

**An exploration of body confidence and recovery in relation to the
client with an eating disorder: meaning and importance for
therapeutic alliance**

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Thesis Abstract

Purpose and Background

This mixed methods study explored the importance of therapist body-confidence and gender upon the Eating Disordered client and recovery. Examination of previous literature highlighted a lack of research exploring negative treatment experiences from the perspective of individuals who have an Eating Disorder. With reference to socio-cultural theoretical models, initial findings in the literature indicate that aspects of therapist appearance may be an important factor in treatment experience. The potential sensitivity of exploring therapist appearance is considered as one reason that this topic remains largely unexplored in the literature.

Method

143 males and females with self-reported current or historical experience of an Eating Disorder completed an anonymous, online survey which was designed by the authors for the purpose of the study. Questions exploring body-confidence and recovery were analysed using Thematic Analysis incorporating Saliency Analysis. Questions pertaining to therapist gender and body-confidence were analysed using statistical tests. Rationale is provided for the epistemological stance, methodological approach and design of the current study.

Results

Thematic Analysis revealed three overarching themes about body-confidence and three overarching themes about recovery. The body-confidence themes suggested that individuals who have an ED progress along a continuum of beliefs about body-confidence, initially believing that it is linked to body-size, before acknowledging that their Eating Disorder is unrelated to body-confidence and finally realising that body-confidence is possible regardless of size. The recovery themes indicated that individuals who have an ED go through a cycle where they feel restricted, begin to reconcile self and culture and achieve resilience on the path to recovery. Statistical analysis revealed that participants rated therapist body-confidence

as highly important and showed a strong preference for a gender-same therapist. There was also some indication that participants judged the body-confidence of male and female therapists differently, although the effect size of this finding was small. The results are discussed within the context of previous literature and in keeping with the epistemological position of the current study.

Conclusions

These findings offer further support for the continued investigation of therapist appearance, in particular body-confidence and gender, and how it might impact upon the therapeutic experience of Eating Disordered clients. Further contribution is the addition of the perspective of individuals who have an Eating Disorder to the literature about recovery from an Eating Disorder. There are important implications for services, how they are organised and how therapists are trained to work with this population. Future research should further explore the ways in which aspects of therapist appearance impact upon therapeutic experience for Eating Disorder clients and whether there are mediating factors. Finally, the principle researcher's critical reflection about theoretical, scientific and ethical aspects of the research process is provided.

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Statement of Contribution

Project Design:	Emma Rodgers with supervision from Louise Braham
Survey Design:	Emma Rodgers with supervision from Louise Braham and advice from members of First Steps Derby
Applying for Ethical Approval	Emma Rodgers with supervision from Louise Braham
Writing the review of the literature	Emma Rodgers with supervision from Louise Braham and Danielle de Boos
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SYSTEMATIC REVIEW

**What therapeutic factors are important for positive outcome for clients
with an eating disorder: A systematic review**

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THERAPEUTIC FACTORS FOR POSITIVE OUTCOME FOR ED

Abstract

Objective: Poor outcome in the treatment of eating disorders is costly for healthcare provision and confers poor prognosis for individuals receiving treatment. Positive outcomes have been linked to therapeutic factors in the wider psychotherapy literature. This review aimed to identify therapeutic factors important for positive outcome for individuals with an eating disorder. Additionally, no consensus definition of positive outcome from eating disorder treatment exists. Therefore, assessment of outcome was considered in the context of the current focus on recovery in mental health services in the UK.

Method: A systematic search of online databases and reference lists was conducted in July 2013. All articles were considered and screened against a priori inclusion/exclusion criteria and appraised for quality. The therapeutic factors and treatment outcome were examined across ten studies.

Results: Therapeutic factors important for positive outcome were therapeutic alliance, supportiveness, collaboration, confidence in therapist and acceptance or feeling respected by the therapist. Important therapist characteristics were empathy, understanding, interest and trustworthiness. Treatment outcome focused upon weight gain or reduction in eating disorder pathology immediately following treatment. The studies did not consider long-term outcome.

Discussion: Therapeutic factors identified as important for positive treatment outcome for individuals with an eating disorder are in keeping with those identified in the broader psychotherapy literature. Neglected were factors that might disrupt the effectiveness of important therapeutic factors. Treatment outcome measurement narrowly focuses upon improvement in physical or behavioral symptoms and fails to account for psychological or social impact of an eating disorder upon the individual.

What therapeutic factors are important for positive outcome for clients with an eating disorder? A systematic review

Eating disorders (ED) are complex mental disorders with a poor prognosis; over 50% of individuals with an ED are likely to develop a chronic disease¹. ED is the third leading cause of illness in young females². Though more common in females (gender ratio of 4:1³), males account for 10% of anorexia nervosa (AN) and 15% of bulimia nervosa (BN) populations^{4,5}. Prevalence of ED in the UK is high; 1,400 people per 100,000 suffer from an ED that interferes with their life⁶. The overall cost to healthcare for treating ED in England is £1.26 billion per year⁶.

Treatment outcome

Poor treatment outcome is well documented. Treatment satisfaction is low⁷ and typical dropout rate from outpatient treatment may be as high as 70%⁸, leading to high rates of repeated admission for inpatient treatment⁹. However, there is limited understanding of the process of recovery^{10,11} and the therapeutic ingredients that lead to positive outcome¹. There is a lack of consensus across studies about what constitutes a good treatment outcome. Many treatment programmes focus on weight gain and the reduction of behaviours associated with the ED, such as restrictive eating patterns, or bingeing and purging behaviours. Targeting weight loss and behaviors associated with the ED risks oversimplifying the nature of the ED. Individuals who suffer from an ED experience major psychological, social and economic consequences as well as medical complications¹². Treatment focussing upon weight gain may not achieve long-term positive outcome for the individual; lingering concerns about shape and weight predict relapse¹³. Relapse rates are high, ranging between 30-63%¹². Therefore, weight gain and reduction in behaviours associated with the ED does not necessarily convey remission or recovery.

In general, remission is taken to mean free from symptoms¹⁴. Recovery is a state distinguished from remission by time-frame; the individual must have been free from symptoms for long enough that the ED

can be considered over¹⁴. The psychosocial construct of recovery encompasses all aspects of 'successful living' such as self-esteem, empowerment and quality of life¹⁵. This construct is reflected in the reports of individuals with an ED, who value treatment with a focus upon self-esteem and positive body image. Therefore, a focus upon weight gain and symptom management immediately places the treatment at odds against the client¹⁶. Importantly, both the concept of remission and recovery are not necessarily related to treatment response and may occur spontaneously. This introduces complexity in their measurement, particularly when a treatment outcome must be isolated for the purposes of research. Nevertheless, many treatment studies do not even equate maintenance of treatment effects to remission status¹⁶.

Measurement of treatment outcome may be fraught with complexity. However, recent political focus has been drawn particularly to the concept of recovery in healthcare and treatment^{17,18}. This suggests that outcome studies may need to broaden how treatment success is evaluated. Indeed the application of a broader definition of recovery, including psychological and social aspects, may improve long-term outcome¹³. The conceptualisation of ED centres upon ideas of disease and physical symptoms, thus largely neglecting the wider psychosocial implications upon an individual who has disordered eating patterns. Therefore, an individual who exits therapy having successfully attained targets pertaining to weight gain may not have successfully addressed psychosocial correlates of their disorder, such as distressing cognitions relating to eating and close relationships. Importantly, individuals who consider themselves recovered from their ED tend to place little importance on weight gain in recovery¹⁰ and often state that the conquering of anxiety and cognitive disturbance regarding eating was pivotal¹⁶.

Clearly, broadening the definition of treatment outcome to incorporate psychosocial factors is warranted, particularly since treatment will necessitate the formation of interpersonal relationships. In order to ascertain how this definition might be expanded, factors that differentiate successful

and unsuccessful treatment must be elucidated¹⁹. One method of investigating this issue is to highlight processes that are active within the clinical relationship during treatment⁷.

Therapeutic Factors

The literature provides convincing evidence that strong therapeutic alliance is an important factor underlying positive outcome in psychotherapeutic treatment²⁰. This view is supported by both researcher and ED client opinion^{10,21}. However, the impact of therapeutic alliance upon clinical outcome appears to vary across different therapeutic approaches²². Thus there may be other factors active during the process of therapy that impact upon outcome.

The role of non-specific therapy factors has been explored in the psychotherapy literature. Dimensions shared by most psychotherapeutic approaches such as therapeutic alliance, adherence to therapy protocol and therapist competence have been associated with treatment outcome²³. Traditionally, outcome may be influenced by the client's perception of a therapist who provides acceptance, empathy, positive regard and genuineness²⁴. Similarly, reviews of psychotherapy literature have found therapist characteristics that positively impact upon outcome include openness, rapport building, trustworthiness, confidence and competence in delivering therapy²⁵. Further studies have highlighted the importance of encouragement from the therapist in producing positive outcome^{26,27}.

Some evidence in the ED literature exists to suggest that non-specific therapeutic factors may be associated with treatment outcome^{16,28,29}. However, it is not clear what particular factors are important for positive treatment outcome with this client group. Therefore, the aim of this review is to explore what therapeutic factors are important for positive outcome for ED clients. For this purpose, therapeutic factors were defined as a combination of therapist skills, personal attributes, attitude and perceived competence. Particular attributes and attitudes such as trustworthiness, confidence, openness and empathy¹⁶ have been shown to impact upon outcome. Skills

such as interpersonal interaction and rapport building have also been cited as important¹. Additionally, therapists who attend to the quality of the therapeutic alliance and the client experience (forming an effective therapeutic alliance), offer encouragement and facilitate emotional expression have been cited as helpful for positive outcome by ED clients²⁹.

