalle Grave, Pasqualoni & Calugi (2008)	Anorexia specific study Day patient 20 (19 female) Mean age: 18.2 Mean BMI: 16.6	Trial of CBT-E in a day patient setting	EDE – Q Start, end of treatment and 6 month follow-up BMI Symptom checklist – 90	65% completion Completers obtained significant weight gain Significant decrease in global EDE-Q score Decrease in weight and ED psychopathology at follow-up	67.0%

Dalle Grave, Calugi, Doll & Fairburn (2013)	Anorexia	Trial of CBT – E in an outpatient setting	BMI	63% completion	81.0%
Italy	Outpatient		EDE – Q	In those that completed significant increase in weight	
	49 female		Symptom checklist – 90	96.1% had an EDE-Q score of 1.74 or below at end of treatment	
	Mean weight: 40.0kg			At 60 week follow up minimal changes	
	Mean age: 15.5				
	Mean duration of ED: 0.86 years				
Dalle Grave, Calugi, El Ghoch, Conti & Fairburn (2014)	Anorexia	Trial of Inpatient CBT-E	BMI	96% completion	78.0%
Italy	Inpatient		EDE – Q	Significant improvements in weight gain, 38.5% had an EDE-Q score of 1.74 or below at end of treatment	
	27 (26 female)		Brief symptom inventory	Improvements maintained at 12-month follow-up	
	Mean body weight: 38.6kg				
	Mean age: 16				
	Mean duration of ED: 2 years				
Dalle Grave, Calugi, Sartirana & Fairburn (2015)	68 (66 female)	Trial of CBT-E in an outpatient setting	BMI	75% completion (65% BN, 71% BED, 82% EDNOS)	75.0%
Italy	Mixed sample of diagnoses (20 BN, 14 BED, 34 EDNOS)		EDE - Q	No change in weight	
	Mean age: 16.5		Brief symptom inventory	Significant reduction in bingeing and purging	
	Mean BMI: 56.1kg			67.6% had minimal residual ED psychopathology by the end of treatment. 82.4% for treatment completers	
	Mean duration of ED: 1.7 years				

1.4. Results

In six studies the sample comprised a mixture of EDs. Other studies focused on anorexia or bulimia specifically. For each group of studies (mixed studies, anorexia specific, bulimia specific and adolescent) the results present completion rates. The results also present the effect of CBT-E on weight restoration, behaviour (bingeing and purging) and ED psychopathology. In addition the results present follow-up data in order to assess any maintenance of change. Where included within studies significance values and effect sizes are reported.

1.4.1. Studies with a Mixed Sample of Eating Disorder Diagnoses.

From the six studies which included a mixed population, two were RCTs, which investigated the effect of CBT-E. In addition, four open studies in clinical settings were undertaken.

1.4.1.1. Treatment Completion Rates in a Mixed Sample of EDs

The RCTs reported treatment completion at 77.8% (Fairburn et al., 2009) and 77.7% (Fairburn et al., 2015). Studies within a routine clinical setting, report lower completion rates of between 44.1% and 56% (Allen et al., 2011; Byrne et al., 2011; Turner et al., 2015; Watson et al., 2015). Allen et al. (2012) also found there was no significant difference in completion rates when motivation-focused therapy (MFT) was used prior to CBT-E compared to CBT-E alone (44.2% and 46.5% completion respectively).

Three of the studies reported completion by diagnosis. For anorexia the completion rate was 32.3% to 36% (Allen et al., 2012; Byrne et al., 2011; Watson et al., 2012).

Completion rates were higher for bulimia at 55% to 65.5% (Allen et al., 2012; Byrne et al., 2011; Watson et al., 2012) and EDNOS at 56% to 58.8% (Byrne et al., 2011; Watson et al., 2012). There was no significant difference in completion rates between conditions (MFT and CBT-E vs. CBT-E alone) for both anorexia and bulimia (Allen et al., 2011).

1.4.1.2. Weight Restoration in a Mixed Sample of EDs

A number of studies using a mixed sample of EDs found no significant difference in participants' weight pre- and post-treatment. This is due to participants' mean weight falling within the average BMI range prior to treatment and post-treatment (Allen et al., 2012; Byrne et al., 2011; Fairburn et al., 2009; Fairburn et al., 2015). The study by Watson et al. (2015) did not comment on weight post-treatment.

Turner et al. (2015) reported that within their sample, there were 18 participants with a BMI less than 17.5 who completed treatment. A significant mean weight increase from BMI 15.7 pre-treatment, to 18.43 at post-treatment was found ($p < .001$, $d = .81$).

1.4.1.3. Behaviour Changes in a Mixed Sample of EDs

In the reported studies, ED behaviour was described in terms of episodes of bingeing and purging, which is more commonly associated with bulimia. Across studies, there was a reported reduction of this behaviour post-treatment. For example, Fairburn et al. (2009) report significant change in bulimic episodes from baseline to eight weeks for CBT-Ef ($p < .01$) and CBT-Eb ($p < .01$) with no difference between treatments. Additionally, Fairburn et al. (2009) and Fairburn et al. (2015) report that,

38.6% and 44.8% of their total samples reported no episodes of bingeing and purging over a 28-day period post-treatment. This was significantly higher than participants who had undertaken interpersonal therapy (IPT), where 21.7% reported no bingeing and purging at the end of treatment ($p = .003$) (Fairburn et al., 2015). There were no significant differences between CBT-Ef and CBT-Eb (Fairburn et al., 2009).

The results were reflected in studies undertaken in routine clinical settings with Byrne et al. (2011) reporting significant reduction in bingeing and purging, with 57.6% reporting absence of these behaviours at treatment end ($p < .001$). Allen et al. (2011) and Turner et al. (2015) also found that in those that had completed treatment, there was a significant reduction in binge eating ($p = .008, p < .001$) and purging ($p < .001, p < .001$) from baseline to end of treatment. Effect sizes were moderate, at $d = .38$ and $d = .48$ (Allen et al., 2011) and $d = .53$ and $d = .40$ (Turner et al., 2015).

1.4.1.4. Eating Disorder Psychopathology in a Mixed Sample of EDs

Across studies ED psychopathology was measured by the EDE-Q². All studies reported a reduction in ED psychopathology. An EDE-Q score of 1.74 or below was used as measure of remission. 1.74 is less than one standard deviation (SD) above the community mean and Fairburn et al. (2009) note in identifying change it is common to make comparisons of this type. Fairburn et al. (2009) report significant change from baseline to eight weeks for both CBT-Ef ($-0.94, p < .001$) and CBT-Eb ($-1.17, p < .001$) with no significant difference between treatments. At the end of treatment, 51.3% (Fairburn et al., 2009) and 65.5% (Fairburn et al., 2015) of the total

² The Eating Disorder Examination – Questionnaire (EDE-Q) (Fairburn & Beglin, 2008; Fairburn & Cooper, 1993) is a self-report measure which contains four subscales; dietary restraint, weight concern, shape concern and eating concern. A global score can be calculated by averaging the four subscales. In addition it generates frequency ratings for behaviour such a binge-eating and vomiting)

sample met criteria for remission. However, this increased for treatment completers, with 66.4% and 75.5% meeting remission criteria. Remission rates were also significantly improved for those who had undertaken CBT-E compared to ITP ($p < .001$). For example, within the intent-to-treat sample, 33.3% of those in the ITP condition met remission rates. This rose to 37.7% in treatment completers. There was no difference between CBT-Ef and CBT-Eb (Fairburn et al., 2009).

Within open trials in routine clinical settings, lower remission rates are reported. While there were significant reductions in the EDE-Q scores for Byrne et al. (2011) ($p < .001$, $d = .68$), Turner et al. (2015) ($p < .001$, $d = .95$) and Watson et al. (2012) ($p < .001$, $d = .89$) they report remission rates at 32%, 19% and 31%. This increased for treatment completers, to 56.1%, 32% and 54%. Effect sizes were larger for treatment completers, with 1.19, 1.49 and 1.18 reported by Turner et al. (2015), Byrne et al. (2011) and Watson et al. (2012) respectively.

Allen et al. (2012) find similar results; they found post-treatment, 44% of MFT+CBT-E met remission criteria and 55% in the CBT-E only group (there was no difference between conditions). Across groups, there was significant improvement in EDE-Q scores from baseline to end of treatment ($p = .002$, $d = .49$).

In addition Watson et al. (2011) report the highest remission rates were in bulimia (60%) and EDNOS (50%), and the lowest in anorexia (36%).

1.4.1.5. Maintenance of Changes in a Mixed Sample of EDs

Only the two RCTs investigated whether changes to behaviour and psychopathology were maintained at follow-up. Fairburn et al. (2009) reported at 60 weeks, 50% of the sample had an EDE-Q score of below 1.74 compared to 66.4% at treatment end. Additionally, ceasing to binge and purge had risen to 45.6% from 38.6%. There were no significant differences between CBT-Ef and CBT-Eb.

Conversely, Fairburn et al. (2015) found at follow-up, participants meeting the criteria for remission increased (CBT-E 69.4%, IPT 49.0%). In the IPT condition, ED psychopathology decreased and many of the differences between treatments were no longer significant. However the number of participants in remission remained significantly higher in the CBT-E group compared to IPT ($p = 0.028$).

1.4.2. Anorexia Specific Studies

Three studies focused solely on the treatment of anorexia both within inpatient and outpatient settings.

1.4.2.1. Treatment Completion Rates for Anorexia Specific Studies

Completion rates for the two outpatient RCTs were reported at 63.6% (Fairburn et al., 2013) and 81.2% (Zipfel et al., 2014). Additionally Zipfel et al. (2014) found a 66.2% completion in those receiving focal psychodynamic therapy (FPT). Within an inpatient setting completion was reported at 90% (Dalle et al., 2013).

1.4.1.2. Weight Restoration for Anorexia Specific Studies

Fairburn et al. (2013) reported participants' weight increased significantly, from a mean BMI of 16.1 to a mean BMI of 17.9 ($p < .001$) in the intent-to-treat sample. In treatment completers mean BMI increased to 18.8 ($p < .001$). Additionally, at the end of treatment, 62% of the sample had a BMI of more than or equal to 18.5. Within an inpatient group Dalle et al. (2013) also reported significant increases in BMI. Eighty six percent% of treatment completers achieved a BMI of 18.5 or more ($p < .001$). There was no significant difference between CBT-Eb and CBT-Ef (Dalle et al. (2013).

Zipfel et al. (2014) also observed an increase in weight across treatment conditions. For example, an increase of 0.73kg in the FPT group ($p = .003$, $d = .62$), 0.83kg in the CBT-E group ($p < .001$, $d = 1.0$) 0.69kg in the treatment as usual group ($p < .001$, $d = 0.71$). However, at end of treatment, no participants had reached a BMI of 18.5. The mean BMI appeared to 17.7 for the CBT-E condition and 17.3 for the FPT condition.

1.4.1.3. Eating Disorder Psychopathology in Anorexia Specific Studies

Fairburn et al. (2013) reported EDE-Q scores decreased significantly between baseline and end of treatment ($p < .001$). In the intent-to-treat sample 68% had a global EDE-Q score below one SD above the community mean. This rose in treatment completers to 88.7%. Dalle et al. (2013) also found significant reductions in ED psychopathology ($p < .05$), but at lower levels than reported in the Fairburn et al. (2013) study. For example, 51.8% of participants who completed treatment had a

global EDE-Q score below one SD above the community mean. Again there was no significant difference between CBT-Eb and CBT-Ef (Dalle et al., 2013).

Similarly, Zipfel et al. (2015) report significant reductions in ED psychopathology for CBT-E ($p < .0001$, $d = 1.0$) and FPT ($p = .0003$, $d = 0.62$). There was no significant difference between interventions post-treatment. The percentage of participants in remission at treatment end was not reported. However, reviewing the graph that is used to highlight the results, it appears that remission was around 11% for both CBT-E and FPT.

1.4.1.4. Maintenance of Changes for Anorexia Specific Studies

While changes appeared to be maintained in the Fairburn et al. (2013) study, there was a slight deterioration in BMI and ED psychopathology features at 12-month follow-up. However, participants remained significantly improved from baseline ($p < .0001$ for BMI and ED psychopathology). For example, the proportion of those with minimal ED psychopathology fell from 87% to 78%. Alongside this the proportion with BMI of 18.5 or more fell from 62% to 55%.

A similar pattern was observed within the Dalle et al. (2013) inpatient study, with a reported decrease in BMI at the 6-month and 12-month follow-up. For example, within the whole sample, mean weight decreased from 50.1kg at discharge to 46.8kg at 6-months and 46.7kg at 12-months. While this was significantly higher than baseline at 12-months ($p < .05$), it was significantly reduced from end of treatment ($p < .05$). In addition treatment completers with a BMI of 18.5 or over, decreased from 86.1% at discharge to 47.8% at 6-months and 50% at 12-months. ED

psychopathology continued to improve, but there were no significant differences between treatment end and follow-up. Additionally there were no differences between CBT-Ef or CBT-Eb at any point.

Interestingly, the Zipfel et al. (2014) study reported continued weight gain at 12-month follow-up with a 1.64kg gain in the FPT group, a 1.30kg gain in the CBT-E group and 1.22kg in the treatment as usual group. Again, the mean BMI at follow-up in all groups was less than 18.5. The mean BMI was around 18.2 for the FPT group and around 18 for the CBT-E group. Scores on the EDE-Q also continued to improve. At 12-month follow-up, those meeting remission criteria was reported to be higher for the FPT group (35% remission) compared to CBT-E (20% remission) and treatment as usual (13% remission). There was no significant difference between FPT and CBT-E.

1.4.3. Bulimia Specific Studies

Two studies focused on a bulimia only sample.

1.4.3.1. Treatment Completion Rates for Bulimia Specific Studies

Poulsen et al. (2014) and Wonderlich et al. (2014) conducted RCTs comparing CBT-E to two years weekly psychoanalytic psychotherapy and Integrative Cognitive Affective Therapy (ICAT) respectively. Completion rates for CBT-E were 77.8% (Poulsen et al., 2014) and 75% (Wonderlich et al., 2014). Completion rates for psychoanalytic psychotherapy and ICAT were 70.6% (Poulsen et al., 2014) and 85% (Wonderlich et al., 2014) respectively.

1.4.3.2. Behaviour Changes for Bulimia Specific Studies

ED Behaviour was measured in terms of bingeing and purging episodes. Poulsen et al. (2014) found an improvement in ED behaviour for both interventions, but greater for those who received CBT-E. At treatment end 42% who received CBT-E had ceased to binge and purge compared with 15% in psychoanalytic psychotherapy. These differences were significant ($p < .001$, $p = .009$). It appears changes were achieved more rapidly for CBT-E. For example, at five months 42% in the CBT-E condition had stopped bingeing and purging, compared to 6% in the psychoanalytic condition. These differences were significant ($p < .001$, $p < .001$).