The current importance of the concept of recovery was highlighted above^{17,18}. However, the relevance of this concept to treatment outcome is relatively recent and there exists a lack of consensus in the literature about what constitutes good outcome. For these reasons, the current review chose to incorporate any study that evaluated treatment outcome, with a particular focus on those that described positive outcome. Since recovery has only recently come to the forefront in mental health services¹⁷, the search was limited to studies from the past ten years in order to maintain a focus on factors that are currently relevant to therapy services.

The aim of this review was to establish what therapeutic factors appear to be of importance for positive outcome of treatment, from the point of view of the individual with an eating disorder. A secondary aim was to critically appraise the quality of the existing literature, in order to indicate the overall usefulness of existing evidence as well as to highlight particular areas that might be improved upon by future research.

Method

Inclusion Criteria

First, a set of a priori inclusion criteria were defined. The main focus of the review was adult literature, so studies were included in the review if they included participants with an ED over the age of 16. Only studies that were published in the last ten years were included, in order to ensure that the literature reviewed would be relevant to current issues and models of ED treatment. Finally, only literature published in English language in a peer-reviewed journal was sought for inclusion. Though this introduces a degree of bias into this review, theses, dissertations and other forms of grey literature were excluded due to resource limitations and to control for quality.

Although commonly used in the literature, not all studies of individuals who have an ED refer to diagnostic criteria, such as those specified by the DSM or ICD manuals. Indeed, due to their symptom-focused nature there was a risk that limiting the search to diagnostic criteria would omit studies using a broader, psychosocial definition of ED and treatment outcome. Therefore this review did not use a strict definition of ED. Rather, any study that included participants diagnosed as having an ED or receiving treatment for an ED was included. Further, no restrictions were placed on ED diagnosis subtype or research design in order to ensure a broad search that would encompass the full ED population in any treatment setting.

Searching

Relevant studies were identified using online databases PsycINFO, EMBASE, Medline, Web of Science and the Cochrane Library in July 2013 and alerts set up on the databases to highlight new literature of relevance to this review.

The search retrieved references for studies containing keywords relating to key concepts encompassed by this review: eating disorder, positive outcome and therapeutic factors. Where possible, subject headings were selected and exploded in order to retrieve studies where authors had used a different term for the same concept. In addition, several search terms

were used to ensure sufficient breadth to the review. For example, search terms aimed at retrieving studies pertaining to positive outcome included not only 'positive outcome' but also 'treatment outcome' and 'intervention outcome'. Individual searches for studies related to eating disorders, therapeutic factors and positive outcome were combined by 'and'. Additional limits were then applied according to the a priori inclusion criteria: published between 2003 and 2013, English language, adult age 16 or over. Finally, only studies published in a peer reviewed journal were identified and saved within the search engine. A full description of the search strategy is presented in table 1.

Table 1. Systematic search strategy

	PsycINFO, Embase, Medline ¹	Web of Science	Cochrane Library
Limits:		Time-span: 2003-2013. Databases: SCI-EXPANDED, SSCI, CCR-EXPANDED, IC	Year: 2003-2013
1.	exp eating disorder\$	therap* ingredients OR therap* factors OR interpersonal interaction OR therap* competence OR therap* trustworthiness OR therap* confidence OR therap* openness OR therap* empathy OR therap* encouragement OR therap* characteristics OR therap* experience OR therap* alliance OR working alliance OR therap* relationship (topic)	therap* ingredients OR therap* factors OR interpersonal interaction OR therap*competence OR therap* trustworthiness OR therap* confidence OR therap* openness OR therap*empathy OR therap* encouragement OR therap* characteristics OR therap* experience OR therap*alliance OR working alliance OR therap* relationship (title, abstract, keywords)
2.	(therap\$ ingredients OR therap\$ factors OR interpersonal interaction OR therap\$ competence OR	AND positive outcom* OR treatment outcome* OR intervention outcome* (topic)	AND positive outcom* OR treatment outcome* OR intervention outcome* (title, abstract, keywords)

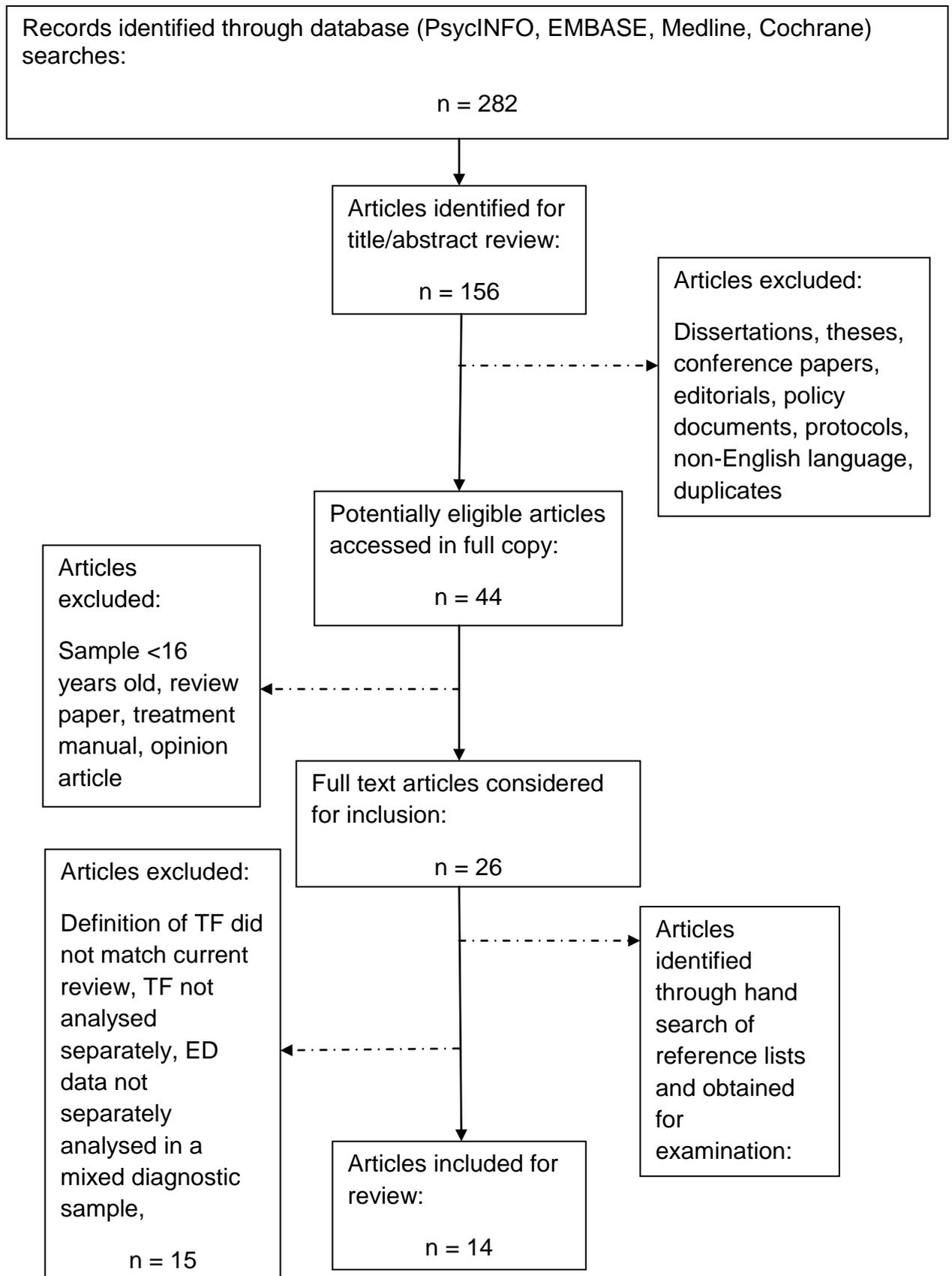
	PsycINFO, Embase, Medline ¹	Web of Science	Cochrane Library
	therap\$ trustworthiness OR therap\$ confidence OR therap\$ openness OR therap\$ empathy OR therap\$ encouragement OR therap\$ characteristics OR therap\$ experience OR therap\$ alliance OR working alliance OR therap\$ relationship)		
3.	treatment outcome\$	AND eating disorder OR eating disorders (topic)	AND eating disorder OR eating disorders (title, abstract, keywords)
4.	positive outcome\$		
5.	intervention outcome\$		
6.	Or 3-5		
7.	And 1,2,6		
8.	Limit 7 to English language		
9.	Limit 8 to 2003-2013		
Records retrieved:	PsychINFO, 135; Embase, 18; Medline, 6	49	74

¹Search terms entered into each database independently

Selection

The database search retrieved 156 studies, screened by reading title and abstract to ensure that they met a priori search criteria. Following application of these criteria and removal of duplicates, 44 potentially eligible studies remained and were examined in full copy. A further 18 studies were excluded due to a priori search criteria and the references of the remaining 26 studies. One paper that reported having one participant aged 15 years was included since all other participants were over 16 and the study met all other inclusion criteria. The final review sample comprised 14 papers. Figure 1 presents a detailed outline of the selection process.

Figure 1: Search strategy used to identify and screen relevant studies for review



Data Abstraction

The quality assessment tool contained eight questions that examined study aims, sampling, procedure, intervention and outcome, data analysis, ethics and bias, results and transferability of findings. A numerical rating was awarded for each question to provide a summary score for each study³⁰ so that they could be ranked according to quality.

Due to time constraints, the quality assessment of the 14 studies relevant for the review was undertaken by the first researcher (ER; table 2). To control for potential bias in quality appraisal, five of the studies were also appraised by another researcher (LB) and agreement calculated. Inter-rater agreement for both study summary score and methodological rigour score using Cohen's³¹ Kappa was good ($\kappa = .73$).