Wonderlich et al. (2014) also found significant reduction in bingeing and purging in both treatments ($p < .05$). For example, in the ICAT treatment condition there was a reduction of binge episodes from 23.2 to 6.1 at end of treatment. In the CBT-E condition, there was a reduction in binge episodes from 22.4 to 5.3.

1.4.3.3. Eating Disorder Psychopathology in Bulimia Specific Studies

Poulsen et al. (2014) reported improvements in ED psychopathology in both the CBT and Psychoanalytic treatment groups. However at five months, the CBT group had significantly lower scores than the psychoanalytic group, indicating improvements occur more quickly with CBT-E ($p < .001$). 36.1% in the CBT-E group had a global EDE-Q score below one standard deviation above the community mean, compared to 23.5% in the psychoanalytic group. It is noted that five months was treatment end for the CBT group. At 24 months, which was treatment end in psychoanalytic psychotherapy group, 50% had a global EDE-Q score below one standard deviation above the community mean.

Similarly, Wonderlich et al. (2014) found both treatment groups (CBT-E and ICAT) showed significant improvement in ED psychopathology at end of treatment ($p < .05$). Effect sizes were reported as between .83 to 1.50 for ICAT and .71 to 1.30 for CBT-E. However there were no significant differences between treatment groups. For example, 47.5% of participants in the ICAT condition were within one standard deviation of the community mean on the EDE global scale at the end of treatment, compared to 37.5% of those in the CBT-E condition.

1.4.3.4. Maintenance of Changes for Bulimia Specific Studies

Poulson et al. (2014) highlight that changes were maintained. There were no significant differences between CBT-E and the psychoanalytic group at 24 months. For example, 50% of participants in the psychoanalytic group and 47.2% in the CBT-E group had a global EDE score one SD above the community mean. There was a decrease from 15 to 10 of those reporting to be binge and purge free at 24 months. Five reported being binge and purge free in the psychoanalytic group. It is important to note that 24 months was end-of-treatment in the psychoanalytic group, but was follow-up for the CBT-E group. In effect, there was no follow-up for the psychoanalytic group.

Wonderlich et al. (2014) also investigated follow-up, but over a shorter duration (4 months after end-of-treatment). They found no significant differences between treatment groups (ICAT and CBT-E). There was indication that improvements in ED behaviour were maintained. For example, binge episodes decreased from 6.1 at end of treatment, to 5.6 at follow-up in the ICAT condition. They rose slightly in the

CBT-E condition from 5.3 to 8.5. In both conditions this was still significantly reduced from baseline ($p < .05$).

In terms of ED psychopathology, the percentage of participants within one standard deviation of the community mean on the global EDE score, increased from 47.5% to 55% in the ICAT condition and from 37.5% to 50% in the CBT-E condition. Effect sizes were reported between .82 to 1.61 for ICAT and .63 to 1.32 for CBT-E for behaviour and ED psychopathology. Rates of remission are comparable with the Poulsen et al. (2014) study.

1.4.4. Adolescent Specific Studies

Four of the studies focused on treatment for adolescents. Of the four studies, three focused on anorexia specifically. One study focused on a sample that comprised bulimia, BED and EDNOS in participants who were not underweight.

1.4.4.1. Anorexia Specific Studies with an Adolescent Population

1.4.4.1.1. Treatment Completion Rates in an Adolescent Sample with Anorexia

Dalle et al. (2013) found 63% completion in an outpatient sample. This was mirrored in a day patient sample (Dalle et al., 2008), with 65% completing. With an inpatient sample (Dalle et al., 2014) completion rates were 96%.

1.4.4.1.2. Weight Restoration in an Adolescent Sample with Anorexia

Significant improvements were reported across studies. In an outpatient sample, Dalle et al. (2013) found a significant mean weight gain of 8.60kg from baseline to end of treatment ($p < .001$). 32.1% achieved the expected weight for their gender and

age. In a day patient sample, Dalle et al. (2014) also reported significant improvement in weight gain at end of treatment (38.6kg to 50.4kg, $p < .001$), with 96.2% achieving a BMI equal to or more than 18.5. With an inpatient sample, Dalle et al. (2008) report a significant average BMI increase, from 14.6 to 18.2 post-treatment ($p < .001$).

1.4.4.1.3. Eating Disorder Psychopathology in Adolescent Sample with Anorexia

ED psychopathology improved across studies, but there was variability between populations. For example, Dalle et al. (2013) found that 96.6% of participants in the outpatient sample had a global EDE-Q score below one SD above the community mean at treatment end. This was significantly improved from a baseline of 37.9% ($p < .001$). However Dalle et al. (2014) found that within a day patient sample 38.5% of participants had a global EDE-Q score below one SD above the community mean. This was significantly improved from baseline ($p < .001$). Dalle et al. (2008) also found that end of treatment there was a significant decrease in participants global EDE score ($p < .01$). There was no information on the number of participants with a global score of one SD or less above the community mean.

1.4.4.1.4. Maintenance of Changes in an Adolescent Sample with Anorexia

With regard to follow-up it appears improvements are maintained and although there was a slight decrease in improvements in some studies this was not significant. For example Dalle et al. (2013) found that mean weight gain increased by 2.2kg with 44% of participants reaching the expected weight for their age and gender. This was significantly improved from baseline ($p < .001$). However Dalle et al. (2014) found that BMI decreased slightly from end of treatment to 6-month follow-up (46.4kg)

and 12-month follow-up (48.4kg), but this was not significant. At 12-month follow-up 82.6% of participants had a BMI equal to or more than 18.5. Dalle et al. (2008) found at 6-month follow-up the mean BMI had decreased slightly from 18.2 to 18.1. This was still significantly higher than at baseline ($p < .001$).

Dalle et al. (2013) found that in terms of ED psychopathology 89.7% of participants had a global EDE-Q score below one SD above the community mean at 12-month follow-up. Although this had slightly declined from treatment end it was still significantly improved from baseline ($p < .001$). Dalle et al. (2014) found that at 12-month improvements were maintained with 60.9% of participants having a global EDE-Q score below one SD above the community mean. This was significantly increased from baseline ($p < .001$). However with an inpatient sample Dalle et al. (2008) found that at 6-month follow-up global EDE score had increased. Although this was still lower than at baseline, it was no longer significantly different.

1.4.4.2. Bulimia, BED and EDNOS Studies with an Adolescent Sample

Only one study of adolescent ED included a mixed sample. Dalle et al. (2015) investigated the use of CBT-E in an outpatient setting, with adolescents who were not underweight. Overall, 75% completed. By diagnosis, the completion rates were 65% for bulimia, 71% for BED 71% and 82% for EDNOS.

With regard to behaviour, there was a decrease in those reporting binge and purge episodes, which was significant at the $p < .001$ level for intent-to-treat and treatment completers. For example, within the intent-to-treat sample, 50% reported to have ceased these behaviours by treatment end. This increased for those who had

completed, with 76.5% reported to have ceased bingeing and purging by treatment end.

In terms of ED psychopathology, there were significant improvements in global EDE-Q scores from baseline to treatment end. This was significant, with a large effect sizes ($p < .001$, $d = 1.03$ for the intent to treat sample and $p < .001$, $d = 1.64$ for treatment completers). 67.6% of the intent to treat group had an EDE-Q score below one SD above the community mean. In treatment completers, this increased to 82.4%. There was no follow-up.

1.5. Discussion

There is a growing evidence base for the use of CBT-E in the treatment of EDs. In all of the reviewed studies, there is improvement in outcomes, particularly in those that completed treatment, which provides a positive indication for the efficacy of the approach.

1.5.1. Summary of Main Findings and Implications for Practice

Within studies with a mixed sample of EDs, completion rates are variable and appear to be lower in routine clinical settings than in RCTs. For example, RCTs report completion rates at around 78% compared to the open trials, which report completion rates between 45-53%. It appears that completion rates are lower for anorexia (32-36%) than bulimia (53-65%) and EDNOS (56%).

Overall, studies report improvements in behaviour and ED psychopathology. It is encouraging that outcomes in clinical settings show similar results to the RCTs

indicating that the results are transferable. However, it is important to note that remission rates are lower within clinical settings. For example, while remission rates are reported at between 51-75% in the RCTs, this decreases to between 32-56% in open trials in routine clinical settings.

The lower remission rates may be due to a more varied patient population presenting within clinical settings. It could be that patients presenting within clinical settings have more complex needs than patients used in RCTs. For example, it is noted that the RCTs (Fairburn et al, 2009; Fairburn et al, 2015) excluded those with a co-morbid DSM axis 1 diagnosis. Additionally, it may be harder to control for the competency and training of therapists in ensuring that treatment is delivered in a standardised way. This may increase the risk for potential therapeutic drift from the model.

It is also important to consider the factors that predict dropout. One factor could be linked to whether patients are ready to engage in an active form of therapy such as CBT-E. It is key that assessment draws out the contra-indicators for treatment such as motivation to engage. Although it was not significant, there was suggestion that motivational work could be effective in developing treatment retention and engagement (Allen et al., 2012). This is an area that would warrant further research.

It is noted that within the anorexia specific studies, completion rates are much higher than in the mixed studies (between 64-90%). One explanation could be in the way the treatment was delivered. In the Dalle et al. (2013) study, the unit was set up for treatment using CBT-E. In addition patients received additional input from dieticians and medics.

While there is an increase in weight and a reduction in ED psychopathology, rates of remission vary between studies (between 11% - 88%). The lowest remission rates are reported at 11% in the Zipfel et al. (2014) study. One explanation could be that clinicians had received less training within the model. It is interesting to note that in the Fairburn et al. (2013) study, therapists received 6-months training in the model, followed by weekly supervision. Additionally, the anorexia specific studies report a lower duration of onset (between 3 – 5 years) compared to the mixed studies (between 7 – 10 years) which may have an impact on completion and remission rates.

Within bulimia specific studies completion rates are more consistent than in anorexia only studies (75-77%) and in the main higher. There is a reported reduction in behaviour and ED psychopathology that appears to be maintained (37 – 50%). This appears to mirror research for bulimia specific CBT (Hay et al., 2009; Shapiro et al., 2007).

Taken together, the results of the mixed sample and specific studies suggest that CBT-E is more effective for bulimia than anorexia. This could suggest that anorexia may be more difficult to treat. A consideration may be whether EDs can be explained in a purely transdiagnostic way, as there may be alternative mechanisms involved in the cause and maintenance of anorexia. In support of this, Birmingham, Touyz and Harbottle, (2009) point to differences in neuroimaging and response to medication treatment between diagnoses.

In addition, while CBT-E aims to focus on individualised formulations of an ED and highlights that not all factors will be present for all individuals, it is important to note

that research has found maintaining factors which are specific to diagnoses. For example, Lampard, Tasca, Balfour and Bissada (2013) carried out a study to investigate if the relationship between additional maintaining factors and core ED maintaining factors described within CBT-E are transdiagnostic. They found an indication that over-evaluation of shape and weight and dietary restraint were significant in all groups, but differed between diagnostic groups. For example, it was found to be greater for bulimia than for anorexia or EDNOS. This suggests those with bulimia may show a tendency to evaluate themselves by weight and shape. It is suggested that this is an important factor associated with subsequent behaviours to control weight. Lampard et al. (2013) highlight that this reflects results showing that CBT for bulimia is effective in reducing bulimic symptoms when it focuses on reducing over-evaluation of weight and shape.

Additionally, perfectionism was related to core ED maintaining factors in anorexia and EDNOS, but not bulimia (Lampard et al., 2013). This links to previous research that indicates elevated perfectionism scores at pre-treatment link to decreased response to treatment and higher dropout in anorexia (Lampard et al., 2013). Therefore targeting perfectionism may be a way to improve treatment response. An area for further research would be to investigate how effective CBT-E is at targeting this.

With regard to anorexia, it is also questioned whether recovery in terms of weight restoration needs to be considered differently. For example, studies highlight weight restoration to BMI 18.5. This is just at the threshold of healthy weight. There is an indication that following treatment there was slight weight loss (Dalle et al., 2013;

Dalle et al., 2008; Fairburn et al, 2009; Fairburn et al., 2013). If patients are just at threshold of a healthy weight, they could easily move back into the underweight range. Hence, it may be beneficial to weight restore to a higher BMI such as BMI 20 (Baran Weltzin & Kaye, 1995; Howard, Evans & Quintero-Howard, 1999). In addition, studies may want to consider recovery in an alternative way. For example, Zipfel et al. (2014) report full recovery based on ED psychopathology, yet patients were still within an underweight BMI range.

It is important to consider not all patients want to engage in CBT or feel that they are suited to this form of treatment. Alongside this it is noted that CBT-E is not the only form of intervention for EDs. From the studies, treatment outcomes for other interventions such as ICAT, FPT and psychoanalytic psychotherapy produce similar treatment outcomes to CBT-E. Overall, what appears significant is that results are achieved more rapidly for CBT-E. This has implications for practice and policy given there is a need for timely and effective treatment. It might be that CBT-E is a first line approach where applicable.

A comparable treatment outcome with other approaches also highlights the potential for patient choice and patients working with a model that suits them. In support of this, is that one of the contraindications for CBT-E is a patient not liking the model.

It is also noted in studies, which compared CBT-Ef and CBT-Eb there was no difference in treatment outcomes. However, there is indication that the broad form may be more effective for complex presentations. For example, whilst not significant 54 patients who were described as complex (defined by mood intolerance,

clinical perfectionism, low self-esteem or interpersonal difficulties) appeared to respond better to the broad form of CBT (Fairburn et al., 2009).

With regard to adolescents, the research is limited and has focused more on anorexia. Treatment adherence appears to be higher than adult studies (between 63 to 90%) with significant improvement in weight and a reduction in ED psychopathology. This could be due to the way that treatment is delivered with the intensity of treatment appearing to be higher. For example, within the Dalle et al. (2008) study, patients received intensive outpatient treatment whereby they attended a unit between 12.45pm - 7.45pm weekdays. Meals were supervised and they received twice weekly CBT-E sessions and a psychoeducation group. Similarly in an inpatient setting (Dalle et al., 2014), the treatment was described as ‘CBT-E immersion’ whereby the ‘entire inpatient experience consists of CBT-E, 24 hours a day’. It is important to note that within an outpatient setting, comparable results were found. However in this sample patients had less than one year onset of their ED. The results do point towards CBT-E being an alternative option to family therapy, but additional research is needed.

1.5.2. Strengths and Limitations of Studies

The strength of the reviewed studies is that they use standardised measures for outcomes. The measures can be applied to the different aspects of CBT-E, for example, weight, behaviour and ED psychopathology. Additionally, the EDE-Q is shown to have good internal consistency and test-retest reliability, particularly for attitudinal features (Rose, Vaewsorn, Rosselli-Navarra, Wilson & Striegel-Weissman, 2013). Alongside this, studies have also investigated treatment

adherence and combined, the studies comprise a variety of ED samples, which is vital when investigating the effects of a transdiagnostic model.

Agras, Brandt, Bulik, Dolan-Sewell, Fairburn, Halmi and Wilfley (2004) suggest that using control or comparison groups improves ED research. It is positive that some of the studies used a comparison to other interventions. However, a limitation of the combined studies is that few have investigated follow-up over a longer period. While there is an indication that changes are maintained for those who undertook CBT-E, there is no longer-term follow-up to further support this. In addition, within the comparison studies there is also no long-term follow-up to assess the outcomes of psychodynamic interventions. This makes it difficult to determine the impact of this approach and how it compares to CBT-E in the longer term.

CBT-E is a symptomology-focused treatment where it could be argued that other forms of treatment focus more on underlying causes. For example, some evidence (Poulson et al., 2014) indicates that CBT-E is more effective in reducing bulimic symptoms than psychodynamic psychotherapy. Therefore, questions are raised as to whether a treatment approach which focus on the underlying causes over a prolonged period of treatment has a more sustained outcome than shorter-term symptomology focused interventions. It is therefore important to consider the long-term impact of different approaches and investigate whether the intensity, duration and focus of treatment impacts long-term outcome. At present this is unclear and should be a focus for future research

In addition, it is not clear in the follow-up studies that have been completed if all the changes can solely be attributed to CBT-E. For example it is unclear if there has been any further intervention within this time period. A further limitation is that not all studies report effect sizes. However, it is noted that studies which reported these, indicated a moderate to strong effect size.

There are also some limitations with the sampling. For example, the participants are mostly white females and there are either no or few male participants in the cited studies. This is of concern, when estimates suggest that between 10 and 25% of those with an eating disorder are male (Health and Social Care Information Centre, 2013; Hudson, Hiripe & Pope, 2007). Additionally, it is important to note that even if males are included, the majority of measures are designed and normed on a female population.

It is noted that some studies have used a sample with a lower weight, but no studies have worked with participants with very low BMIs. Therefore, the impact of the intervention on those with a low weight (BMI 15 or below) is untested. The sample also varies between including those with a short duration of onset and those with a longer duration. However, there is no study that includes particularly long durations. Taken together, this indicates that there could be more scope for looking at the impact of the intervention on a chronic population. Within this, there is scope for research to focus on using the intervention with an older population. All studies used populations of below aged 30.

Few studies looked at BED, although this is likely to be included under the previous diagnostic label of EDNOS. This is an area for further research.

It is important to note that the same groups of researchers who developed the CBT-E model of treatment have completed most of the studies. It could be argued that they therefore have a vested interest in the success of CBT-E. However, it is encouraging that independent studies have reflected the results of studies by those who developed the protocol.

1.5.3. Strengths and Limitations of the Review

A strength of the review is that it has built upon the previous review by Groff (2015) by incorporating 9 additional studies. In addition, this review has synthesised the data from the various studies allowing a more detailed analysis of the effect of CBT-E.

It is noted within the cited studies that a number of secondary outcome measures were also used. In the main these focused on measuring general psychiatric features such as anxiety, depression, self-esteem and quality of life. As these were not the primary targets of a CBT-E intervention the decision was made not to look at these outcomes. They may be some use in looking at the impact of the intervention on secondary measures. This could form the basis for future research.

When considering the methodology of the review a meta-analysis was considered. It was felt that although similar outcome measures were used there were discrepancies within the population. For example, there was a mix of diagnoses and a large range

in the severity of presentations. In addition there were also discrepancies in the way the model was delivered. For example, some studies used the broad or focused forms of CBT-E and one intervention was based on elements of the protocol. Further to this, some studies offered additional interventions alongside the model. When there is a collection of more consistent studies, a meta-analysis would be warranted.

1.6. Conclusion

Overall, EDs can be difficult to treat, but it is encouraging that CBT-E appears to be an effective treatment option. The indication is that results transfer to clinical settings with the suggestion that the approach is transferable across diagnoses, but appears more effective for bulimic presentations. The review highlights the approach is not effective for all clients, and that other approaches such as ICAT, FPT and psychoanalytic psychotherapy are comparable. It appears that results are achieved more quickly with CBT-E with patients who have BMI's that are closer to the healthy weight threshold range and a diagnosis of relatively short duration.

The review has raised gaps in knowledge and areas for future research. For example, studies need to address whether the impact of the intervention is maintained longer-term. It would be beneficial to investigate both what makes treatment successful, and what predicts dropout. This could be investigated by exploring participants' experiences of treatment. Additionally it is important to investigate how effective treatment is with more chronic presentations. There is also a need to include more diversity within the recruitment of participants. In particular, the lack of males in the cited studies indicates generally how underrepresented males are in research on EDs.

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*Studies included within the systematic review

Chapter 2: Empirical Paper

Exploring Men's Experiences of Developing and Living with an Eating Disorder

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2.1. Abstract

Eating disorders (EDs) are often viewed as a female phenomenon. As such, men with EDs are often overlooked and qualitative research into men's experiences is scarce. Studies thus far have broadly focused on experiences of accessing services and treatment. Some consideration has been given to development and living with an ED, but the evidence base is limited. The current study used Interpretative Phenomenological Analysis (IPA) to provide an in-depth exploration into men's experiences of developing and living with an ED and in particular how they experience the function of the ED in their lives. On completion of the analysis, four super-ordinate themes emerged; 'The ED taking control', 'Consumed by the ED', 'Letting go vs. holding on' and 'Questioning masculine identity'. Each super-ordinate theme consisted of a number of subordinate themes. Results are discussed within the context of existing literature. Implications for clinical practice and study limitations are also discussed alongside directions for future research.

Key words: Men, Eating Disorders, Experiences, Phenomenological

2.2. Introduction

Men are estimated to comprise around 10% to 25% of those affected by an eating disorder (ED) (BEAT, 2015; Health and Social Care Information Centre, 2013; Hudson, Hiripe & Pope, 2007; Weltzin, Weisensel, Franczyk, Burnett, Klitz, & Bean, 2005). In spite of evidence suggesting relatively high prevalence in men, EDs are often viewed as a female phenomenon. As such males with EDs are often overlooked (Greenberg & Schoen, 2008). Alongside this, treatment approaches are often based on interventions developed for women and there are no treatment guidelines specific to men (NICE, 2004).

Additionally, Robinson, Mountford and Sperlinger (2012) report that the majority of research studies looking at men have been quantitative, with gender differences in ED psychopathology as a focus. While this contributes to understanding of EDs in men, it is criticised as it often uses measures and diagnostic criteria that have been designed for women (Robinson et al., 2012).

Robinson et al. (2012) also point to the fact that there has been increased recognition placed on the importance of gaining accounts of the experience of those with EDs. While this has led to a number of qualitative studies with female participants, there are only a limited number of qualitative studies which have investigated men's experiences.

2.2.1. Accessing Services and Experiences of Treatment

Some of the qualitative research thus far has focused on men's experience of accessing services and treatment. Cooperman (2000) interviewed nine British men

and identified difficulty in discussing the ED with peers, and limited recognition of EDs by GPs. This was mirrored by Robinson et al. (2012) who interviewed eight men accessing specialist treatment for an ED. Using interpretive phenomenological analysis (IPA), they identified males' difficulty in admitting having an ED both to themselves and others.

For men, there is an indication that difficulty in admitting the ED is due to the stereotype that EDs do not affect men. Robinson et al. (2012) reported that participants identified feeling invisible and that this is 'only something that happens to women'. They highlight that participants reported a fear of negative reactions from others if they disclosed the ED. Räsänen and Hunt (2014) also reported participants fear of disclosure and not been taken seriously by professionals. This again appeared to be linked to a gendered understanding of EDs. It is also interesting to note that following identification of an ED, Cooperman (2000) reports the importance of friends, family and professionals in supporting men in accessing services.

In addition, Robinson et al. (2012) considered men's experience once in treatment and whether gender was an issue. Findings highlighted the main importance for men was feeling cared for by professionals. Following this, Bjork, Wallin and Peterson (2012) considered how men perceive life after recovery. They identified themes of body acceptance and self-worth. Included within this was relating in a balanced way to exercise and food, using strategies to avoid relapse, sense of self-acceptance and autonomy. Recovery was viewed as either coping with the ED or complete remission.

2.2.2. Living with an Eating Disorder

Studies have begun to explore what it is like for a male to develop and live with an ED. With regard to development, Räisänen and Hunt (2014) interviewed 10 men aged between 14-22 years. It was found that participants described recognition of their ED as either a gradual process or sudden awareness. In particular, recognition of the problem became clear once it could not be contained privately. Participants viewed their behaviours as coping mechanisms to manage difficult situations. The study provides some insight into the development of an ED in young males. However, it does not offer an insight into the experiences of older men and the development and recognition of the ED longer term.

In terms of living with an ED, Cooperman (1999, 2002) examined the experiences of eight Australian men. The study identified three themes: that men experienced the ED as a form of competition and described competing against oneself and others as an essential element; a fear of becoming fat and a cultural shift in perceptions of the male body as muscular and devoid of fat; finally that of masculine identity. In particular, participants described the experience of feeling that they did not conform to the Western cultural model of the masculine image.

The descriptive study by Drummond provides valuable insight into the experiences of these men. However, there was no assessment of ED status and a lack of general demographic information. It is therefore difficult to situate the sample. In addition, both articles (Drummond, 1999, 2002) appear to describe the same participants (Robinson et al., 2012).

Robinson et al. (2012) also explored what it was like for men to live with an ED. They reported participants linked their ED to discomfort with identity and difficulty in seeing the ED as a problem when it was viewed as a solution (e.g. emotional regulation and management of sexuality).

2.2.3. Rationale for the Current Study

Overall research into men's experiences is scarce. Studies so far have broadly focused on accessing services, and treatment and recovery. There has been some consideration to the development of and living with an ED, with a suggestion that for men this includes cultural perceptions of masculinity. However, studies have been mainly limited to a non-UK population, and adolescents and young adults. While there is suggestion of using the ED as a way of managing other difficulties, no studies have focused on exploring specifically what function the ED serves, and the factors which maintain an ED in males.

2.2.4. Aims of the Current Research

The study aims to build upon existing research by using interpretative phenomenological analysis (IPA) for an in-depth analysis of men's experiences of developing and living with an ED. The research will focus on how men experience the function of their ED and the role that it plays within their lives. This has clinical significance, as a better understanding of the development, function and maintenance of EDs in males could help to inform decisions regarding interventions. This has implications for service development and in helping to expand the information available to male clients.

2.3. Method

2.3.1. Design

The research question is focused on understanding participants' experiences; as such a qualitative methodology is the most appropriate (Yardley, 2000). IPA was chosen as a methodological design and form of analysis, as the research aims are consistent with its epistemology. The use of IPA allows for detailed exploration of how participants make sense of their personal and social world (Smith, Flowers & Larkin, 2009). The current study is interested in how people view life experiences, in this case, the development of an ED and how they make sense of it.

2.3.2. Participants

The participants were selected purposively to offer insight into their particular experience. In line with IPA, a small sample size was chosen (Smith et al., 2009; Smith & Osborn, 2003). Five participants took part in the present study. The data collected provided the study with the required detail, allowing for the examination of similarities and differences without the data becoming overwhelming (Smith et al., 2009).

To ensure sample homogeneity, only men aged over 18 who identified as having an ED were recruited. Participants were excluded if they were unable to speak English or were identified as being too physically or psychologically unwell to take part. Table 2.1 highlights participant characteristics.

Table 2.1. Participant characteristics*

Participant	Age	Eating Disorder Diagnosis	Approximate Duration of Eating Disorder
Paul	35	AN ³	12 years
Andrew	40	BN ⁴ /BED ⁵	20 years
Ben	25	AN	10 years
Nathan	34	AN/BN	20 years
Max	47	OSFED ⁶	20 years

* Names have been changed to ensure confidentiality.

2.3.3. Procedure

2.3.3.1. Ethical Procedure

The research was designed and conducted in line with the British Psychological Societies Code of Human Research Ethics (BPS, 2011). Ethical approval was granted by Coventry University (Appendix D), the NHS Research Committee (Appendix E) and Coventry and Warwickshire NHS Trust Research and Development Department (Appendix F).

2.3.3.2. Materials

A semi-structured interview was used (Smith et al., 2009) which acted as a framework to guide the interview. Interviews were flexible in order to respond to and follow the participants' experiences. Questions were designed in collaboration with the research team to meet the aims of the study. Service users were consulted

³ Anorexia Nervosa

⁴ Bulimia Nervosa

⁵ Binge Eating Disorder

⁶ Other Specified Feeding or Eating Disorder

on the acceptability of questions and topic areas (see Appendix G for interview schedule).

2.3.3.3 Recruitment

Participants were recruited from a specialist NHS Eating Disorder service and through the Charity BEAT⁷. When recruiting from the specialist NHS service, participants were initially approached by their clinician and provided with a written information sheet detailing aims of the research (Appendix H). If participants wanted to take part, they contacted the researcher and an interview was set up at the ED service. When recruiting from BEAT, an advertisement was placed on their website and a link emailed to those who had expressed a prior interest in being contacted for research. Participants who expressed interest by contacting the researcher were sent a copy of the information sheet (Appendix H). If they were happy to take part, an interview was arranged at a location that was convenient to them.

2.3.3.4. Interview Procedure

Prior to the interview, the researcher explained the information sheet detailing the aims of the study. Time was also allowed to answer additional questions. The participant's consent was obtained and they were asked to sign an informed consent form (Appendix I) confirming they understood the information and were willing to participate. Demographic information was also taken.

⁷ BEAT (Beating Eating Disorders) is a UK charity supporting anyone affected by eating disorders or difficulties with food, weight and shape.

All interviews were audio recorded and lasted between 50 and 80 minutes. When completed, time was given to debrief and reflect on the interview experience. Participants were given a debrief sheet (Appendix J) containing contact details of the researcher and details of support services if required.

2.3.4. Data Analysis

The researcher transcribed the interviews verbatim. To ensure confidentiality, interviews were anonymised and identifiable data removed. The interview transcripts were analysed by the main researcher using the IPA technique described by Smith et al. (2009) (Appendix K). Excerpts from a transcript are provided to demonstrate the process of analysis (Appendix L). For cross comparison between accounts, each participant's emergent themes were put into different coloured fonts. This enabled the researcher to develop a visual map of emerging themes. Groups of themes were produced, including sub-themes within super-ordinate themes (see Appendices M, N and O for examples of this process).

2.3.5. Credibility of the Study and the Researchers Position

Attempts were made to increase the credibility of the study. For example, the supervision team checked initial coding and emergent themes. Additionally, an independent researcher coded an excerpt of transcript and this was compared to coding undertaken by the main researcher. This allowed for a measure of validity for the process of coding the transcript and developing emergent themes.