Table 2: Quality assessment ratings and summary scores for all studies included in the review

Study and Year	Quality Criteria and Rating (good = 2; fair = 1.5; poor = 1; very poor = 0.5)								Method. Rigour	Summary Score
	Aims	Sampling	Procedure	Intervention and outcome	Data Analysis	Ethics and Bias	Results and Discussion	Transferability and generalisability	Score	
Ertelt ⁵³	2	1.5	1.5	1.5	1.5	0.5	1.5	1.5	6	11.5
Waller ³³	2	1.5	2	1.5	2	0.5	1.5	1.5	7	12.5
Brown ⁵⁴	2	1.5	1	2	2	1	1.5	1.5	6.5	12.5
Loeb ³²	2	2	1.5	1.5	2	0.5	2	1.5	7	13
Zeeck ⁴¹	2	2	2	2	2	0.5	1.5	2	8	14
Constantino ⁴⁰	2	2	1.5	2	2	0.5	2	2	7.5	14
Sly ⁵⁵	2	2	1.5	1.5	2	1	2	1	6	13
Traviss ³⁶	2	2	2	1.5	1.5	1	1.5	1.5	7	13
Prestano ³⁴	2	1.5	2	2	1.5	1	1.5	1.5	7	13
de la Rie ⁵⁶	2	1.5	2	1.5	1.5	1.5	2	1.5	6.5	13.5
de la Rie ³⁵	2	2	2	1.5	1.5	1.5	2	2	7	14.5
Tasca ³⁸	2	2	2	2	2	1	2	2	8	15
Maxwell ³⁹	2	1.5	2	2	2	1	2	2	7.5	14.5

Study and Year	Quality Criteria and Rating (good = 2; fair = 1.5; poor = 1; very poor = 0.5)								Method. Rigour	Summary Score
	Aims	Sampling	Procedure	Intervention and outcome	Data Analysis	Ethics and Bias	Results and Discussion	Transferability and generalisability	Score	
Gulliksen ²⁹	2	2	2	2	2	1.5	2	2	8	15.5

Results and Discussion

Of the 10 studies reviewed, eight found therapeutic factors important for positive outcome. One study³² found that therapeutic alliance was not related to symptom change, but noted that strong therapeutic alliance was significantly associated with therapist adherence to treatment protocol. Another³³ found that although therapeutic alliance was rated highly important, it was not associated with symptom improvement.

With regards to treatment outcome, seven studies defined positive outcome as weight gain or reduction in behaviours associated with the ED. One study³⁴ regarded positive outcome as attainment of a level of functioning more likely to fall within a functional population. Two studies compared recovered and non-recovered ED clients^{29, 35}.

The ten studies are summarised in table 3. The following section considers setting, samples and treatments represented by these studies in order to provide context within which to demonstrate their findings. Second, the treatment outcome and important therapeutic factors are considered, alongside methodological rigour and suitability of measurement.

Table 3. Summary of studies included in the review

Study	Type of study	Context & Setting	Sample characteristics	Intervention	Positive outcome	Therapeutic factors (TF)	Main measures
Tasca ³⁸	Mixed method systematic case study	Canada, outpatient centre for ED in an urban hospital	20 participants (10 per group): BED diagnosis; 90% female; mean age* 43.74; mean illness duration* 20.91	GCBT: 16-weekly, 90-minute manual based sessions GPIP: 16-weekly, 90-minute manual based sessions	Number of days binged in the past 7 days <1	Interpersonal behaviours of CBT & psychodynamic therapists and levels of complementarity	Outcome: EDE (inter-rater reliability .97) (clinician interview) TF: SASB (researcher report)
Maxwell ³⁹	Between groups experimental design	Canada, Outpatient group therapy	102 participants (8/9 per group): BED diagnosis; 100% female; mean age 43; mean illness duration not	Group psychodynamic interpersonal psychotherapy	Decrease in symptoms of depression and binge frequency	Complementarity of therapist behaviour in group psychodynamic psychotherapy (Complementarity	Outcome: EDE (inter-rater reliability .98) (clinician interview) TF: SASB

Study	Type of study	Context & Setting	Sample characteristics	Intervention	Positive outcome	Therapeutic factors (TF)	Main measures
			reported			related to establishing therapeutic rapport & alliance	(researcher report)
de la Rie ³⁵ (2008)	Exploratory cohort study	Netherlands, ED clients recruited from community & specialist centres	156 current & 148 former ED clients: 98.1% & 96.6% female, respectively; mean age, 28.2 & 29.3, respectively; mean illness duration, 9.8 & 8.5, respectively	Questionnaire rating importance of 70 items related to treatment content, mental health professionals and organisations providing treatment	10 items rated as most important	Treatment contentment, mental health professionals and organisations providing treatment	Outcome: EDE-Q (client report) TF: Questionnaire developed for study (client report)
Constantino ⁴⁰	Re-analysis of RCT data	USA, Outpatient	220 participants: BN diagnosis;	CBT/IPT for BN 19 individual	Post-treatment	Quality of therapeutic	Outcome: Purge

Study	Type of study	Context & Setting	Sample characteristics	Intervention	Positive outcome	Therapeutic factors (TF)	Main measures
		individual therapy	100% female; mean age 28.1; mean illness duration 11.4 (bingeing), 9.8 (purging)	outpatient sessions, 50 minutes, over 20 weeks.	purge frequency	alliance: therapist helpfulness, supportiveness & working collaboratively	frequency form (client report) EDE (clinician interview) TF: Helping Alliance Questionnaire (client report)
Prestano ³⁴	Single case design	Italy, Outpatient group therapy	8 participants: AN diagnosis; 100% female; mean age 16; mean illness duration 3	Psychodynamic analytic group – 1.5 hours per week for 2 years. Emphasis on group role in treatment of individual	Behaviour falls into 'functional population' range, reduction in AN/BN severity	Strength of the members-therapist alliance in groups: patient ability to form an working alliance, patient attitude toward therapist & patient	Outcome: Outcome Questionnaire-45, SEED, EDI (client report) TF: Californian Psychotherapy Alliance Scale

Study	Type of study	Context & Setting	Sample characteristics	Intervention	Positive outcome	Therapeutic factors (TF)	Main measures
Traviss ³⁶	Qualitative process study	UK, Outpatient guided self help	12 participants (7 ED clients): BED, BN & EDNOS diagnosis; 100% female; mean age 44.7; mean illness duration not reported	Guided self help RCT – interviews post-treatment of sample of clients who had completed treatment	Perceptions of the intervention and its effect upon therapeutic relationship	perception of therapist's empathic understanding Role of the guide, relationship of client and guide, particularly in regard to establishing, developing & maintaining relationship	(client report) Outcome: No diagnosis at 6 month follow up (?client report) TF: Semi-structured interview, (client report)
Zeeck ⁴¹	Exploratory cohort study	Germany, Inpatient & day clinic specialist treatment	38 participants: AN diagnosis; 97.4% female; mean age 23.82; mean	Individual psychotherapy treatment sessions for AN	Weight gain; either after 6 weeks/12 sessions i.e. initial phase	feelings of doubt toward therapist/therapy & feelings towards therapist	Outcome: Weight and height measures TF:

Study	Type of study	Context & Setting	Sample characteristics	Intervention	Positive outcome	Therapeutic factors (TF)	Main measures
			illness duration 5.6			between sessions	Studenbogen, Intersession Experience Questionnaire (client report)
Waller ³³	Cohort study	UK – outpatient individual therapy service	44 participants: 95% female; mean age 27.2; illness duration not reported	Individual CBT sessions for ED	Reduction in eating pathology at session 6	Therapeutic alliance – common therapeutic tasks, shared goals and attachment bond	WAI-short form-revised, EDE-Q
Gulliksen ²⁹	Descriptive, qualitative grounded theory	Netherlands – former in- or out- patients	38 participants: 100% female; mean age 28.3; mean illness duration 9.5	Semi- structured interview	Patient satisfied with treatment	Derived from themes in participant interviews: acceptance, vitality, challenge and expertise	Semi- structured interview, no structured measures
Loeb ³²	Re-analysis	USA,	81 participants:	Manualised	Frequency	Therapeutic	Outcome:

Study	Type of study	Context & Setting	Sample characteristics	Intervention	Positive outcome	Therapeutic factors (TF)	Main measures
	of RCT data	University based medical centre, part of RCT	BN diagnosis; gender not reported; mean age 28.86; mean illness duration 12.62 bingeing, 11.04 purging	CBT & IPT for BN sessions recorded and transcribed	of purging, derived from EDE	alliance and therapist adherence to manual	EDE (clinician interview) TF: Vanderbilt Therapeutic Alliance Scale, Minnesota Therapy Rating Scale, Therapy Rating Scale (researcher report)

*All mean values are reported in years.

Abbreviations in table: ED = eating disorders; BED = binge eating disorder; AN = anorexia nervosa; BN = bulimia nervosa; GCBT = group cognitive behavioural therapy; GPIP = group psychodynamic interpersonal psychotherapy; EDE = Eating Disorder Examination; SASB = Structured Analysis of Social Behaviour; SEED = Short Evaluation of Eating Disorders; EDI = Eating Disorder Inventory; EDE-Q = Eating Disorders Examination-Questionnaire

Study context and setting

Context and setting was noted since health and treatment services vary in different locations, for example in access to services and the type of treatment provided. These factors are important to consider in the context of recent recovery-oriented policies in the UK^{17,18}. Only two studies took place in the UK^{33, 36}. The remaining studies were undertaken in Europe, America and Canada. Although these studies are being reviewed together, caution is warranted in the generalisation of their findings due to the differences in the healthcare systems involved and the populations that they serve.