IPA acknowledges the researcher as part of the context. It describes this as the 'double hermeneutic' where the researcher attempts to make sense of participants'

interpretations of what is happening to them. This generates a hermeneutic circle as the researcher is in turn influenced by the participant (Smith et al., 2009). In light of this, it is important to acknowledge factors that affect the researchers own position in relation to the research. To aid in this, the researcher kept a reflexive diary and took part in a bracketing interview which gave space to think about and develop awareness of their own experiences and beliefs in regard to the topic area (Ahern, 1999; Rolls & Relf, 2006). For example, the researcher has not had experience of living with an ED, but has worked as a healthcare assistant with men on an inpatient ED unit. They have also worked as a Trainee Clinical Psychologist within an ED Service. In addition the researcher is male and working within a profession (Clinical Psychology) that is predominantly female, providing an insight into being in a minority group.

2.4. Results

On completion of the analysis, four super-ordinate themes emerged; “The ED taking control”, “Consumed by the ED”, “Letting go vs. holding on” and “Questioning masculine identity” Each super-ordinate theme consisted of a number of subordinate themes; see table 2.2. Consideration was given to convergence and divergence within themes.

Table 2.2. Super-ordinate and subordinate themes

Super-ordinate Themes	Subordinate Themes
The ED taking control	a. Emerging awareness of the ED b. “I was never any good” c. Emotional regulation
Consumed by the ED	a. “This has got you right by the balls” b. Loss: The cost of the ED c. Shame: Keeping the ED hidden d. A provider, friend and protector
Letting go vs. holding on	a. Fear of letting go b. Facing up to the ED c. The grip loosening
Questioning masculine identity	a. “Am I a proper man?” b. “I’m different from other men and from other ED clients”

2.4.1. The ED taking control

All participants discussed feeling like the ED had taken control. This process was experienced as recognition that they had an ED, considerations of the ways it developed as a solution to deal with the consequences of negative self-identity and served to offer a way to manage difficult feelings.

2.4.1.1. *Emerging awareness of the ED*

All participants highlighted how the ED embedded itself into their lives and that this process occurred gradually.

It was a really gradual thing...⁸a preoccupation with food in terms of obsessions and compulsions and also exercise.

(Ben, 32-36)

⁸ The use of ... indicates a pause

At the time I wouldn't have said I had an eating disorder (...) ⁹ I don't think I knew that I was using the eating disorder as a way of managing.

(Nathan, 128-134)

Nathan highlights the ED was already serving a function in his life for which he was unaware. This suggests the ED was something outside of conscious awareness. For some participants, although not conscious, there was a sense that something was wrong. However, the ED itself was not acknowledged. For example, Paul talked about attributing symptoms to other causes.

thinking the tiredness (...) and the way my weight was going down it was just cos I wasn't fit enough.

(Paul, 26-32)

For some participants, the lack of initial awareness of the development of the ED stemmed from the idea that an ED is a female disorder which men do not experience.

the idea of a man having an eating disorder...just didn't compute (...) because it wasn't the sort of thing boys did.

(Nathan, 141-152)

The majority of participants stated that the gradual development of awareness of the ED meant it was established and entrenched by the time they were aware they had a problem. There was a sense of the men feeling powerless against the onset of the ED.

⁹ The use of (...) indicates material omitted

(I) was not aware of how entrenched that kind of problem is and how long it can take to sort out...while at the same time....the eating disorder was worsening and embedding itself.

(Ben, 137-145)

2.4.1.1. 'I was never any good'

Participants described difficult experiences which appear to have led to development of negative beliefs about themselves and in particular a sense of being different from others. For example, Andrew talked about how entering puberty early emphasised a difference from others and compounded a negative self-identity.

I went through puberty quite early...I just remember being absolutely horrified with the body I got...I hated it.

(Andrew, 24-26)

Most participants described how difficult experiences in their past had contributed to the development of negative self-beliefs such as "not being good enough". Max described an early experience of abandonment by his parents, alongside a strict upbringing by his grandparents, which led to a negative self-view.

I went through my formative years thinking I wasn't very good at this and I wasn't very good at that. I was the kid in school who was the loner and had no friends...I grew up like that thinking I was not very good at anything.

(Max, 27-32)

For Nathan and Paul, there were also incidences of bullying which impacted their view of themselves.

at school I got bullied a lot, one of the many things that they picked upon was my weight, the other things were mainly my glasses and the fact that I was a bit of a swot. I thought...the one thing I can do is change my weight.

(Paul 481-489)

For participants, their weight became tied to a negative self-representation in terms of their worth as an individual and friend. Max explained that for him being overweight represented a “no good loner with no friends” (111-112). Other participants also highlighted how weight linked to a negative self-identity.

whenever the thought of putting on weight came up, it was always those people at school having a go at me that came back to me...yeah, that's all fat meant to me.

(Paul, 562-570)

Participants described how the ED became a way to manage negative self-identity. Weight loss led to increased self-esteem and self-confidence, which was initially reinforced by others. Low weight then appears to become tied to a positive self-conception, particularly a sense of achievement at being good at something.

taking laxatives was able to make me thin, was able to give me self-esteem, was able to give me a set of friends who were praising me, who weren't putting me down...I was good enough for them...

(Max, 401-406)

2.4.1.3. Emotional regulation

Participants described how the ED helped them to manage their emotions. For some, the ED served as a way of suppressing emotions and acted as a strategy to avoid difficult feelings.

that obsession takes over and if you are worrying about that...then I couldn't be obsessing about other things.

(Nathan, 285-288)

Andrew described how the ED behaviours alleviated feelings of stress, but may also be connected with managing both positive and negative emotions.

it was the only thing I had, the only sort of stress release (...) if things went well I overate...if I had a bad time I overate.

(Andrew, 138-144)

For some, the ED was fulfilling emotional needs that were not being met by others. Ben highlighted the ED was “a way of...regulating emotions, expressing my emotional needs which weren't necessarily being fulfilled as a child by my parents...” (230-232). Ben also highlighted a fear of expressing emotions to others for worry of how they would be met.

they were feelings that were scary and which I did not feel safe in expressing, certainly at home.

(Ben, 292-293)

2.4.2. Consumed by the ED

Participants described how they felt that the ED was in control of their lives and that their life had been taken over. The ED also served a positive function and participants were often willing to live with the costs to maintain this. Alongside this, there was a sense of sadness at what had been lost and for some a need to keep the ED hidden.

2.4.2.1. *“This has got you right by the balls”*

All participants experienced being “in the grip” of the ED. There was a sense that the ED had a tight control on their life with little room to manoeuvre. Again a sense of the ED as powerful and serving a function in helping to distance and avoid emotions was present.

This has got you right by the balls and I cannot see a way out of this...and I've got nothing left other than an eating disorder.

(Paul, 1023-1024)

I was mapping out my daily life, weeks and months ahead around my laxative use...in the end it came to the stage where I stopped doing things because I was only happy to get up in the morning, take the laxatives, go for a run and come home and be happy if we were not doing anything that day. My life and the life of my family was revolving around the laxatives.

(Max, 450-465)

All participants experienced becoming more entrenched within the ED as time progressed.

it just sort of spiralled and (...) I suppose I just got sucked into the obsessing about it and it went from wanting to get myself down below BMI 25, to down to BMI 20...then from weighing myself once a week, to once a day, to two times a day to three times a day.

(Nathan, 271-279)

In particular, participants experienced feelings of not being able to escape from the ED even when they recognised that it had become a significant problem.

Why do I have to think about the most anorexic way to walk across this road (...) 'oh, there's three steps and a slope, lets go up the steps you use more energy that way' ...its the constant aspect of it that really grinds you down.

(Paul, 708-714)

2.4.2.2. Loss: The cost of an ED

Participants' experiences reflected a sense of loss and sadness for what the ED had taken. Again this seemed to be something that was out of the control of participants resulting in them missing out on socialising and relationships.

it was my emotional and social well-being that it pretty much destroyed (...) it wiped out the quality of my social life and my family life.

(Ben, 78-86)

I occasionally went out for a drink with my mates, but it was like one soft drink and then home (...) I barely even talked to women let alone asked any of them out.

(Paul, 823-829)

For some, this sense of loss was compounded by a realisation of how much relationships had been impacted.

I've caused an awful lot of pain to my parents (...) realising how many people did care about me and had been worried about me...was really hard to think about.

(Nathan, 465-476)

2.4.2.3. Shame: Keeping the ED hidden

Though not true for all participants, there was a sense of wondering about how their ED would be viewed, linked to perceived embarrassment and shame. Andrew talked about the shame he experienced for spending his holiday savings on food and having to hide this from his parents.

[money] would be saved up for when we went on holidays (...) then I didn't have money because I'd spent it on food, but I didn't dare tell my mam and dad so I just made stuff up...Just the shame of it (...) It was like 'where has all this...[money gone]?

(Andrew, 118-130)

For some, there was a need to keep their ED behaviours hidden. Max highlighted how he felt a need to keep his laxative use hidden from friends.

I was worrying about how I was going to take these laxatives...I didn't want these people...these were my new set of friends to know.

(Max, 295-299)

Andrew described elaborate efforts to conceal ED behaviours such as bingeing and purging from his housemate.

so much calculation would go into it...I had to time it, I had to make sure she [housemate] was going out to do something...So then I could get the food in the house. It would all go up to my bedroom and then I would just spend the entire day eating and by the time she got home...I'd have been to the gym for four hours and then it would begin again.

(Andrew, 381-393)

2.4.2.4. A Provider, Friend and Protector

While entrenched in the ED, the men also experienced it in a positive light. Participants described a willingness to live with the associated costs of the ED for the perceived benefits.

I could cope with it all...the fact I was cold all the time, just put on another jumper. I could cope with that I couldn't really run, I could go for a walk. I could cope with the fact I missed out on a few things, because at least I'm happy within myself.

(Paul, 676-681)

Participants identified the feeling of safety they gained from the ED. For some, the ED protected the sense of self that they had built up.

It's [the ED] maintaining feelings of safety (...) preserving my self-identity in the only way I knew how.

(Ben, 326-339)

For others, the ED protected them from confronting situations that were feared.

I didn't have to do some of the things that I was scared of. I didn't have to go out and meet new people (...) It allowed me to just live in my own little world without expectations on me at all.

(Paul, 777-787)

Participants suggested that avoidance of feared situations meant that life was placed on hold. Alongside this, the ED also offered a sense of control.

it felt like for the first time I had control over my eating (...) it was the one thing in my life, the losing weight and the running and the exercising (...) those were the few things I was succeeding at.

(Nathan, 294-310)

Many participants came to view the ED as a friend. Max described how the ED provided a gift of a better life. As such it was difficult to refuse the demands of the ED.

the eating disorder was a friend...it was good for my self-esteem (...) and that came from the fact I was taking laxatives (...) it had given me a life I never had before.

(Max, 391-416).

Participants' feelings towards the ED began to change when the costs began to impact on something that was important to them. For example, Andrew held work and his profession as important and when the ED impacted this he felt this was a signal that something was wrong.

I didn't really go off work sick even when I had a cold (...) when I realised I was on the verge of actually I don't want to go to work, I want to go to the supermarket and buy a load of food and stay in bed... that's when I knew something was really wrong

(Andrew, 354, 399-402)

For other participants it felt like the costs of the ED outweighed the benefits when it began to affect their physical health. Nathan explained how he was admitted to hospital when he became physically unwell and how this highlighted the seriousness of his situation.

*lying on my back with a drip in my arm (...) thinking 'actually I don't want to die right now'... I had to do something different (...) that was the moment I realised you know when they talked about putting your life at risk they were not 'bulls*****g...and that was quite scary.*

(Nathan, 660-674)

2.4.3. Letting go vs. holding on

For all participants there was a sense of conflict about giving up the ED which was characterised by a fear of what it would mean for them. Participants discussed difficulty of “facing up” to the ED, but how in doing so led to a “loosening of the grip”.

2.4.3.1. Fear of letting go

Participants' experiences highlight the battle between holding on and letting go of the ED.

I think I genuinely felt that I wanted to sort it out...whereas my actions were quite different...the typical mismatch between the drive to do something and actually being able to do anything about it.

(Ben, 147-151)

Difficulty letting go appeared to be linked to fear of weight gain. The fear reflected a return to negative self-conceptions that were tied with being at a higher weight.

I couldn't or just didn't want to break the cycle (...) I was frightened...I had all of these thoughts that 'I'm going to be 16 stone, I'm going to lose all my friends...my self esteem will have gone' (...) I didn't want to go back because there was such bad memories.

(Max, 213-231)

For others, it was a fear that they would lose their strategies for coping.

I was so unwilling to let go of it...it was that thing of what do you do if you're not going to go and purge after you've binged or go back to having to sit with the hideous kind of self-talk.

(Andrew, 691-695)

This ambivalence to change impacted upon their initial engagement with treatment.

The first year was a, it wasn't a waste (...) but it was a write off in terms of being any help to me (...) I didn't realise it at the time...but the first year I was so resistant to it.

(Andrew, 605-614)

When he said you're going to have to be an inpatient it was, it was, 90% of me said I didn't want to do it.

(Max, 515-517).

2.4.3.2. Facing up

In terms of letting go of the ED, participants' experiences speak to them confronting their fears. In doing so there was a sense of the men taking back control of their lives. For Ben, there was something important about sharing his thoughts and feelings with his parents in a way that he had felt unable to when he was younger due to them being emotionally unavailable.

there have been times when I've gone back to my parents for a visit...and...whether it's me having long conversations or...really digging at earth that they might not want to turn or poking at wounds, sores that should not necessarily be poked...they have felt like defining moments.

(Ben, 529-537)

In "facing up", the participants approached treatment in a different way. There is a sense at this point in their experience of the men using their own agency to face the ED. This is reflected in a change in the language used to "I" rather than "the ED". Prior to this the ED was viewed as an external object which was doing something to them.

I went back and made sure I did the stuff I didn't do the first time. I actually didn't go for a walk every day (...) I ate stuff that was a real challenge that I hadn't ate before...I tried to confront everything that didn't work.

(Paul, 1113-1120)

Alongside this was recognition of how difficult treatment could be.

*treatment is really hard work and in some ways f*****g awful...most nights [I] lay in bed thinking 'it just was easier having an eating disorder.*

(Nathan, 646-649)

2.4.3.3. *The grip loosening*

Participants experienced that through facing the ED, its grip began to loosen. What appears to be different is that there was space within their lives for other things.

it's not as dominant...I've let other people in and now I have other things...I've started playing football again, I've got a job I love, I've got a girlfriend and she loves me and I love her and anorexia is still there (...) but I am starting to do stuff about that as well. I am as...blissfully happy as I could ever of hoped to be and how I never would have expected to be when I was at the depths of despair before I went in as an inpatient.

(Paul, 1126-1137).

For all participants, there was an acknowledgment that their ED would always be present, but that it had lost some of its power.

I still have a...conflict laden relationship with food (...) yet at the same time I'm so far from...the obsessions and compulsions of weight and...exercise, which previously distracted me and drove me to distraction and took up my day...that its unrecognisable, my life is unrecognisable... there is time for the rest of life.

(Ben, 556-575)

2.4.4. Questioning masculine identity

2.4.4.1. "Am I a proper man?"

Some participants highlighted that they had no sense of male identity and felt they did not meet the expectations of what a man should be. Andrew explained how he did not have an interest in stereotypically male pursuits which led to a sense of not feeling like a regular boy.

my dad was an avid footballer and he played Sunday league and he played five aside and I didn't like doing any of that...they were expecting this sort of regular little boy and I really wasn't.

(Andrew, 1043-1046)

Similarly Nathan explained not meeting the expectations of what a man should be, but felt that he did not want to associate himself with these characteristics.

one of the things I've learnt I struggle with is that sort of sense of not being a proper man...I've never been sporty...never been...the sort of person who would drink 10 pints, have a fight and shag somebody...and I sort of know that's not the person I want to be, but it all gets mixed up.

(Nathan, 333-343)

For some participants, the ED was a way to actively avoid their masculinity. Ben described how his ED was a way to postpone becoming an adult male. As such he found it difficult to think about what it meant to be a man.

it [the eating disorder] deadened all of those appetites... the sexual drive and anger and feelings of power and the teenage hormonal feelings and that was all tied up in my mind with being a male, being a man...I mean its very hard

to think about masculinity, words like 'man', 'maleness', 'masculinity' in my head and apply them to me at that time because they were so out of my sphere of consciousness...they didn't occur to me, I kept them at bay purposefully.

(Ben, 255-286)

2.4.4.2. "I'm different from other men and from other ED clients"

Participants' experiences suggested that they were different from other men due to the idea that men do not have EDs.

when she said the words 'anorexia' to me, as I say all I knew was this was some illness girls got where you don't eat enough .

(Paul, 951-954)

There was a sense that when participants were diagnosed and were looking for information on EDs, they were searching for an account that would speak to their experiences. Some participants struggled to find this. As Nathan highlighted there were only parts of the literature that he felt spoke to his experience as a man with an ED.

it's one of the things that helped me when I was getting my head around having anorexia was reading some of the literature...research and memoirs and stuff and there's very little that, I can only see parts of it that speak to my experience.

(Nathan, 410-415)

Having an ED diagnosis led to feelings of difference for all participants. For some this was difficult and exacerbated feelings they already held about being an outsider.

There have been times when I thought 'you are a 30 year old bloke with a teenage girl's disease'...It's just another thing to beat myself up with...clearly if I'd become a drug addict or an alcoholic it would have been so much better (smiles)...a proper man's way of destroying themselves...I suppose the other thing it does, it just reinforces my sense of difference, of being on the outside.

(Nathan, 357-370)

Some participants also experienced the environment that treatment takes place in as compounding this sense of difference. They highlighted the fact that treatment can be biased to a female client group. Participants described how this could often be subtle.

it would be nice if all these guys didn't talk about 'her' eating disorder and the ways she's reacting and it would be nice if it wasn't just a 'oh men get eating disorders too' postscript at the end of it.

(Paul, 641-645)

and I remember my doctor gave me, he gave me a leaflet and it was all in sort of pretty pastel colours, which was nice (laughs).

(Andrew, 565-566)

Some participants did not perceive their difference in a negative way. It may be for example that the difference afforded a sense of being special.

I didn't think I'm the odd one out here cos I'm the only man...there were a couple of lads who were in the eating disorder unit when I first came in, but

they went home pretty quickly, but by then I'd got to know everybody and everybody was supportive, we were leaning on each other for support and confidence...I never had an issue being a man in mainly a women's sort of hospital...I always felt at ease.

(Max, 680-691)

Paul also highlighted the positive experiences of being the only male in an inpatient unit. For him it allowed interaction with women and helped him to re-evaluate his views about women being “frightening”.

I'd always been too scared of it [female company], so when I found out I was moving in with nine girls I thought 'oh God this is going to be awful' but it was brilliant, I loved it, it was fantastic and women were not quite as frightening as I thought they were.

(Paul, 1222-1227)

Paul also stated that being male allowed him to remain outside of arguments on the inpatient ward and also enabled him to have his own facilities.

I don't think I've ever suffered because I'm a man (...) on an inpatient unit it was a bit of a benefit because all of the girls were like ratting at each other and I could kind off stand back and be everyone's mate (...) I got my own shower, which was good as well.

(Paul, 592-601)

All participants highlighted feeling that they had been lucky to receive the treatment that they had. There was a sense that because they were male, that this should not have happened as it did.

I don't regard myself as being a typical male anorexic in that I didn't struggle on my own (...) I literally turned up at the GP's office and, sat down, she said 'anorexia' and I said 'fine.

(Paul, 580-588)

Most participants described visiting a university GP and felt that they were better able to identify the signs of an ED.

I really do feel lucky, just the fact I was at a university health centre, meant the doctor was just that bit more attuned to problems that happen in a student population.

(Andrew, 1245-1247)

Despite feeling lucky, some participants felt that being a male did have an impact on what they were offered from services. There was a sense of frustration at this. For Andrew he felt that ED services did not fully understand the male experience.

I don't believe there is a model that has yet got to grips with how men feel about being men with eating disorders because most of the treatment models, is still geared around the predominant users of those services will be women.

(Andrew, 1229-1232)

Nathan talked about an experience where he felt that his gender meant that he had to wait for treatment.

I got knocked back down the waiting list... they didn't think it was appropriate for me to be in, I'm not entirely clear why, but it was partly because of my gender.

(Nathan, 575-580)

In individual treatment, it appeared that gender played a lesser role and other aspects became more important.

my counsellor was female and fantastic in terms of what you want a good counsellor to be, empathic and stuff so I was quickly able to disperse the potential stigma [of being male]

(Andrew, 1237-1239)

In particular participants highlighted the importance of consistency and long-term support as key for recovery.

the vital thing that gave me the best chance of recovery was the continuity of care...quite intensive treatment sustained over what seemed like vastly long periods of time.

(Ben, 598-601)

2.5. Discussion

The study aimed to explore men's experiences of developing and living with an ED, particularly the way in which its function is experienced. Four themes emerged which will be discussed within the context of existing literature. Implications for clinical practice and study limitations are also discussed alongside directions for future research.

2.5.1. The ED Taking Control

The first theme related to the ED taking control of the men's lives and for participants this process reflected a gradual awareness of their ED. Previous research highlighted men finding difficulty admitting they had an ED (Robinson et al., 2012), which may link to gradual awareness or non-recognition. Similarly, in the current study it appeared participants were aware something was wrong, but for some the start of the ED was attributed to other causes. From a psychodynamic perspective, non-recognition of the ED serves as a defence against acknowledgement of reality (Casper, 1987). As such, men in the current study may be defending against conscious awareness of the ED as a way of avoiding the reality of the difficulties they were facing.

The ED taking control and gradual or non-recognition is echoed in the female literature (Serpell, Treasure, Teasdale & Sullivan, 1999; Vandereycken, 2006). However, for men there is an additional idea that EDs do not affect males, which may further impact recognition. For participants in the current study recognition came too late as the ED was already entrenched.

In the current study, the ED appeared to develop as a way to manage negative self-identity formed through difficult childhood experiences. For example, some participants experienced weight-related bullying. This development is also found within the female literature (Nevonen & Broberg, 2000; Tozzi, Sullivan, Fear, McKenzie, & Bulik, 2003). Additionally, using the ED as a way to manage negative self-identity mirrors previous findings with men (Räisänen & Hunt, 2014; Robinson et al., 2012) and women (Serpell et al., 1999; Stein & Corte, 2007). For men in the current study, the attributes of negative self-identity were associated with a higher weight, whereas more positive self-conceptions were linked to a lower weight. This appeared to reflect dichotomous or inflexible thinking, with low weight considered positive and higher or normal weight associated as negative. This may have made it difficult to hold an integrated view of the self.

Additionally for some men, the ED was a strategy to regulate emotions. Again this links to previous research findings with men (Räisänen & Hunt, 2014; Robinson et al., 2012) and women. For example, Serpell et al. (1999) highlighted how the ED serves as a way to avoid difficult emotions. The ED appeared to serve a similar function for men in the current study.

2.5.2. Consumed by the ED

All participants experienced the ED as consuming their life. This again reflects women's experiences of living with an ED (Patchling & Lawler, 1999; Reid, Burr, Williams & Hamersley, 2009). Research has also identified how men have not seen the costs of the ED as it served a function in managing problems (Robinson et al, 2012). This was mirrored to some extent within the present study. However, it

seems men in the current study were aware of the costs of the ED, but were willing to live with these for the perceived benefits. Specifically, there was awareness of what they had lost, with the ED viewed as an external object that had 'stolen' from them. Again loss is mirrored in previous literature with Serpell et al. (1999) highlighting women experiencing loss of friends and relationships and the ED as an external force.

For all participants the ED took on positive aspects as a friend, provider and protector. Previous literature also identified participants experiencing the ED as a protector, with Serpell et al (1999) reporting women's experiences of the ED as making them feel safe. For the men in the current study the ED served to protect them from confronting situations they feared. Ripa di Meana (1999) highlights how in this way the ED becomes a 'language of refusal' or a way to communicate to others that they are unwilling to do something. Only when the costs became too great did they view the ED as negative.

Previous research has highlighted a fear of negative reaction from others when disclosing the ED (Robinson et al., 2012). This idea links to some of the men's experiences in the current study and the feeling of shame and the need to keep the ED hidden. For men it may be that feelings of shame and needing to hide the ED are reinforced by beliefs that 'men do not get EDs'. This may also be linked to cultural beliefs about how men should manage emotions. For example Strother, Lemberg, Stanford and Tuberville (2012) argue that cultural expectations encourage men to hide vulnerability, including shame, while Real (2003) suggests that this emotion may be associated with the stigma of being feminine. It is important to note that not

all men expressed shame and for some there were active moves to share experiences to combat perceived stigma of being a male with an ED.

2.5.3. Letting go vs. holding on

Participants experienced conflict about letting go of their ED. This links to the previous theme in which the perceived benefits outweigh the costs. This idea has been identified in previous research which highlights how positive beliefs about an ED contribute to ambivalence towards treatment in women (Garner & Bemis, 1982; Vitousek, Watson, & Wilson, 1998). This links to the participants' experiences in the current study. However, for these men there was a focus on fear of letting go of the ED. This was tied to returning to a higher weight and the associated negative self-conceptions. There was a sense of willingness to keep the ED while it benefited them. This highlights the 'ego-syntonic' nature of an ED whereby the symptoms become congruent with personal values and indicates why EDs can be difficult to treat (Roncero, Belloch Perciña & Treasure, 2014; Schmidt & Treasure, 2006).

Previous research with women has described recovery as regaining a sense of control over their lives (D'Abundo & Challey, 2004; Garret, 1997; Patchling & Lawler, 2009). This was echoed in the experiences of the men with a sense that although the ED was present it had lost some of its power.

2.5.4. Questioning Masculine Identity

Previous research (Drummond 1999; 2002) has identified that men with an ED have not felt that they meet Western cultures' expectations of masculinity. Drummond (1999; 2002) found this was based on body shape and perceived ideals. For some of

the men in the current study, they felt they did not meet the cultural expectations of what it meant to be a man, based on personality characteristics and attributes. This led to feelings of being different, with the ED reinforcing this sense of difference. For others it may have granted a feeling of being special and having something that others did not. In this way the ED began to serve an important function which may have been difficult to let go of.

There was an expectation from participants that they would be treated differently based on their gender. There were feelings of being 'lucky' when this did not happen. Previous research has identified difficult experiences with accessing services and lack of recognition of EDs in men from GPs (Cooperman, 2000). Participants in the current study reported good experiences of being seen by GPs. Some men saw University GPs who may be more attuned to EDs as they are more likely to present within a younger population. Alternatively there could be an increased awareness among professionals of the fact that men can also have an ED.

2.6. Strengths and Limitations of the Study and Areas for Future Research

The strength of the study is that it allowed an in-depth exploration of the experiences of developing and living with an ED as a man. Due to the limited evidence base, the aims of the study were kept broad. This is important, as research with men is scarce in comparison to the female literature. Due to the nature of IPA, the results highlight the experiences of a small sample of men. However they have built on previous research and add to the widening evidence base. In addition the results are transferable. In part this is due to convergence between participants' accounts, but also to the fact that the results link more broadly to the wider literature and the

experiences of women living with an ED. Of particular note is the theme of ambivalence and the struggle of letting go of an ED. This has implications for the treatment of EDs. However, it is also recognised that some areas around masculinity are unique to men. It is therefore important to continue to investigate discrete aspects of the male experience. One area may relate to shame and its role for males with an ED.

The results capture the experiences of men who have lived long-term with an ED. However, all of the participants had been through therapeutic treatment and there was a sense of distance from initial diagnosis. This may have had an impact on the nature of the men's accounts. For example, participants talked about their experiences articulately which may have reflected time spent in treatment understanding how their ED developed. As such the accounts may reflect more understanding of the process of moving into and out of 'the grip' of an ED. It is recommended that the next step would be to build on this evidence using a grounded theory approach to develop a model of the development of EDs in men.

It is important to acknowledge there may be differences in the way experiences are reported for those earlier on in treatment or for those recently diagnosed. Future research should aim to capture experiences at different stages. In particular, it would be important to investigate how the relationship to the ED changes after recovery.

It is important to consider the researcher was male and whether this impacted on participants sharing experiences. They may have felt more able to be open with another male. Conversely it may be that it was difficult to talk to another male.

The sample comprised white British males. An area of focus for future research could be to explore the experiences of men from different ethnic backgrounds. This is of importance, as a previous research identifies culture as a factor in development and maintenance of EDs (Gordon, Perez & Joiner, 2002) and that ethnic minority communities are less likely to seek and receive treatment for EDs (Sinha & Warfa, 2013).

2.7. Clinical Implications

In developing and living with the ED, the men experienced its function in a way that was broadly similar to that identified in the research on women. Of particular note is the idea of ambivalence towards change and an investment in perceived benefits the ED grants. This appears to make engagement with treatment difficult and highlights that therapeutic interventions can sometimes be long-term, with part of the work in exploring this ambivalence. It is worth considering how this sits within services that are looking for quick outcomes and throughput. It also raises the question of assessing readiness for psychological treatment. For example, if someone were invested in holding on to the ED, it may prove working in some therapeutic models that focus on making active changes such as Cognitive Behavioural Therapy for EDs (CBT-E) challenging. There is something important in engaging people in active treatment at the point of them being willing to confront the ED.

For some of the men in the study, there was a sense of feeling different from other men, but also from other ED clients. This appeared to compound their sense of difference. There was an indication of seeking a shared story that speaks to their experience. Where possible it would be beneficial for services to facilitate the

connecting of men together through a men's group. This could provide space for exploring issues relevant to men. Strother et al. (2012) highlight how the group process can facilitate vulnerability. They explain that when a man takes risks to disclose, this encourages others to do the same, which helps dispel ideas that only women are affected by EDs.

The importance of services questioning the assumptions they make about men is also raised. For example, thinking about subtle things that can sometimes go unnoticed such as activities and facilities that are available and wording and content of information that is provided. There is still a theme that men do not get EDs. Therefore it is a responsibility of ED services to raise awareness. One way of doing this could be to ensure that any training given provides a reflection of the fact that EDs can also affect men. Additionally, men may not be seen by specialist services, so awareness needs to be raised at GP and secondary services.