Six studies were set in outpatient treatment centres^{32-34, 38-40} and one included participants from both inpatient and day clinic treatment⁴¹. One study explored guided self-help which allowed patients to access treatment at home³⁶. While studies of inpatient environments allow more control over extraneous variables, outpatient studies provide greater ecological validity. The mixed day clinic and inpatient setting⁴¹ provides an interesting opportunity to investigate whether difference indeed exists between in- and out-patient treatments. However, the two different settings were not distinguished in the data analysis.

Sample Characteristics

ED are most common in young females². This trend is reflected in the studies, with most samples representing females in their mid-twenties^{32, 33, 35, 40, 41}. Four studies have an older female sample (mean age 43-51 years)^{29, 36, 38, 39}. Three^{36, 38, 39} included individuals with binge eating disorder (BED). BED is thought to have the highest lifetime prevalence of all ED subtypes⁶, which may account for the higher mean age of the participants in these studies.

Though in general the studies represent the ED population in terms of age, the gender ratio of the samples cannot be considered representative. Only four studies included males^{33, 35, 38, 41}. This may reflect the tendency for males to be less likely to seek treatment than females^{5, 9}. Nevertheless, males are thought to account for 10% of the AN population and 15% of the

BN population. The proportion of males in the sample across these studies ranged between 0%-10%, thus falling short of true representation of this population. .

Early treatment of ED has been shown to improve rates of recovery⁴⁴, suggesting that illness duration is an important factor in treatment. All but three studies^{33, 36, 39} report illness duration (range of means 8.5-12.62 years). Two outliers are present: one study of BED reports a mean illness duration of 20 years⁴¹, and one study of AN reports a mean illness duration of 3 years³⁴. This is likely to be reflective of the age of participants; the age of the sample in the BED study³⁸ was 31-56 years old and in the AN study³⁴ was 15-17 years old. The young age in Prestano et al's³⁴ study may have a positive impact upon treatment outcome since the intervention has occurred soon after disorder onset.

Intervention/Treatment

Seven of the studies used a therapy intervention, e.g. group or individual sessions with a therapist^{32-34, 38-41}. In general, these interventions were manualized to standardize treatment for all participants and lasted for between 12 and 19 weeks. Three studies^{33, 38, 40} investigated only initial phase of therapy and measured outcome at the sixth week of treatment. In only one study was treatment long-term, with participants attending a psychotherapy group for two years³⁴. In the current economical climate with the drive for cost-effective treatments, successful short-term interventions may be more attractive. Of particular challenge in treating individuals with an ED are the high dropout⁸ and high relapse¹² rates. Studies of important factors for positive short-term outcome may provide valuable information about treatment adherence in the ED population. However, only one study employed follow up measures³⁶, thus it is difficult to determine the long term impact of these treatments.

Treatment Outcome

Lack of consensus on what constitutes positive treatment outcome is rife in the literature. Many studies class good outcome as increase in weight or

body mass index (BMI) or a reduction in behaviors associated with eating pathology, such as bingeing, purging or restricting food intake. These studies are no different; five define outcome as a reduction in behaviours associated with the ED^{32, 36, 38-40} and one⁴¹ considered good outcome to be represented by an increase in BMI.

One study³⁴ defined positive treatment outcome as the achievement of 'reliable change' from therapy resulting in the individual's functioning being more likely to fall within a 'functional population' following treatment. However, a definition of 'functioning' is not provided so it is impossible to compare this outcome with other studies. Nevertheless, this measure of outcome more closely approximates remission or recovery than the simple attainment of a reduction in behaviours associated with an ED, since there is some comparison with how often the behaviours concerned occur within a wider population.

Treatment Outcome Measures

All studies used well validated measures of outcome. Outcome relating to eating disorder pathology was most often rated using the Eating Disorder Examination (EDE)⁴⁷, with six of the ten studies using it as the main outcome measure. Good psychometric properties have been reported for the EDE^{48, 49} as a measure of ED pathology within a 1-month time frame. Therefore it demonstrates good face validity for all studies measuring change in ED pathology as a treatment outcome^{32, 38-40}. Two studies^{33, 35} used a questionnaire version of the EDE (EDE-Q) to assess outcome. The EDE-Q has been validated against the EDE interview as a self-report measure for assessing ED pathology⁵⁰.

Therapeutic Factors

Four studies found strong therapeutic alliance to be associated with positive outcome^{34-36, 40}. Two studies^{38, 39} identified complementarity as important. Complementarity describes interactions between individuals and is important in building rapport and therapeutic relationship in psychotherapy³⁹. Therefore, six studies identified the relationship between the therapist and

client to be important for positive outcome. Two studies^{32, 33} found that therapeutic alliance was rated highly but was not associated with positive outcome.

Particular ingredients of the therapeutic relationship associated with positive outcome were therapist supportiveness, collaborative working, confidence in therapist and feeling accepted or respected by the therapist. Therapist characteristics identified were empathy, understanding, interest and trustworthiness. Therapists who challenged their clients were also associated with positive outcome. Table 4 summarises therapeutic factors identified across the ten reviewed studies.

Another factor that has been indicated as important in positive outcome is therapist adherence to therapy protocol. One study found an association between adherence and strong alliance³², however other studies^{35, 36} using rigorously trained, highly adherent therapists, observed reduced flexibility and responsiveness of the therapist during therapy sessions. This may negatively influence a client's perception of therapist understanding and empathy. Nevertheless, both studies observed high therapist complementarity or rapport building as important for positive outcome. Importantly, the reduction in flexibility and responsiveness was noted by the researchers reviewing therapy sessions and not by the study participants. Therefore, though these findings highlight the potential negative impact of strong therapy protocol adherence, the ED client perspective on the importance of adherence remains unclear.

Table 4: Therapeutic factors associated with positive outcome by study

Therapeutic Factor	Frequency	Study
Therapeutic alliance	6	Constantino et al. ⁴⁰ , Traviss et al. ³⁶ , Prestano et al. ³⁴ , de la Rie et al. ³⁵ , Maxwell et al., ³⁹ Tasca et al. ³⁸
(Complementarity	2	Maxwell et al., ³⁹ Tasca et al. ³⁸)
Supportiveness	2	de la Rie et al. ³⁵ , Traviss et al. ³⁶
Collaboration	2	Traviss et al. ³⁶
Therapist understanding	1	Prestano et al. ³⁴
Empathy	1	Prestano et al. ³⁴
Acceptance	2	de la Rie et al. ³⁵ , Gulliksen et al. ²⁹
Therapist respects client	2	de la Rie et al. ³⁵ , Traviss et al. ³⁶
Therapist interested	2	de la Rie et al. ³⁵ , Traviss et al. ³⁶
Confidence in therapist	1	Zeeck & Hartmann ⁴¹
Therapist challenges client	1	Gulliksen et al. ²⁹
Therapist adheres to treatment	1	Loeb et al. ³²
Trustworthy therapist	1	de la Rie et al. ³⁵

Measurement of therapeutic factors

One study used an un-validated self-report questionnaire measure to assess therapeutic factors³⁵. Of the remaining studies, three used validated measures of therapeutic factors completed by the researchers^{38, 39} and five used validated client self-report measures^{33, 34, 36, 40, 41}. Finally, one study²⁹ used a semi-structured interview to explore client experiences of treatment. Thus seven studies were able to report on therapeutic factors from the client's perspective, increasing the clinical validity of their findings and providing greater understanding of factors important to recovery⁵².

Studies using observational coding procedures^{32, 38, 39} describe sufficient training of observers prior to the study and report high inter-rater reliability on the observational measures. Therefore, these observations appear to be a

reliable reflection of the interactions that occurred between client and therapist in therapy sessions. Of the three studies where 'blinding' procedures were possible, only Maxwell, Tasca, Gick, Balfour and Bassada³⁹ incorporated it into their study design. Thus the possibility that researcher bias may have influenced the observational data cannot be refuted for all studies.

Three studies^{29, 35, 36} undertook qualitative analysis of their data. The procedure for analysing this data is not detailed by de la Rie et al.³⁵ and no indication of theoretical stance is given. Traviss et al.³⁶ acknowledge that the coding of responses by a single researcher may introduce bias in the interpretation of data, but the steps taken to ensure reliability and validity of codes do not assure convincing credibility, largely due to a lack of detail in the description. Due to the poor methodological rigour in both studies it is difficult to determine the reliability and validity of the findings. In contrast, Gulliksen et al.²⁹ describe their data extraction and credibility checks in detail and bias in the process is acknowledged and controlled for.

One study³⁵ used an un-validated questionnaire measure to assess therapeutic factors. The questionnaire comprised 70 quantitative rating items followed by two open, qualitative questions. However, the validity of the questionnaire is impossible to determine. Firstly, the questionnaire was designed for the study by 'a panel of experts', but no information regarding who comprised the panel is provided. Secondly, the completion of quantitative rating items in the first section may prime the participants to the areas of researcher interest. Thus the responses to the qualitative, open ended questions may not accurately reflect all aspects of participant experience and be biased to include aspects that participants assumed were of interest to the researchers. These limitations are not acknowledged by the study's authors. Thus, although they appear to be in keeping with the broader literature, the findings of de la Rie et al.³⁵ are confounded by poor methodological rigour and must be interpreted with caution.

Summary and Conclusions

Therapeutic Factors

The ten studies included in this review provide evidence to suggest what therapeutic factors are important for positive outcome for ED clients. The most important factor was observed to be strong therapeutic alliance, which was associated with positive outcome in six of the studies. The findings regarding important ingredients in the therapeutic relationship and important therapist characteristics are in keeping with the wider psychotherapy literature, which highlights the importance of collaboration, acceptance, empathy, trustworthiness and supportiveness for positive outcome.

Evidently, the important element in positive outcome from treatment is the relationship of the client and the therapist. As indicated by the therapeutic factors identified in this review, this relationship comprises cognitive clinical interactions such as collaboration, therapist understanding and challenging the client as well as interpersonal elements such as trustworthiness, respect and acceptance. These factors reflect that it is in fact the non-specific therapeutic relationship that is important in affecting positive outcome; the emotional content of therapy sessions and the client's expectations that the therapist will possess knowledge that they themselves do not.

These findings are not particularly surprising when the wider psychotherapy literature is considered. These therapeutic factors are relevant to recovery in general and not just specific to clients who have an ED. The studies that directly measured the impact of therapeutic alliance with positive outcome did not find a significant association^{32, 33}. Therefore, strong therapeutic relationships alone are not indicative of positive outcome and other, non-specific, therapeutic factors must be present to effect positive change.

Indeed, much of the literature is concerned with factors that, when present within a therapeutic relationship, ensure positive outcome for the client. Often neglected by the literature are those factors that, when present within the same relationship, disrupt positive outcome. Yet there is evidence to suggest that such factors do exist; Vocks⁵⁷ surveyed female eating disorder

clients and found therapist body size was important to the therapeutic relationship. Such disruptive factors may have greater specificity to clients who have an ED than factors associated with positive outcome and may lead to further understanding of the high treatment dropout rates in this population.

In addition, studies comparing the opinions of former and current ED clients found differences in the ratings of particular therapeutic factors. This suggests that certain factors may be important in the early stages of treatment in order to engage the client, but may wane in importance as treatment progresses. Alternatively, this divided opinion may reflect different personality characteristics of current and former ED clients. Bilker⁵⁸ suggests that clients who have an ED experience difficulty within intimate relationships. Perhaps as therapy progresses and the client experiences a successful relationship, the impact of disruptive factors becomes less, allowing the non-specific therapeutic relationship factors to affect positive change and outcomes.

Future research should investigate therapeutic factors associated with short-term positive outcome in order to identify particular positive or disruptive factors that may be important for improving early engagement with treatment. Indeed, the identification of disruptive factors may be most important, since the current literature has not identified positive factors that improve outcome specifically for clients who have an ED.

Of further interest would be studies investigating whether therapeutic factors rated as important change with illness or treatment duration, to ascertain whether changes to treatment as it progresses would be supportive of long-term positive outcome. Finally, although studies exploring the opinions of ED clients are important to provide an understanding of important therapeutic factors, quantitative research indicating the effectiveness of these factors would contribute valuable information for treatment design and provision.

Treatment Outcome

As reflected in the wider literature, these studies did not demonstrate a consensus measurement of positive outcome and the definition of change following treatment remained focused upon symptom management or weight gain. Remission and recovery have yet to be included in the conceptualisation of positive outcome. The lack of follow-up data in these studies means that lasting effects of treatment cannot be gauged. Therefore, this review must conclude that the therapeutic factors identified are important for short-term positive behaviour change but that more research is needed to identify therapeutic factors that affect long-term maintenance of behaviour change and the achievement of 'successful living'; aspects considered important for recovery¹⁵.

The current literature tends to focus upon a definition of outcome that pertains to symptom reduction, presumably due to the common conceptualisation of ED as a disease. However, the evidence from both the broader psychotherapy literature and the ED literature indicating that therapeutic relationship is important for attaining positive outcome cannot be overlooked. Perhaps a more helpful definition of treatment outcome that moves away from focusing on physical symptom change would enable identification of factors affecting long-term positive outcome. Understanding long-term positive outcome and recovery would help to address the high relapse rates currently present in the ED population.

Further, there is a paucity of literature from the UK investigating ED treatment outcome. Though the studies in this review report data collected in health settings in Western nations, they do not fully represent individuals with an ED in the UK, receiving treatment from the National Health Service (NHS). Of particular importance is the current political change that is driving mental health services towards a focus on recovery^{17,18}. Since the studies reviewed do not account for long-term maintenance of positive outcome the findings provide little assistance in suggesting how to structure services promoting recovery for individuals with an ED.

Future research should focus on a broader definition of treatment outcome that incorporates physical, psychological, social and economic aspects of an ED. Additionally, studies undertaken in the UK are needed to highlight particular factors important for individuals with an ED that can easily be transferred to services available in this country.

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JOURNAL PAPER

Journal Paper

An exploration of body confidence and recovery in relation to the client with
an eating disorder: meaning and importance for therapeutic alliance

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Abstract

143 females and males who self-reported experience of an Eating Disorder participated in a mixed methods online survey exploring the importance of therapist gender and body-confidence and personal experience of recovery. Responses were analysed using Thematic Analysis incorporating Saliency Analysis. Statistical analyses were also performed. Same-gender, body-confident therapists were deemed highly important. Themes represented recovery as a cycle through being restricted, to reconciling self and culture and finally, resilience. Body-confidence developed along a continuum from 'thinness' to 'possible at any size' alongside the process of recovery. The findings offer argument for consideration of therapist appearance and treatment delivery within Eating Disorder services. Further support is provided for the use of broad recovery criteria that account for psychological and social functioning as well as weight-restoration.

Keywords: therapist body-confidence, therapist gender, Eating Disorder, recovery

Background

Prevalence of eating disorders (ED) has increased over the past 50 years (Garner & Keiper, 2010; Stein et al., 2001; World Health Organisation, 2004). Lifetime prevalence of anorexia nervosa (AN) is up to 4% and bulimia nervosa (BN) up to 2% (Smink, van Hoeken, & Hoek, 2013). Though most common in females, males account for approximately 10% of AN and 15% of BN populations (Carlat, Camargo, & Herzog, 1997; Harvey & Robinson, 2003).

Treatment efficacy and outcome

Recovery rates are low; up to 50% of individuals diagnosed with an ED experience long-term biological, psychological and social problems (Arcelus, Mitchell, Wales, & Nielsen, 2011; Castellini et al., 2011; Fisher, 2003).

Research has generated knowledge about risk factors for developing an ED, efficacious psychotherapeutic treatments and strategies for prevention (Hay, Bakaltchuck, Stefano, & Kashyap, 2009; Wilson, Grilo, & Vitousek, 2007).

Please see Extended Paper - Extended Background for further discussion.

Yet little is understood about the process of recovery. The literature lacks consensus definition; some studies use weight-related criteria (Clausen, 2004; Eckert, Halmi, Marchi, Grove, & Crosby, 1995; Morgan & Hayward, 1988; Pike, Walsh, Vitousek, Wilson, & Bauer, 2003); others argue psychosocial aspects should be incorporated (Bachner-Melman, Zohar, & Ebstein, 2006; Cogley & Keel, 2003; Strober, Freeman, & Morrell, 1997). Different levels of psychosocial functioning and appearance-related self-esteem have been demonstrated between recovered and unrecovered ED clients (Bardone-Cone et al., 2010; Cogley & Keel, 2003; Noordenbos & Seubring, 2006). Psychosocial factors are also highly associated with relapse (Carter, Blackmore, Sutandar-Pinnock, & Woodside, 2004; Keel, Dorer, Franko, Jackson, & Herzog, 2005). Continued lack of consensus about what constitutes recovery causes difficulty designing treatments.

Please see Extended Paper – Extended Background for further discussion

Good therapeutic relationships (TR) are always important (Martin, Garske, & Davis, 2000). Nevertheless establishing and maintaining such relationships with ED clients is challenging. ED clients frequently report low treatment satisfaction (Clinton, Björck, Sohlberg, & Norring, 2004), resulting in poor engagement (Bell, 2001; Leavey, Vallianatou, Johnson-Sabine, Rae, & Gunputh, 2011; Walsh, Fairburn, Mickley, Sysko, & Parides, 2004) and premature dropout rates between 23 and 35% (Burket & Hodgins, 1993; Leavey et al., 2011; Waller et al., 2009).

However, the literature neglects negative treatment experiences (Escobar-Koch et al., 2010). Investigation of patient characteristics has shed little light upon what features might influence dropout. Findings are inconsistent and often contradictory (Escobar-Koch et al., 2010; Fassino, Piero, Tomba, & Abbate-Daga, 2009; Wallier et al., 2009) and have failed to find interpersonal difficulties or ED characteristics that predict poor engagement.

Please see Extended Paper – Extended Background for further discussion.

Researchers and ED clients acknowledge the importance of strong TR for good outcome (Geller, Brown, Zaitsoff, Goodrich, & Hastings, 2003; Keski-Rahkonen & Tozzi, 2005; Martin et al., 2000). This relationship has been strongly associated with treatment dropout (Clinton et al., 2004; Mahon, 2000). Studies have demonstrated ED clients place value upon the TR (de la Rie, Noordenbos, Donker, & van Furth, 2006; Tozzi, Sullivan, Fear, McKenzie, & Bulik, 2003), particularly emphasising the role of non-specific therapeutic factors (McIntosh et al., 2005; Vanderlinden, Buis, Pieters, & Probst, 2007). If an ED client perceives their therapist to be trustworthy, confident and competent they are likely to remain in therapy (Darcy et al., 2010; Drungaitė, 2009; Gulliksen et al., 2012). Further, ED clients reported that a specific therapist or therapeutic rupture caused them to dropout from therapy (Darcy et al., 2010). These findings highlight the importance of eliciting ED clients' opinions about therapy.

Please see Extended Paper – Extended Background for further discussion

Since most clients dropout early in treatment (Mahon, 2000), more immediate factors than treatment approach are likely to be significant. One area receiving increased attention in the literature is therapist characteristics. Research has often focused on therapeutic qualities such as openness, rapport-building and encouragement (Darcy et al., 2010; Gulliksen et al., 2012; Vanderlinden et al., 2007). However, characteristics that may have relevance to the individual being treated have rarely been considered, despite discussion of and evidence in the literature supporting the role of socio-cultural factors in ED (Blechert, Nickert, Caffier, & Tuschen-Caffier, 2009; Franko & Rolfe, 1995; Grabe, Ward, & Hyde, 2008; Stice, 1994; Tovée, Benson, Emery, Mason, & Cohen-Tovée, 2003; Vocks, 2007).