2.8. Conclusion

Experiences of developing and living with an ED as a man were reflected as being taken over and consumed. Additionally, it served as a friend and protector which made 'letting go' challenging. The experiences of the men who took part reflect some of those described within female literature. It is questioned whether this is surprising, as other mental health difficulties are not separated out by gender. However what is different for men is the questioning of masculinity and the role this plays within their ED. There is an expectation that men do not get EDs and this appears to compound a sense of feeling different. It is important that services are aware of this and of the role they can play in supporting men. While the study adds

to the literature on men's experiences, it is acknowledged that the evidence base is still developing. It is important that this client group are not forgotten and that they are recognised within wider society and within services. Qualitative research is a forum to give voice to these experiences.

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Chapter 3: Reflective Paper

Personal Experiences of Undertaking Research and Working Clinically with Eating Disorders

Overall chapter word count (excluding references): 3112

3.1. Introduction

This chapter presents a reflective account of undertaking research into the area of men with eating disorders (EDs). It will consider the experience of being a researcher, the conception of the idea and the development of my relationship to the topic area. During the collection of data and write up of the research I have also been working clinically within an ED service. Consideration will be given to how these experiences have shaped my role as a researcher. In turn, the research process has influenced me and highlighted parallels between the experiences of participants and my own experiences as a man.

3.2. Relationship to the Topic Area and Development of Research

At the start of my journey towards clinical training, I worked as a healthcare assistant in an inpatient ED unit. This was my first job working within the field of mental health and I remember being nervous, but excited to start. I was armed with not much more than my undergraduate psychology degree, from which I had some basic awareness of what an ED was. The role of a healthcare assistant was a challenge, but invaluable in helping me develop skills to engage what can sometimes be a difficult client group. More than that, it allowed me to spend time with people and get to know them and listen to their stories. It gave me some insight into someone's journey into and through an ED. From this my interest in the topic area was borne.

I was struck by the fact that during my time working as a healthcare assistant there were always one or more male patients on the ward. This surprised me, as at the time with my limited knowledge of EDs, this was not something I had considered. As I started to develop in my role and gain more knowledge around the subject I was

struck by how little men featured in the literature. Again I learnt a lot from spending time with these men. Like some of the men I met on the ward, I was aware of my status as a male amongst a primarily female workforce.

Following that role, I have worked in different services with different client groups, but I always held an interest in EDs. When I received a place on clinical training I knew I wanted to experience working with this client group as a psychologist. In beginning to think about my research, I also knew I wanted my topic to focus on EDs and men. In developing my research idea, further attention was turned to thinking about the research methodology.

3.3. Choosing a Research Methodology

As I was interested in investigating men's experiences, a qualitative methodology seemed most appropriate. Initially I was apprehensive, as previously I had only completed quantitative research with experimental designs and statistical analysis. Broadly qualitative research represents a move away from this, with a focus on researchers engaging with the uniqueness of human everyday phenomena (Willig, 2013). While I value the role of quantitative research, I realised a qualitative approach was also more consistent with my role as a psychologist. For example, qualitative research is a way to better understand the intricacies of human social living and explore the diversity of life (Willig, 2013), and this is arguably also part of the role of a psychologist. Qualitative research captures these experiences in a way that quantitative methodologies often fail to (Willig, 2013).

There are a number of qualitative methods. In particular, Interpretive Phenomenological Analysis (IPA) is interested in exploring individuals' perceptions of an account, object or event (Smith & Osborne, 2004). This fitted the research question which was about exploring participants' subjective experience of living with an ED. This exploration felt appropriate, as there was a sense from the literature that they were unheard. During the interviews, I noticed a real willingness from participants to share their story.

When working clinically, part of the role of a psychologist is to understand and help clients make sense of their experiences. For me this mirrored the approach of IPA and drew me towards its use in research. Alongside this, I was drawn to the interpretivist elements that are inherent in IPA. Again this is an element that for me reflects the role of a psychologist. While qualitative methodology was appropriate to the question, IPA also felt like an approach that was consistent with my professional way of working.

Additionally, as part of clinical training we are asked to consider how our beliefs and history inform our clinical practice. In turn we are asked to reflect on how our practice shapes us. This mirrors the idea of reflexivity which is central to qualitative research. For example, Berger (2015) highlights that reflexivity is both thinking about what the researcher brings and taking responsibility for their position in research (Berger, 2015). Unlike the observer in quantitative research, the qualitative researcher is an active participant in the process. This is also reflected in the 'double hermeneutic' of IPA, where the researcher is working to make sense of the participants' experience as the participant themselves are doing the same (Smith &

Osborn, 2003; Smith, Flowers & Larkin, 2009). This generates a hermeneutic circle as the participant influences the researcher.

At the same time, I was aware of holding different aspects of the clinician and researcher as I embarked upon the process of undertaking a research project.

3.4. Clinician vs. Researcher

In thinking about the dual role of clinician and researcher, I have found the skills I have developed as a psychologist have aided me in using a qualitative methodology. For example, in carrying out interviews I was able to draw upon counselling skills to engage the client, such as attending to what they were saying. I was also able to sit with silence which gave the participant room to think. My hope was that this helped participants to feel comfortable enough to share their experiences.

Through clinical training, we are taught as psychologists to assess, formulate and intervene within our clinical work. These skills informed my questioning of participants. For example, I was able to structure questions in a way that draws information out. I was also aware of the tension between being a clinician and a researcher at these points, particularly in my first research interviews. Often assessment uses semi-structured interviews with the aim of trying to understand someone's psychological needs and determining appropriate intervention. My first research interviews felt like I was completing a psychological assessment. I was aware of reminding myself to just follow participant's experiences and not place a pre-existing framework around this.

At other times, I was aware there would be avenues of questioning I might pursue with someone in therapy, but feeling less certain of doing this in research. As a result, I sometimes held back in asking questions I may have asked in other settings. At certain times, when participants seemed to be struggling to articulate, I also named emotions or made an interpretation in a way I would do in therapy. This was about wanting to show participants that I was trying to understand and follow what they were telling me. At the same time, I was aware of reminding myself interviews were not therapy. Noticing and wrestling with this pulled me out of being present with participants. Once again I had to remind myself to just follow the participant's story. I found that when I did this it felt freeing and avenues to explore and follow came more naturally.

One thing that stood out for me was participants' willingness to share their experiences. I feel on one level this was because they wanted to raise awareness, but it may be that they wanted their experience heard. I also had a sense there was something cathartic for participants to share their stories. Whilst not therapy, there may have been something in completing the interview which was therapeutic for participants. I felt I wanted to honour participants' experiences and how it was reflected in the research. As such, the process of cutting out or editing quotes to ensure that I met the word count was difficult. I was aware of how much participants had given of themselves and I hope the research speaks to their experience.

Carrying out the research also informed my work as a clinician whilst I was on placement within an ED service. In particular, the research highlighted the struggle people have in holding on to and letting go of the ED. I found the clients I worked

with therapeutically also articulated this conflict and a lot of work that I did was in exploring this battle and being willing to sit with clients through this. It also highlighted that if clients are not in a place to let go of the ED, starting upon a therapeutic approach such as Cognitive Behavioural Therapy (CBT), which demands behavioural change, may not be a helpful first approach. It may be that it is more beneficial at that time to explore the conflict and what maintains the ED.

Additionally, throughout the process I was aware of some of the parallels between my experiences in completing the research and the themes raised by the participants. The remainder of this chapter will focus on some of these themes.

3.5. Research as All Consuming

One of the themes, which was present for the men who took part in the research was the all consuming nature of their ED. I drew parallels between this and my own experiences of completing the research. Working in the area of EDs and completing research was beneficial as I was able to immerse myself in the topic area. This helped me to situate myself in the world of EDs. However this meant that both work and outside of work were focused on thinking about EDs.

At the same time, the thesis started to feel like it was something I carried with me constantly, and it was always at the back of my mind. The thesis also started to take on a bigger and bigger significance. It is something I have worked for, but I began to see it as the thing which stands between me and being qualified. Due to this at times I felt it turned into something that I needed to conquer.

For me there were times when doubt and questions about being good enough crept in. I set expectations for myself that the research needed to be perfect. Interestingly themes of being good enough, needing to be perfect and setting high expectations were present in the clients that I worked with clinically, and with some of the men that took part in the research. In recognising this tendency in myself, I was able to re-evaluate and step back from the expectations I placed on myself.

An additional theme for participants was using the ED as a form of emotional regulation. Completing training and balancing this with producing research can be stressful. The process has made me think about how I deal with my own emotional difficulties. I have noticed that in facing difficulty I 'dig my heels in, put my head down and get on with things'. This belief has developed from my upbringing and the narrative around my own family's way of dealing with difficulty. In the main this has been adaptive for me, and has allowed me to be resilient and achieve my goals. However, I think alongside this it is important to acknowledge if I find things difficult. I admit sometimes I find this hard to do. On reflection this goes back to core beliefs around being able to cope, being perfect and being self-sufficient. I wonder if this also taps into rhetoric about being a man and what is expected of how a man deals with difficulty.

3.6. Letting Go

Participants' experiences highlighted the idea of letting go or holding on to the ED. In some ways I could relate to this as both part of the research process, but also in completing training. At this point, the thesis has been something that has been held for a number of years and now is the time to hand it over and step away. There is

something exposing in putting your work, and yourself, up to the scrutiny of others. At the same time, there is a sense of wanting to be done with it, to draw a line under it and distance yourself from it. Coming to the end of the process there is also a sense that the research has been possible to complete. If I consider the journey, it has moved from an avoidance to a 'facing up' to it. There have been battles along the way (ethics and recruitment), but I have fought these. Now I'm standing at the other side there is a sense that the grip is beginning to loosen and I can re-emerge into the world.

More broadly, completing the thesis also signifies the beginning of stepping away from being a trainee and thinking about life as a qualified psychologist. For all the challenges of training, there has been something about feeling you are safe and protected in this role. You also are with other people who are going through a similar experience so there is a sense of being on a shared journey. Part of me wants to hold onto all of these aspects and there will be a sense of loss for this. At the same time, I'm looking forward to stepping out into the unknown. Though apprehensive there is a sense of excitement for the future.

3.7. The Only Man

The theme of masculinity was something that was present for participants and I found, as a man, I could relate to this aspect. For participants, there was a sense they were often the only man. Psychology is a predominantly female profession and there are times when I am the only male. As the participants have articulated, this then marks you out as different. However, my experience is that this difference is

embraced. I wonder if, in this way men within the profession are treated as special and as such stand out in a way that benefits them.

At the same time, there are still gendered expectations of the role of healthcare professionals outside of the medical profession. It may be that there is an assumption that attributes of the role are predominantly associated with women. For example, caring, being empathic and listening. I have always identified with and found attributes such as these important. Similarly to some of the participants, I have also thought about my own masculinity and can identify on some level with themes of not feeling like a typical man. As a teenager, I was aware of feeling like I did not meet cultural expectations of what a man is. For example, growing up I was never 'sporty' and I do not like team games, either playing or watching. I have also tended to have more female friends. Drummond (2002) highlights how in Western culture, sport and physical activity are perceived as being masculine areas. In addition Drummond (2002) proposes the idea that boys are socialised to view certain sports or activities as a rite of passage into manhood. For boys that do not take part in perceived masculine sports, this can act as an indication of their difference and lead to a marginalisation by peers. However, I always felt my parents encouraged my interests and there was never an expectation I should like or participate in certain activities. This helped me feel comfortable with my identity and myself as a male and the idea that not everyone is the same.

Completing the research has also made me think about the construct of masculinity. In thinking about maleness and masculinity, I feel that these are separate constructs. For me, maleness refers to biological makeup whereas masculinity and femininity

exist on a continuum and are not determined by sex. Therefore, I feel that I can hold a number of different attributes. Additionally, I feel that as I was growing up societal views of masculinity have changed. I think of people in the public eye, such as David Beckham, who seem comfortable to hold different attributes. On one hand there is a sense that it is more acceptable to be interested in things that in the past may have been deemed typically feminine, such as fashion. However, on the other hand I wonder if it is only acceptable to show these attributes if typically masculine attributes are also held alongside this, such as excelling in sport.

I have also thought about myself as a male in carrying out research and what it was like for the participants to be interviewed by a man. I noted at times the language used by participants included swearing and one of the themes was ‘this has got you by the balls’. It may be as a male interviewer there was a shared understanding between men of how uncomfortable this would be and was a way to articulate the grip of the ED. I wonder if this language would have been used if the researcher were female.

I have also thought about myself as a male clinician working primarily with female clients and what this is like for them. I am reminded of research which points to other attributes being more important. For example, Bhati (2014) highlights gender becomes less important when other factors are taken into account. For example, the quality of the therapeutic relationship (Vosciano et al., 2004). There was sense that this was mirrored for participants in their experiences of treatment.

3.8. Conclusion

Completing the research has highlighted the importance of the place research holds within clinical psychology. In the context of my own research, this has been linked to raising awareness in underrepresented populations and why clinically it is important this is done. For me, this is one of the benefits of qualitative research in that it gives voice to these experiences. I hope my research has been able to do this for the men who were willing to take part. While there can sometimes be a tension between the role of clinician and researcher, the skills that are gained through training leave psychologists well placed to carry out research. Completing the research has also allowed me to think about what I bring as a researcher and how the experience has shaped me. While the process has, at times, felt consuming it has offered opportunity for personal reflection and learning. On some level, I identified with the participants' experiences, particularly in terms of thinking about masculinity. As I let go of the research and my role as a trainee and move towards life as a qualified psychologist, I will take this experience with me.

3.9. References

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Appendix A: Instructions to authors for submission to the European Journal of Eating Disorders

European Eating Disorders Review

© John Wiley & Sons Ltd and Eating Disorders Association

Edited By: Professor Fernando Fernandez-Aranda

Impact Factor: 2.461

ISI Journal Citation Reports © Ranking: 2014: 33/119 (Psychology Clinical)

Online ISSN: 1099-0968

Author Guidelines

Manuscript Submission

From now on all submissions to the journal must be submitted online at <http://mc.manuscriptcentral.com/erv>. Full instructions and support are available on the site and a user ID and password can be obtained on the first visit. If you require assistance then click the Get Help Now link which appears at the top right of every ScholarOne Manuscripts page. If you cannot submit online, please contact Maurine Balansag in the Editorial Office (EEDRedoffice@wiley.com).

Illustrations must be submitted in electronic format. Save each figure as a separate file, in TIFF or EPS format preferably, and include the source file. We favour dedicated illustration packages over tools such as Excel or Powerpoint. Grey shading (tints) are not acceptable. Lettering must be of a reasonable size that would still be clearly legible upon reduction, and consistent within each figure and set of figures. Supply artwork at the intended size for printing. The artwork must be sized to the text width of 7 cm (single column) or 15 cm (double column).

Manuscript style. All submissions, including book reviews, should be double-spaced and clearly legible.