Socio-cultural Factors

Researchers have noted high levels of body dissatisfaction (BD) in Western society (Thompson & Stice, 2001) and investigated socio-cultural factors that might contribute to ED development. Studies identified thin-ideal internalisation and BD were highly associated with development of ED (Anschutz, Engels, & Van Strien, 2008; Grabe et al., 2008; Stice, 2001). Such ideals develop from social pressure from peers, family and the media and act to change an individual's health-related behaviours, such as dieting and exercise (Berel & Irving, 1998; Lowery et al., 2005; Young, Clopton, & Bleckley, 2004).

Please see Extended Paper – Extended Background for further discussion

High levels of BD and thin-ideal internalisation are consistently found in Western culture, yet only a small proportion of women in Western societies develop an ED. Low self-esteem, common within the ED population, may be a mediating factor (Fairburn, Cooper, Doll, Norman, & O'Connor, 2000; Pastore, Fisher, & Friedman, 1996). Low self-esteem is associated with high levels of social comparison (Bailey & Ricciardelli, 2010; Morrison et al., 2003) which occurs at elevated levels in the ED population (Blechert et al., 2009; Corning, Krumm, & Smitham, 2006; Trampe, Stapel, & Siero, 2007). Individuals who have an ED engage in frequent comparisons with the bodies of others, particularly women of their own age (Espeset, Gulliksen, Nordbø,

Skårderud, & Holte, 2012), leading to negative self-evaluation and increased ED behaviours (Blechert et al., 2009; Cogley & Keel, 2003; Lindner, Tantleff-Dunn, & Jentsch, 2012; Troop, Allan, Serpell, & Treasure, 2008).

Some authors have investigated how these factors might affect TR between an ED client and their therapist. Similarities between therapists and their ED clients in terms of demographics, age and culture have been highlighted (Bilker, 1993; Satir, Thompson-Brenner, Boisseau, & Crisafulli, 2009). Therefore, perhaps ED clients engage in the same figure comparisons with their therapists. Indeed, Vocks (2007) found therapist body-size was rated as highly relevant to the TR. Other studies have shown overweight therapists are evaluated as incompetent (Warren, Crowley, Olivardia, & Schoen, 2009) and underweight therapists as untrustworthy (Hoogerwerf, 2013).

Other characteristics have been highlighted as important and relevant by individuals who have an ED. In one study, ED clients identified therapist body-confidence as desirable and important (Hoogerwerf, 2013), but did not indicate how they perceived body-confidence. Studies have found ED clients consider improved evaluation of their appearance as important for recovery (Carter et al., 2004; Federici & Kaplan, 2008). A body-confident therapist may demonstrate high self-esteem or an ideal that does not equate to 'thinness', thus providing an alternative yet desirable standard for comparison and facilitating focus on positive self-evaluation. If this is the case, therapist body-confidence may be less relevant if the therapist was gender-different from their client.

The absence of ED clients' voice from empirical literature has made systematically evidencing theory regarding therapist characteristics difficult, despite existence of evidence to suggest its importance to ED clients and TR. This may be due to the sensitivity of the topic; nevertheless it remains an important area for exploration.

Please see Extended Paper – Extended Background for further discussion.

Study aims

The current study employs a mixed-methods design to explore the meaning of body-confidence and recovery to the ED client, from their perspective. A secondary aim was to ascertain whether recovered and unrecovered ED clients might rate importance of therapist body-confidence differently and whether body-confidence of gender-opposite therapists would be considered as relevant. Finally, the study hoped to indicate whether therapist gender and body-confidence might be important for therapeutic alliance.

Method

(For more in depth discussion please see Extended Paper, Extended Methodology)

The study was conducted using an online mixed-methods questionnaire, advertised on websites and mailing lists of ED charities BEAT, Men Get Eating Disorders Too and First Steps Derby, as well as Rethink Mental Health and “Call for Participants”, a website for advertising research studies. The local research and ethics committee reviewed and gave the study favourable opinion.

Instrument:

The online questionnaire was designed by the authors specifically for the study. It includes the Contour Drawing Rating Scale (CDRS) (Thompson & Gray, 1995) which has been shown to be a reliable measure of body-size and has good psychometric properties. The percentage agreement on figure order is 95.2% for female figures and 96.1% for male figures; test-retest reliability coefficient is within the moderate range (Thompson & Gray, 1995). The CDRS has recently been used to elicit preferred therapist body-size (Vocks, 2007) demonstrating its appropriateness for use in assessing ED clients' perception of others.

CDRS scores are not reported in the journal paper because the ratings were used for further analysis on which the current study is based. On their own, individual participants' CDRS ratings were not considered part of the study's primary aims. However, CDRS ratings were used in the secondary analysis (please see Extended Paper, Extended Results Table 9 on page 118).

The questionnaire comprised two sections. The first asked participants for information about their ED, treatment they had received and ended with open-ended questions designed to elicit participants' views about recovery and body-confidence. The second section presented the CDRS. Participants were asked to imagine the figures represented therapists and to rate which of 9 female and 9 male therapists was most and least body-

confident. Finally, participants were asked to rate, on a Likert scale of 1-9, how important therapist body-confidence was to them.

Participants:

Participation was voluntary. Inclusion criteria were controlled as far as possible using skip-logic within the online questionnaire and were:

- aged over 16 years;
- identify as currently having an ED or having had an ED in the past;
- speak English;
- access to the internet.

Data Analysis:

Quantitative data was analysed using IBM SPSS Statistics version 22. Participants' descriptions of therapy experienced were coded into total number of years to allow comparison of length of time in therapy with other variables. Data was checked for normality of distribution prior to selection of tests.

Qualitative data was collected from questions pertaining to body-confidence and recovery in section one. Participants' written responses were analysed using thematic analysis (TA), following Braun and Clarke's (2006) guidelines, supplemented by reference to guidelines from Miles and Huberman (2014). To justify selection of the main themes, Saliency Analysis (Buetow, 2010) was undertaken.

Analysis comprised several stages. Firstly, to increase familiarity with the data, responses were read several times. During this phase, the researcher's initial responses were recorded by making notes in the margins. Secondly, salient data was transferred to a table cell with other data assigned the same code. Similarities and differences in data were used to group codes into subthemes. A process of refinement was undertaken during which subthemes with close similarity were collapsed and re-coded to create a main theme. Subthemes considered to be distinct were retained under main themes. For example, the subtheme '*enjoy life*' was sorted under the

main theme, *'live life well'*. As analysis developed, theme definitions were adjusted and validated by comparison with original participant responses through a process of confirmatory and selective coding. Finally, interpretation organised the themes to represent a cycle of recovery, incorporating evolution of body-confidence.

Initial analysis and code assignment was undertaken by the primary researcher. The developing analysis was supervised by the second and third authors. Concepts and interpretations were continuously discussed, challenged and reassessed; saliency analysis highlighted codes considered highly important and recurrent (Buetow, 2010) resulting in 7 main themes and 17 subthemes. Over-arching themes that represented participants' descriptions of progression toward recovery and body-confidence were used to further group main themes.

For a more detailed discussion of this process please refer to extended paper, Extended Analysis.

Results

Sample characteristics

The sample comprised 143 participants (139 female; 4 male) aged between 16 and 58 years. Mean illness duration was 6.97 years and 14% of participants identified as 'recovered'. Most participants (93%) had received formal psychological therapy for ED. Mean length of time in therapy was 2.48 years; 64% of the sample reported more than one period of therapy. Further description of the sample characteristics is provided in Table 5.

Table 5. Sample characteristics

	N	Mean	Standard Deviation
Gender			
<i>Male</i>	4	-	-
<i>Female</i>	139	-	-
Age		25.17	7.53
ED subtype ¹			
<i>Anorexia Nervosa</i>	84	-	-
<i>Bulimia Nervosa</i>	26	-	-
<i>EDNOS</i>	24	-	-
<i>BED</i>	8	-	-
Length of illness	-	6.97	3.51
Recovery status			
<i>Recovered</i>	20	-	-
<i>Not recovered – receiving therapy</i>	73	-	-
<i>Not recovered – not receiving therapy</i>	42	-	-
Therapist			
<i>Clinical Psychologist</i>	92	-	-
<i>Counselling Psychologist</i>	25	-	-
<i>Counsellor</i>	42	-	-
<i>CBT therapist</i>	47	-	-
<i>Nurse</i>	33	-	-
<i>Dietician</i>	33	-	-
<i>Other</i>	28	-	-
<i>Don't know</i>	6	-	-
Type of therapy			
<i>CBT</i>	99	-	-
<i>IPT</i>	22	-	-
<i>Psychodynamic</i>	33	-	-
<i>Family Therapy</i>	43	-	-
<i>Systemic Therapy</i>	5	-	-
<i>Other</i>	43	-	-
<i>Don't know</i>	19	-	-
Length of therapy ²	-	2.48	2.72

Abbreviations in table: EDNOS, eating disorder not otherwise specified; BED, binge eating disorder; CBT, cognitive behavioural therapy; IPT, interpersonal therapy.

¹ ED subtype most strongly identify with. Most participants identified with more than one ED subtype, or had previously been diagnosed with a different subtype.

² Most participants had received more than one period of therapy. The total length of therapy for each participant was used to calculate the sample mean.

Overview of themes

The 7 main themes, respective subthemes and recurrence in the data are presented in table 6. Though interconnected, they have been presented as distinct for simplicity.