The first page should contain the title of the paper, full names of all authors, the address where the work was carried out, and the full postal address including telephone, fax number and email to whom correspondence and proofs should be sent. The name(s) of any sponsor(s) of the research contained in the paper, along with grant number(s) should also be included.

The second sheet should contain an abstract of up to 150 words. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work. **Include up to five keywords that describe your paper for indexing purposes.**

- **Research articles** reporting new research of relevance as set out in the aims and scope should not normally exceed 6000 words with no more than five tables or illustrations. They should conform to the conventional layout: title page, summary, introduction, materials and methods, results, discussion, acknowledgements and references. Each of these elements should start on a new page. Authors may not find it necessary to use all of these subdivisions, and they are listed here only as a guide.
- **Review articles** should offer a synthesis of current knowledge in a field where rapid or significant progress has been made. The text should ideally not exceed 7000 words, 50 references and 5 figures or tables.
- **Brief reports** should concisely present the essential findings of the author's work and be comprised of the following sections: Abstract, Introduction and Aims, Method, Results, Discussion, and References. Tables and/or figures should be kept to a minimum, in number and size, and only deal with key findings. In some cases authors may be asked to prepare a version of the manuscript with extra material to be included in the online version of the review (as supplementary files). Submissions in this category should not normally exceed 2500 words in length.

Brief reports bring with them a whole host of benefits including: quick and easy submission, administration centralised and reduced and significant decrease in peer review times, first publication priority (this type of manuscript will be published in the next available issue of the journal).

Case Reports. The journal does not accept case reports for publication. Authors of case reports are encouraged to submit to the Wiley Open Access journal, Clinical Case Reports www.clinicalcasesjournal.com which aims to directly improve health outcomes by identifying and disseminating examples of best clinical practice.

Reference style. The APA system of citing sources indicates the author's last name and the date, in parentheses, within the text of the paper.

Appendix B: Quality Assessment Framework

Caldwell, Henshaw and Taylor (2005; 2011)

All studies were scored against 18 quality criteria and for each criterion studies were rated as 0 if the criterion was not met, 1 if the criterion was partially met and 2 if the criterion was fully met. The rating for each article was calculated by adding the scores for all 18 criteria, so that each article would receive a score between 0 and 36. It was proposed that papers which scored below the midpoint of 18 would be excluded as not reaching a satisfactory level of rigour in terms of the quality assessment framework.

Criteria

1. Does the title reflect the content?
2. Are the authors credible?
3. Does the abstract summarise the key components?
4. Is the rationale for undertaking the research clearly outlined?
5. Is the literature review comprehensive and up to date?
6. Is the aim of the research clearly stated
7. Are all ethical issues identified and addressed?
8. Is the methodology identified justified?
9. Is the study design clearly identified, and is the rationale for choice of design evident?

10. Is there an experimental hypothesis clearly stated? Are the key variables clearly defined?
11. Is the population identified?
12. Is the sample adequately described and reflective of the population?
13. Is the method of data collection valid and reliable?
14. Is the method of data analysis valid and reliable?
15. Are the results presented in a way that is appropriate and clear?
16. Are the results generalisable?
17. Are the results transferable?
18. Is the conclusion comprehensive?

Appendix C: Instructions to authors for submission to the British Journal of Psychology

British Journal of Psychology

© The British Psychological Society

Edited By: Stefan R. Schweinberger

Impact Factor: 2.254

ISI Journal Citation Reports © Ranking: 2014: 28/129 (Psychology Multidisciplinary)

Online ISSN: 2044-8295

Author Guidelines

The Editorial Board of the British Journal of Psychology is prepared to consider for publication:

- a. Reports of empirical studies likely to further our understanding of psychology
- b. Critical reviews of the literature
- c. Theoretical contributions Papers will be evaluated by the Editorial Board and referees in terms of scientific merit, readability, and interest to a general readership. All papers published in The British Journal of Psychology are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 8000 words (excluding the abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Submission and reviewing

All manuscripts must be submitted via Editorial Manager. The Journal operates a policy of anonymous (double blind) peer review. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review to avoid unnecessary delays. Before submitting, please read the terms and conditions of submission and the declaration of competing interests. You may also like to use the Submission Checklist to help you prepare your paper.

4. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. A template can be downloaded from [here](#).
- The main document must be anonymous. Please do not mention the authors' names or affiliations (including in the Method section) and refer to any previous work in the third person.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript but they must be mentioned in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labeled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi. All figures must be mentioned in the text.
- All articles should be preceded by an Abstract of between 100 and 200 words, giving a concise statement of the intention, results or conclusions of the article.
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.

Appendix D: Ethical Approval from Coventry University



Certificate of Ethical Approval

Student:

Marc Deeming

Project Title:

Exploring Men's Experiences of the Development, Function and Maintenance of an Eating Disorder

This is to certify that the above named student has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Medium Risk

Date of approval:

08 February 2015

Project Reference Number:

P28950

Appendix E: Ethical Approval from the NHS Research Committee



Health Research Authority

NRES Committee West Midlands - Coventry & Warwickshire

The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 883 9525

20 April 2015

Mr Marc Deeming

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Dear Mr Deeming

Study title:	Exploring Men's Experiences of the Development, Function and Maintenance of an Eating Disorder
REC reference:	15/WM/0106
Protocol number:	n/a
IRAS project ID:	169765

Thank you for your submission of 16 April 2015, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the REC Manager.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager, Tracy Leavesley, NRESCommittee.WestMidlands-CoventryandWarwick@nhs.net Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the

start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance]	1	26 February 2015
GP/consultant information sheets or letters [Letter to clinician version 2]	2	04 April 2015
Interview schedules or topic guides for participants [Interview schedule]	1	02 February 2015
IRAS Checklist XML [Checklist_16042015]		16 April 2015
Letter from sponsor [Coventry ethics]	1	26 February 2015
Participant consent form [Participant consent]	2	04 April 2015
Participant information sheet (PIS) [Debrief sheet]	1	02 February 2015
Participant information sheet (PIS) [Participant Information Version 2]	2	04 April 2015
REC Application Form [REC_Form_16042015]		16 April 2015
Research protocol or project proposal [Research Proposal]	1	06 October 2014
Summary CV for Chief Investigator (CI) [CV]	1	02 February 2015
Summary CV for supervisor (student research) [Supervisor CV]	1	02 February 2015

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:

<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

15/WM/0106

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely



Dr Helen Brittain
Chair

Email: NRESCommittee.WestMidlands-CoventryandWarwick@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Professor Ian Marshall*

Ms Natassia Embury, Coventry and Warwickshire Partnership Trust

Appendix F: Ethical Approval from Coventry and Warwickshire Partnership Trust Research and Development

Coventry and Warwickshire Partnership Trust

National Institute for Health Research Clinical Research Network: West Midlands
Fourth Floor, Rotunda (ADA40014)
University Hospitals Coventry & Warwickshire NHS Trust
University Hospital
Clifford Bridge Road
Coventry CV2 2DX

13 August 2015

Mr Marc Deeming
Clinical Psychologist
c/o Coventry University
Priory Street
Coventry CV31 5FB

Dear Marc

Project Title: Exploring men's experience of the development of an eating disorder

R&D Ref: CWPT0008/RS

REC Ref: 15/WM/0106

IRAS Ref: 169765

I am pleased to inform you that the R&D review of the above project is complete, and NHS permission has been granted for the study at Coventry and Warwickshire Partnership NHS Trust. The details of your study have now been entered onto the Trust's database.

The permission has been granted on the basis described in the application form, protocol and supporting documentation. The documents reviewed were:

Document	Version	Date
REC Favourable Opinion Letter		20/04/2015
Protocol	1	06/10/2014
Participant Information Sheet	2	04/04/2015
Participant Information Sheet – Debrief	1	02/02/2015
Consent Form	2	04/04/2015
GP Letter	2	04/04/2015
Interview Schedule	1	02/02/2015

All research must be managed in accordance with the requirements of the Department of Health's Research Governance Framework (RGF), to ICH-GCP standards (if applicable) and to NHS Trust policies and procedures. Permission is only granted for the activities agreed by the relevant authorities.

All amendments (including changes to the local research team and status of the project) need to be submitted to the REC and the R&D office in accordance with the guidance in IRAS. Any urgent safety measures required to protect research participants against immediate harm can be implemented immediately. You should notify the R&D Office within the same time frame as any other regulatory bodies.

It is your responsibility to keep the R&D Office and Sponsor informed of all Serious Adverse Events. All SAEs must be reported within the timeframes detailed within ICH-GCP statutory instruments and EU directives.

In order to ensure that research is carried out to the highest governance standards, the Trust employs the services of an external monitoring organisation to provide assurance. Your study may be randomly selected for audit at any time, and you must co-operate with the auditors. Action may be taken to suspend Trust approval if the research is not run in accordance with RGF or ICH-GCP standards, or following recommendations from the auditors.

You will be sent an annual progress report which must be completed in order to ensure that the information we hold on our database remains up to date, in line with RGF requirements.

I wish you well with your project. Please do not hesitate to contact me should you need any guidance or assistance.

Yours sincerely



Louise Alston
Senior Research Support Facilitator
CRN West Midlands
Tel: 01902 447202
Email: l.alston@nhs.net

cc: *J Knibs, Academic Supervisor*
Professor I Marshall, Sponsor Rep.
Dr K Goss/Dr K Herbert, Service Lead
K Wright, R&D Manager

Appendix G: Interview Schedule

General Introductions. Researcher informs the participant that they are interested in hearing their experience.

1. When would you say your problems with eating began?

Prompts: What was it like? How did you feel? What was happening at the time?

2. How did you experience the development of your eating disorder?

Prompts: What was it like? How did you feel? What was happening at the time? What do you think led you to develop an eating disorder? (Media, family, peers, identity, sexuality). In what way/how did these factors contribute? Did others notice? What was this like?

3. What is it like to live with an eating disorder as a man?

4. In your experience what role did the eating disorder play in your life?

Prompts: In what way was your life affected? Were there any benefits to the eating disorder? How did the eating disorder help?

Were there any difficulties that arose from the eating disorder for you? (Relationships, work, school, home life, physical difficulties). What was this like?

What kept the eating disorder going?

5. Did your feelings towards the eating disorder change over time? What was that like?

Prompts: was there a point when it was experienced as a problem? What was that like?

6. As a man what are your experiences of treatment?

Prompts: experiences of diagnosis, experiences of receiving treatment experiences of professionals

7. How do you experience the eating disorder now?

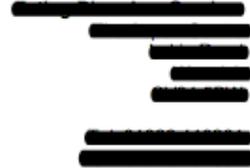
Prompts: What role does the eating disorder play now for you? (What are the benefits/consequences)

General prompts for probing deeper: Can you tell me more? What was that like? How did you feel? What were you thinking?

Appendix H: Participant Information Sheet

Version 2

Coventry and Warwickshire Partnership NHS Trust ^{4/4/15}
NHS Trust



Participant Information Sheet

Invitation to take part in a research study

Study Title: Exploring Men's Experience of the Development, Function and Maintenance of an Eating Disorder

Hello,

My name is Marc Deeming and I am a trainee clinical psychologist studying on the Doctorate Course in Clinical Psychology at the Universities of Coventry and Warwick. I would like to invite you to be part of some research I am carrying out. Before you make a decision about whether you would like to be involved I would like to give you some information about the research and what is involved should you wish to take part.

Please read the following information carefully:

What is the research looking at?

The research is looking to explore men's experience of the development of an eating disorder. In addition the study is interested in looking at the part that an eating disorder plays in a mans life and what things may maintain an eating disorder in men. This is important, as research into men's experiences is limited. It is hoped that by developing an understanding of the development; function and maintenance of eating disorders in males that this could help to inform decisions regarding treatment interventions.

Philip Bushill-Matthews – Interim Chair
Rachel Newson – Chief Executive

Coventry & Warwickshire Partnership NHS Trust
Wayside House, Wilsons Lane, Coventry, CV6 6NY
Tel: 024 7636 2100 Fax: 024 7636 8949
www.covwarkpt.nhs.uk



in partnership with:



Why have I been chosen?

All male clients who have input and support from [REDACTED] have been asked if they would like to participate in this research.

In addition males who have identified as willing to be contacted for research through the charity BEAT have been contacted.

Do I have to take part?

Participation is entirely voluntary and has no impact on the treatment you receive from the eating disorder service.

What is involved in taking part in the study?

If you choose to participate, I will arrange a time to come and meet with you for an interview. If you are receiving support from the NHS services listed above the interview will take place at the service that you are linked to at a time that is convenient for you. If you are contacted through BEAT I will contact you to arrange a meeting place for the interview that is convenient for you. It is expected that the interview will last approximately one hour. Prior to the interview I will go through information about the study and you will have an opportunity to ask any questions. Following this I will ask you to sign a consent form to say you agree to being interviewed.

As part of the interview I will ask you some questions about developing an eating disorder and its impact on your life, but I am most interested to hear about your story and experiences. You will be able to stop the interview at any time that you wish. With your permission the interview will be audio recorded.

What are the possible risks of taking part?

I acknowledge that talking about your experiences may be upsetting, as it is a sensitive topic. It is important to note that you do not have to disclose any information that you are uncomfortable sharing. You are also free to stop the interview at any time.

Following the interview time will be available to answer any questions you may have. Should you feel it is necessary details of support services will be provided.

Philip Bushill-Matthews – Interim Chair
Rachel Newson – Chief Executive

Coventry & Warwickshire Partnership NHS Trust
Wayside House, Wilsons Lane, Coventry, CV6 6NY
Tel: 024 7636 2100 Fax: 024 7636 8949
www.covwarkpt.nhs.uk



in partnership with:



Can I withdraw from the research?

You are free to stop the interview at any time. If you wish to withdraw part or all of your data from the study after the interview please contact me before 31st January 2016 and data from your interview will be removed. You do not have to provide a reason for withdrawing from the study.

What will happen to my interview?

After the interview I will make detailed notes from the audio recording. Only myself and the other members of the research team will have access to your recording. This will be kept confidential and the recording will be kept in a secure location. When writing up the study quotations from the interview may be used. However the information gathered will use false names and will not be attributable to you. A copy of your transcript can be made available if you wish to see it by contacting the main researcher.

Confidentiality

Everything you say in the interview will be kept confidential and used solely for purpose of the research. All participants will be assigned a participant code and all information they provide will be identified by this. Only myself and the responsible clinician at the service will know the names and contact details of participants. There are circumstances in which confidentiality may be broken. For example, if the researchers have concerns about your safety or the safety of others. If concerns are raised the researcher will attempt to discuss these concerns with you before breaking confidentiality. The detailed notes from interview will be made anonymous. It is likely that this anonymous data will be shared with the other researchers in the team and parts with a peer supervision group to ensure reliability of analysis. Relevant sections of anonymous interview data may be looked at by individuals from Coventry University, regulatory authorities or from the NHS Trust. All data will be made anonymous promptly after its collection.

How will my interview data be stored?

All data will be stored in locked cabinets at the NHS sites or Coventry University. Any electronic data will be kept on encrypted memory devices and also kept in locked cabinets at these sites. Once the study is complete, your name and contact details will be destroyed. Anonymous data which will include demographic information and interview transcripts will be kept securely at Coventry University for 5 years after which they will be destroyed.

Philip Bushill-Matthews – Interim Chair
Rachel Newson – Chief Executive

Coventry & Warwickshire Partnership NHS Trust
Wayside House, Wilsons Lane, Coventry, CV6 6NY
Tel: 024 7636 2100 Fax: 024 7636 8949
www.covwarkpt.nhs.uk



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What will happen to the results of this study?

It is hoped that the findings of the study will be submitted for publication in a peer reviewed journal. A final report will be submitted to the Universities of Coventry and Warwick as part of my doctorate course. In addition the findings will be presented to the Eating Disorder Service in Coventry and Warwickshire. A summary of the findings will be available to you should you want it.

Who has reviewed the study?

The research has been reviewed by the Coventry University Research Ethics Committee and the NHS Research Ethics Committee.

What if something goes wrong?

If you have concerns about how the study was conducted you may wish to contact the Patient Advice and Liaison Service (PALS) who offer confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers. The contact details are: PALS, City Of Coventry Health Centre, Stoney Stanton Road, Coventry, West Midlands CV1 4FS Tel: 0800 212 445

Who is the research team/who can I contact?

Chief Investigator: Marc Deeming, Trainee Clinical Psychologist. Clinical Psychology Doctorate, Coventry University, James Starley Building, Coventry, CV1 5FB. Tel: 02476 888328. Email: deemingm@uni.coventry.ac.uk

Research Supervisor: Dr Kate Herbert, Clinical Psychologist, The Aspen Centre, Lakin road, Warwick, CV34 5BW. Tel. 01926 41028

Research Supervisor: Ms. Jacky Knibbs, Consultant Clinical Psychologist, Clinical Psychology Doctorate. Coventry University, James Starley Building, Coventry, CV1 5FB. Tel: 02476 888328

Research Supervisor: Dr. Sarah Simmonds, Chartered Clinical Psychologist and Clinical Tutor. Research Tutor, Clinical Psychology Doctorate. Coventry University, James Starley Building, Coventry, CV1 5FB. Tel: 02476 888328

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Appendix I: Participant Consent Form

4/4/15

Version 2

Coventry and Warwickshire Partnership 
NHS Trust



Centre Number:

Study Number:

CONSENT FORM

Title of Project: **Exploring Men's Experience of the Development, Function and Maintenance of an Eating Disorder**

Name of Researcher: Marc Deeming, Trainee Clinical Psychologist

Please initial box

1. I confirm that I have read the information sheet dated 4/4/15 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. I understand if following the interview I change my mind about all or part of my data being used in the study I should contact the main researcher before 31st January 2016 using the contact details provided on the participant information sheet.
3. I understand that relevant sections of my data (made anonymous) collected during the study, may be looked at by individuals from Coventry University, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.

When completed: 1 for participant; 1 for researcher site file; 1 (original) to be kept in medical notes.

4/4/15

Version 2

4. I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers. I will not be identifiable from any published findings.
5. I agree to my Primary Clinician Practitioner being informed of my participation in the study.
6. I understand that information I share in the interview will be treated in confidence with the exception of circumstances where the researchers have concerns for my safety or the safety of others
7. I give permission for my interview to be audio recorded and transcribed and have been made aware that I can request to see a copy of my transcript.
8. I understand that all my data with the exception of personally identifiable data and contact details will be stored securely for the duration of the study. In addition this data will be kept securely for a further 5 years at Coventry University before it is destroyed. Personal and contact details will be destroyed as soon as analysis is complete.
9. I agree to take part in the above study.

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

When completed: 1 for participant; 1 for researcher site file; 1 (original) to be kept in medical notes.

Appendix J: Participant Debrief Sheet

Version 1

2/2/15

Participant Debrief Sheet

Project title: Exploring Men's Experience of the Development, Function and Maintenance of an Eating Disorder

Researcher: Marc Deeming, trainee clinical psychologist, Clinical Psychology Doctorate, Universities of Coventry and Warwick.

Thank you for taking the time to participate in the research interview. The research is looking to explore men's experience of the development of an eating disorder. In addition the study is interested in looking at the part that an eating disorder plays in a man's life and what things may maintain an eating disorder in men.

If taking part in the study has raised any personal issues or feelings of distress you are encouraged to access support. This may include contacting your clinician at the base at which you receive treatment. You may also wish to contact your local G.P. In addition you could to contact BEAT. Contact details are below:

BEAT

www.b-eat.co.uk

**Helplines: Monday and Wednesday from 12 noon to 8.30pm
Tuesday, Thursday and Friday from 12 noon to 5pm.**

The Beat Adult Helpline is open to anyone over 18

Helpline: 0345 634 1414
Email: help@b-eat.co.uk

If you are 25 or under, you can call the Beat Youthline.
Youthline: 0345 634 7650

What happens now?

I will make detailed notes from the audio recording. Only myself and the other members of the research team will have access to your recording. This will be kept confidential and the recording will be kept in a secure location. When writing up the study quotations from the interview may be used. However the information gathered will use false names and will not be attributable to you. A copy of your transcript can be made available if you wish to see it by contacting the main researcher.

Can I withdraw my data from the study?

If you wish to withdraw part or all of your data from the study please contact me before 31st January 2016 and data from your interview will be removed. You do not have to provide a reason for withdrawing from the study.

Confidentiality

Everything you have said in the interview will be kept confidential and used solely for purpose of the research. All participants will be assigned a participant code and all information they provide will be identified by this. Only myself and the responsible clinician at the service will know the names and contact details of participants. There are circumstances in which confidentiality may be broken. For example, if the researchers have concerns about your safety or the safety of others. If concerns are raised the researcher will attempt to discuss these concerns with you before breaking confidentiality. The detailed notes from interview will be made anonymous. It is likely that this anonymous data will be shared with the other researchers in the team and parts with a peer supervision group to ensure reliability of analysis. Relevant sections of anonymous interview data may be looked at by individuals from Coventry University, regulatory authorities or from the NHS Trust. All data will be made anonymous promptly after its collection.

How will my interview data be stored?

All data will be stored in locked cabinets at the NHS sites or Coventry University. Any electronic data will be kept on encrypted memory devices and also kept in locked cabinets at these sites.

Once the study is complete, your name and contact details will be destroyed. Anonymous data which will include demographic information and interview transcripts will be kept securely at Coventry University for 5 years after which they will be destroyed.

What will happen to the results of this study?

It is hoped that the findings of the study will be submitted for publication in a peer reviewed journal. A final report will be submitted to the Universities of Coventry and Warwick as part of my doctorate course. In addition the findings will be presented to the Eating Disorder Service in Coventry and Warwickshire. A summary of the findings will be available to you should you want it.

Who has reviewed the study?

The research has been reviewed by the Coventry University Research Ethics Committee and the Coventry and Warwickshire NHS Research Ethics Committee.

Who is the research team/who can I contact?

Chief Investigator: Marc Deeming, Trainee Clinical Psychologist. Clinical Psychology Doctorate. Coventry University, James Starley Building, Coventry, CV1 5FB. Tel: 02476 888328. Email: deemingm@uni.coventry.ac.uk

Research Supervisor: Dr Kate Herbert, Clinical Psychologist, The Aspen Centre, Lakin road, Warwick, CV34 5BW. Tel. 01926 41028

Research Supervisor: Ms. Jacky Knibbs, Consultant Clinical Psychologist, Clinical Psychology Doctorate. Coventry University, James Starley Building, Coventry, CV1 5FB. Tel: 02476 888328

Research Supervisor: Dr. Sarah Simmonds, Chartered Clinical Psychologist and Clinical Tutor. Research Tutor, Clinical Psychology Doctorate. Coventry University, James Starley Building, Coventry, CV1 5FB. Tel: 02476 888328

Appendix K: Stages of IPA Analysis (Smith, Flowers and Larkin, 2009)

1. The first step required immersion in the data which was achieved through the reading and rereading of the transcript. Additionally, the audio recording of the data was listened to repeatedly in order to further facilitate immersion in the data.
2. The second stage is initial noting which involved descriptive summarising of the transcript. The aim of this stage of analysis is to produce a clear, comprehensive and detailed set of notes on the data. This was recorded in the left hand margin of the transcript in black pen. The data was then be analysed again in an interpretative way which involved thinking about what it means for the participant to have said what they have said. This was recorded in the left hand margin in red pen. Linguistic coding was also recorded in the left hand margin in green pen. This explored the use of language by the participant.
3. The third stage of IPA involves the identification of emergent themes within the data. Interpretations of the narrative were incorporated into the emergent themes. These were recorded on the left hand margin of the transcript.
4. The fourth stage then looks at how the emergent themes fit together. This provides a structure outlining the most interesting and important aspects of the participant's account. In order to facilitate this, the researcher printed a list of themes for the participant and cut these up so that there was one theme per piece of paper. This allowed the researcher to move themes around and group them together. This helped to develop super-ordinate and subordinate themes for the participant.

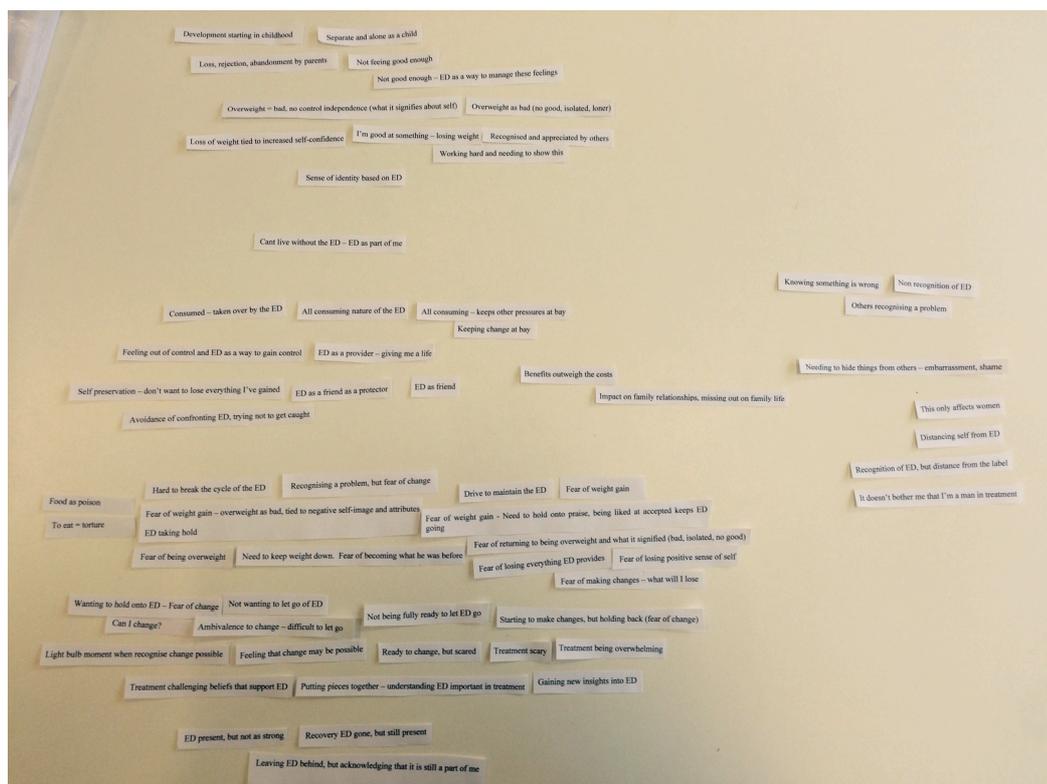
5. The researcher then moved onto the next participant's transcripts and repeated stages 1-4.
6. The final stage of analysis asks the researcher to identify patterns and connections across the data as a whole. To support this process each participants emergent themes were printed in a different colour font, cut up and grouped. This supported comparison between participants sub themes. Based on grouping of sub themes final super-ordinate themes were developed. The researcher then examined the final themes to check if they represented the data set. The results of the analysis were then presented in a table. To demonstrate each theme direct quotes from all participants were used.

Appendix L: Excerpt of Analysed Transcript

348
349 I: mmm
350
351 erm and how so I suppose the more and more I
352 read up about it the illness the more and more,
353 these things about two year recoveries and
354 thinking actually maybe this isn't going to be
355 that easy. The more the illness probably got
356 chance to entrench itself, because I got a
357 diagnosis...
358
359 I: mmm
360
361 but I didn't see a therapist then for about three
362 or four months so in that time once I'd come
363 back from [redacted] it was just basically me and
364 my head erm stuck in it so I tried to get involved
365 in the college work, didn't really enjoy it, didn't
366 really make any friend so it was just basically
367 just me and my head, 24 hours a day (laughs)
368 which at that point was probably not a very
369 helpful place to be, but erm and even though I
370 knew that I had to put on weight and that the
371 only way to do that was not to exercise and eat
372 stuff it was really, really difficult to eat at that
373 point
374
375 I: mmm
376
377 erm because again there was that fear that was
378 building up and building up and the thought that
379 that first step would just lead onto my weight to
380 ballooning like hell..... So every day I woke up
381 with the feeling that today would be the day that
382 I would make that first step
383
384 I: mmm
385
386 and by the end of it I just got on the scales,
387 noticed nothing had changed and went to bed
388 happy I suppose.
389
390 I: and how long would you say that cycle carried
391 on for?
392
393 err well as I say I didn't get a therapist
394 appointment for, got diagnosed in the October
395 and don't think I saw a therapist until the
396 January so ...
397

Handwritten notes:
 - 348-357: Becoming a specialist in ED, the ED is to be feared, the struggle is over.
 - 357-358: more time thinking about ED, maybe it won't be easy to manage, more time to rationalise/get control in ED?
 - 358-360: sense of taking control, entering myself?
 - 360-361: No immediate treatment
 - 361-368: Not enjoying it, not making friends, me and my thoughts all day, ED becoming focus at expense of other exercises
 - 368-374: Conflict of letting go and keeping ED -> benefits? way to avoid? if eat focus on any else?
 - 374-381: Fear that making first step would have negative consequences, keeping trapped in cycle of ED?
 - 381-386: If weight hadn't changed he wouldn't walk away with weight = good with weight = bad?
 - 386-390: waiting for treatment, recent weight gain?
 - 390-397: weight need to self-conception?

Appendix M: Map of emergent themes for one participant



Appendix N: Super-ordinate and subordinate themes for one participant

Super-ordinate Theme	Subordinate theme
ED taking hold	Non-recognition A way to manage emotional difficulty Sense of self tied to the ED Only affects women
Taken over	It's a friend Hiding: Shame/embarrassment? Missing out: loss?
Breaking the cycle	Fear of change Gone, but still there Understanding ED

Appendix O: Map of emergent themes across participants

The process of mapping themes across participants