Table 6. Themes and salience

Theme ¹	Number of Responses (%)
“Not engaging in ED thoughts or behaviour”	93 (65)
<i>“Disorder always present”</i>	17 (12)
<i>Coping with emotions</i>	14 (9.5)
<i>“Not using disorder to cope”</i>	9 (6)
Control disorder	23 (16)
<i>Overcome fear of food</i>	10 (7)
<i>Treat body as important</i>	8 (5.5)
<i>Spontaneity</i>	7 (5)
<i>“Independence”</i>	5 (3.5)
Self-awareness	32 (22)
Self-compassion	50 (35)
<i>“Stop comparing to others”</i>	7 (5)
<i>Body-confidence difficult for everyone</i>	4 (3)
Proud of body	81 (57)
<i>Not preoccupied with appearance</i>	21 (14)
<i>Clothes for expressing not hiding myself</i>	17 (12)
“Being happy in own skin”	25 (17)
<i>Coping with others’ opinions</i>	15 (10.5)
<i>Personal worth not related to size</i>	4 (3)
Living life well	23 (16)
<i>Healthy weight</i>	31 (21)
<i>Healthy relationship with food</i>	15 (10.5)
<i>“Being normal”</i>	9 (6)

¹ Quotation marks indicate theme title taken directly from participant response

Main themes derived from participants' descriptions of recovery were grouped under over-arching themes restricted, reconciling self and culture and resilience; chosen to depict the emergence of distinct stages from the data. Participants' descriptions of body-confidence were difficult to isolate from their conceptualisations of recovery. Nevertheless, distinct stages were identified for both concepts. Three over-arching themes emerged; body-confidence requires thinness, ED is not related to body-confidence and body-confidence is possible at any size. Although these themes had low recurrence, they were considered highly important since they reflected change in how participants viewed body-confidence.

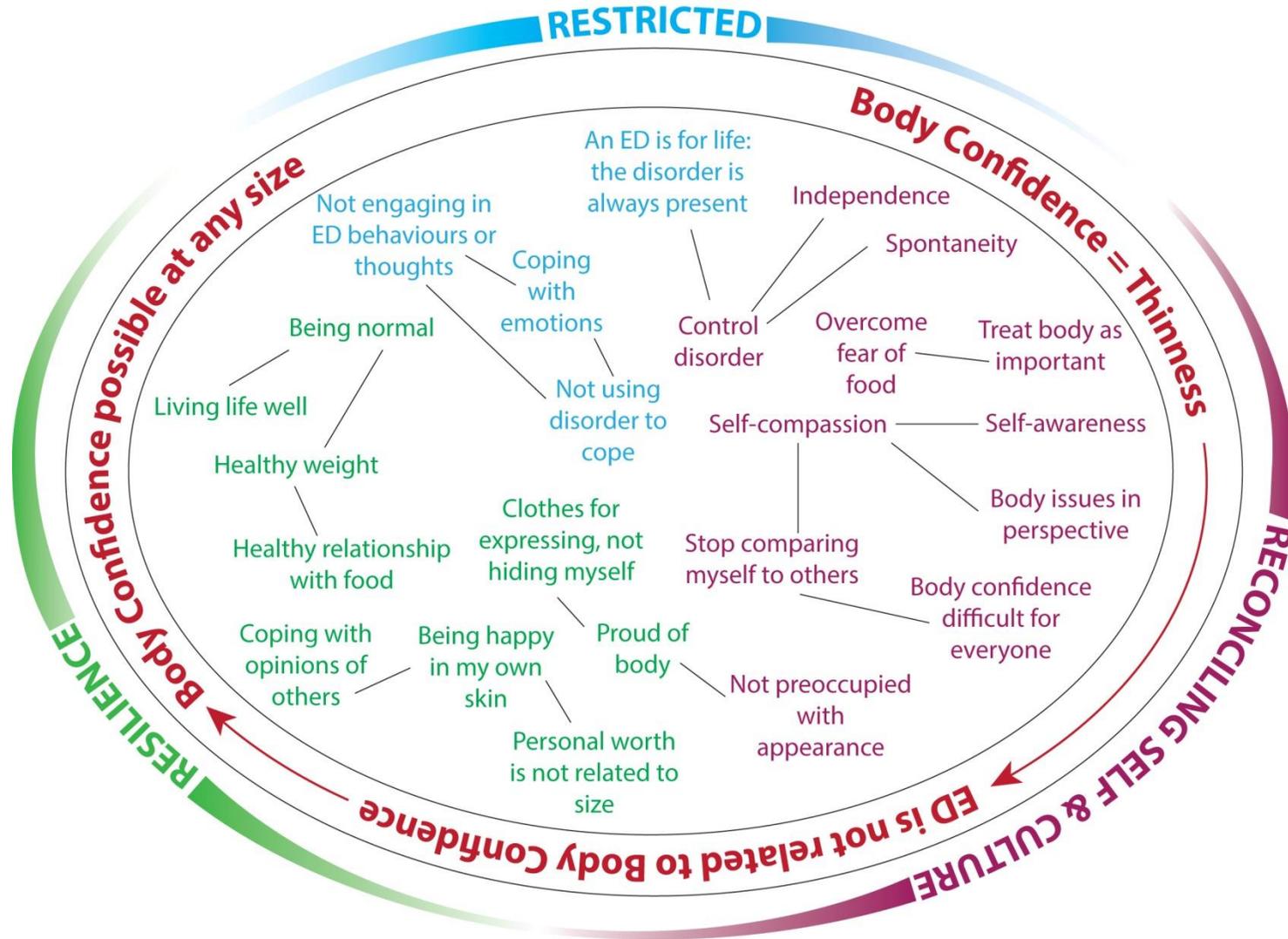
Recovery as a cycle

Recovery was represented in the thematic map as a cycle comprising three stages (figure 2). This representation was chosen since participants were clear recovery was not a finite state. Rather, though they had developed a more positive sense of self, greater ability to reconcile social pressures and maintain a fulfilling life, participants truly experienced *an ED is for life; you can never unlearn what you know*. At times of stress participants were tempted to return to ED coping strategies, though they were less strongly embedded into behaviour than at earlier stages of recovery.

[225] *"If I have any difficulties my eating goes 'wonky' and my weight will drop a little but comes back quite quickly. I occasionally wish I was very thin again, mainly when I'm feeling lonely or if things are difficult."*

Therefore, to represent the possibility that experiencing negative life events could lead to the resumption of ED behaviours, the map was arranged as a cycle.

Figure 2. Map of how an individual with ED progresses toward recovery and through ideals of body confidence



Body-confidence

In the 'restricted' stage of recovery, due to the influence of ED related thoughts, participants' constructed body-confidence as being thin:

[73] *"I'll be body-confident when I weigh 88lbs"*

[165] *"(body-confidence is) for me to be thin"*

However, this idea was not uniform across participants. Some stated body-confidence was not necessarily linked to the ED:

[3] *"I think a lot of people struggle with this now so it doesn't just pertain to eating disorders anymore."*

Finally, some participants believed body-confidence was possible at any size:

[142] *"You can be any size to be body-confident"*

This attitude was considered the definitive goal in recovery:

[171] *"To be able to manage confidence in your own body...This would be the ultimate recovery from an anorexia point of view."*

These three interpretations of body-confidence appeared to represent a continuum. Since participants viewed the final stage as '*the ultimate recovery*' it was placed within the recovery cycle to demonstrate how attitude towards body-confidence might change as an individual progressed toward recovery.

Themes pertaining to both recovery and body-confidence are represented in the centre of the cycle to illustrate how changing ideas about body-confidence relate to the process of recovery. Each theme and subtheme is described in more detail below.

Recovery stage 1: Restricted

Themes within this stage reflected a sense of imprisonment by the ED, eliciting hopelessness and resentment. The titles of the themes in this stage are taken directly from participant responses to illustrate feelings of

restriction. The main theme, '*not engaging in ED thoughts and behaviour*' was strongly linked to two sub-themes, discussed inclusively here to offer detailed examples of the restricting nature of the ED.

For a more detailed discussion of subthemes, please see Extended Paper, Extended Results

Participants described that *coping with emotions* was impossible unless they engaged in ED thoughts and behaviours. *Using the disorder to cope* was their most successful strategy. Unfortunately, reliance upon these strategies placed restriction upon their current life and future goals.

[3] *"Just o stop bingeing and purging. I hate purging, but I lack the willpower to not binge. I still binge because I feel I need to, or I just want to, I am bored, lonely, or just because I like the food. Recovery to me is no bingeing and purging."*

[210] *"Able to eat anything you want without fear/guilt/'making up' for it, able to go into any situation without food/eating being a concern, acceptance of body shape/size, not counting calories, exercising in a normal way... able to cope with difficult situations/emotions without feeling the need to rely on food related behaviours"*

An ED is for life: Disorder is always present

The remaining theme within this stage reflected the sense of imprisonment. The idea that the disorder would always be present led to hopelessness; the desire for freedom from the ED appeared impossible due to its everlasting presence.

[21] *"An eating disorder is for life – you can never unlearn what you know."*

However, some participants were more optimistic, suggesting progression toward recovery remained possible:

[85] *"(Recovery) does not mean that the individual becomes cured from the eating disorder but that they are able to find the strength to manage it and live life to the fullest."*

[179] *“My recovery means acknowledging my problems with food may never fully disappear, but they will get better.”*

Nevertheless, the restricting influence of the ED over the individual remained visible:

[103] *“Yet you must remain vigilant for the rest of your life. No dieting, no negative body talk and exercise with caution.”*

Stage 2: Reconciling self and culture

Themes within this stage captured participants' descriptions of learning to live with the ED. Two main themes represent skills necessary for this process: 'control the disorder' and 'self compassion'. As well as demonstrating participants' development of a better relationship with themselves, subthemes communicate social (*not comparing to others*) and cultural aspects (*it's normal to find body-confidence difficult*).

For a more detailed discussion of the sub-themes, please see extended paper, Extended Results.

Control the disorder

This theme differs from *coping with the disorder* in the “Restricted” stage. Rather than describing desire for ED thoughts and behaviours to be absent, participants developed the idea that the ED did not rule them. Participants acknowledged the disorder may never depart but realised they held control over their decisions, not the ED. Gaining control over the disorder enabled *independent choices* and *spontaneity*.

[7] *“To have enough control in your life to rationalise those thoughts and recognise that they are not healthy...Being able to understand these thoughts do not control you and that you are allowed to eat whatever you like and enjoy it.”*

[38] *“No longer being controlled by anorexic thoughts and feelings. Taking back control and not letting food and weight dictate mood, places I can/can't*

go, what I can/can't do etc...Being free from rigid rules about meal times and amounts, not counting calories every day, allowing myself to eat when I want to and what I want to and not by strict rules."

Participants also learned to *overcome fear of food* and to *treat body as important*.

[36] *"I can live my everyday life without the overwhelming fear of eating"*

These changes represented the first steps toward developing a different attitude about themselves.

Self-compassion

As well as accepting the presence of the ED, participants wrote about learning to accept and like their body and themselves. They talked about feeling *comfortable, feeling confident being yourself* and *not expecting yourself to be perfect*.

[39] *"Being able to be accepting and tolerant of my physical self. Being able to look at myself in the mirror and say 'there may be things about myself that I want to change, but for each thing I want to change, there are double as many things I like about myself.'"*

Sub-themes captured participants' developing ability to be more accepting of themselves to *stop comparing to others* and the realisation that, in society as a whole, *body-confidence is difficult for everyone*. This also represented a shift in perspective from self-focused to greater awareness of others.

Stage 3: Resilience

This stage encapsulates themes relating to participants' descriptions of taking control of their life and developing a positive sense of self. Self-compassion learned during stage 2 evolves into ability to separate appearance from value as a person. Finally, participants spoke about achieving a level of normality in their life, of *being able to function like every other person*.

Proud of body

This theme captures how participants thought body-confidence would feel. In part this meant being able to enjoy their body:

[156] *“Appreciating and loving one’s body not only for how it looks but for all the wonderful things it can do”*

Additionally, it meant freedom from constraints they experienced due to wanting to hide their body:

[186] *“Not letting shame/embarrassment about body get in the way of taking part in work/social/leisure activities.”*

The sub-themes capture other elements of freedom, such as being able to *dress in a way that expresses my personality* rather than using clothes to *disguise my body*.

Being happy in my own skin

This subtheme was similar to “proud of body” but remained distinct since it captured participants’ developing positive sense of self. It reflected acceptance of themselves as a whole person rather than being appearance-focused as in the previous theme.

[7] *“Being able to recognise your flaws but to love yourself regardless and be happy in your own skin.”*

[116] *“Being able to truly love myself inside and (eventually also) out. Feeling comfortable in my skin...”*

The developing positive sense of self led participants to realise that *personal worth is not related to size*. This revelation helped them *cope with the opinions of others*.

Being normal

This theme reflected participants’ descriptions of living unconstrained by the ED, capturing a sense of hope for the future and for a meaningful life.

[191] *“Being able to live life normally like everyone else.”*

[157] *“You can do normal things like work, study and socialise without limitations.”*

Living life well

Getting back to normal things was being able to live life fully, to enjoy oneself and have a social life.

[4] *“Living a life in which I can function without the eating disorder dominating to the extent that I can’t work, socialise or gain fulfilment from life.”*

[38] *“Actually living rather than existing.”*

Being normal was also linked to appearance; being able to maintain a *healthy weight* supportive of general good health as well as developing a *healthy relationship with food*, enabled participants to appear ‘normal’ and maintain their new freedom.

[210] *“A healthy weight for you (i.e. not minimum BMI 18-20), a weight that is easily maintained without counting calories/excess activity, and reasonably stable”*

[63] *“Being able to build a relationship with food in which restriction and bingeing were not an everyday part of life. There would no longer be forbidden foods and eating in public would be possible.”*

[223] *“Eating 3 meals a day with snacks, eating when hungry and stopping when full, eating whatever food you crave or would like, being spontaneous and unrestricted with food.”*

Statistical Analysis

For a more detailed discussion of test assumptions and secondary analysis, please see Extended Paper, Extended Results

Hypothesis One: Same-gender therapists will be preferred over gender-different therapists.

Data from each group was inspected prior to analysis. Frequency counts are displayed in table 7. Level of significance was set at $p < 0.5$. Since 50% of the cells had an expected frequency of < 5 , the appropriate test was Fisher's Exact Probability giving $p = 0.02$ for a two-tailed hypothesis ($d = 1.48$). The value of Cramer's V was 0.24, showing nearly 6% of the variance in frequencies of preferred therapist gender is determined by participant gender. Therefore a significant preference for same-gender therapist was demonstrated. The large effect size indicates that this difference may have clinical value.

Table 7. Group characteristics and frequency counts preferred therapist gender

		Mean	SD	Preferred Therapist	
				Female	Male
Participant	Female	1.18	0.39	114	25
Gender	Male	1.75	0.5	1	3

Hypothesis Two: Unrecovered individuals will rate therapist body-confidence as more important than recovered individuals.

Descriptive statistics of the sample's response to the question 'how important is it for your therapist to be body-confident (0-9)' revealed that overall therapist body-confidence was considered important (median = 7; inter-quartile range = 5.75-9)

In order to investigate whether a difference existed in ratings of importance between 'recovered' and 'unrecovered' individuals, participants were split into two groups based on outcome of therapy. Participants who had selected 'recovered' were compared with those who had selected one of the remaining two options. This group were classified 'unrecovered'.

Histograms for the two groups were inspected and skewness and kurtosis calculated. Data violated parametric assumptions and group sizes were unequal, so a Mann-Whitney was performed. Recovered and unrecovered groups were compared on their response to the question ‘how important is it for your therapist to be body-confident?’ Level of significance was set at $p < 0.5$. Group characteristics are presented in Table 8. Mann Whitney U was found to be 505 ($z = -1.24$; $p = 0.81$).

Table 8. Unrecovered and recovered importance of therapist body-confidence group characteristics

	Unrecovered		Recovered		
	Median	IQR*	Median	IQR*	Effect size <i>d</i>
Therapist body confidence	6.00	5 – 7.75	7.00	4.5 – 8.5	0.06

*Abbreviations in table: IQR = inter-quartile range

Discussion

The current study explored body-confidence and recovery and whether therapist body confidence and gender may be important within these processes, from the perspective of individuals who have an ED. Participants demonstrated significant preference for gender-same therapists and three overarching themes pertaining to body-confidence and recovery were identified. Beliefs about body-confidence were represented in a continuum which evolved alongside the cyclical process of recovery. The importance of body-confidence for recovery was supported by findings that all participants rated therapist body-confidence as important. However, statistical analysis did not support different perceptions of body-confidence between recovered and unrecovered participants.

The findings provide further support to the literature that indicates therapist appearance is important to ED clients. The themes contribute further understanding about the process of recovery from the perspective of individuals who have an ED.

Gender

The finding that participants prefer same-gender therapists corresponds to hypotheses in the literature examining social comparison processes in interactions between ED clients and their therapists. Social comparison theory posits salient features such as gender are used to determine relevance and usefulness of a comparator. The literature has noted therapists often serve as role models (Tantillo, 2004; Zunino, Agoos, & Davis, 1991) and may fulfil this function for their ED clients by demonstrating a healthy outlook towards their body and eating (DeLucia-Waack, 1999; Hoogerwerf, 2013). In line with social comparison theory, same-gender therapists are likely to be preferred as a role model since the client can make more relevant and direct comparison of the effect of adopting a healthy outlook toward their body.

In the context of the current study's limitations this finding remains speculative. Future research should investigate this preference further. In order to make recommendations for services regarding therapist gender, empirical evidence demonstrating that same-gender therapists produce better outcomes would be required. Nevertheless, the largely female ED population is currently reflected in services, since most therapists are female (Satir et al., 2009). Therapists should be made aware of client preference for a same-gender therapist. It may be helpful to acknowledge this preference and discuss how it might impact upon therapy. Notably services are already likely to provide gender-same therapists for ED clients. The impact of body-confidence may be one factor explaining continuing high rates of premature dropout from therapy in this population.

For further discussion, please see Extended Paper – Extended Discussion

Body-Confidence

Participants' changing perspective towards body-confidence was represented as a continuum, anchored by the converse perceptions that thinness equated body-confidence and body-confidence is possible at any size. The themes demonstrated the importance of psychological processes such as self-compassion, self awareness and self esteem in driving progression along this continuum. These processes enabled changes in perspective, leading to the realisation that size does not indicate personal worth. This reflected other processes in the cycle of recovery; for instance developing self-compassion, reducing use of appearance as an index for evaluation and having a healthy relationship with food.

Importance of a body-confident therapist may be explained with reference to the literature suggesting that therapists function as a role model, supported by the occurrence of social comparison. A body-confident therapist will enact processes in recovery that appeared alongside the evolving perspective toward body-confidence. By being body-confident, therapists may increase the attractiveness of this outlook and decrease

the attractiveness of being thin. Upward comparisons refer to instances when a superior other is observed to provide standards for self-improvement. A crucial factor in upward comparison is that the standard is considered attainable; body-confident therapists likely demonstrate this. As highlighted above, this effect is likely to be stronger if the therapist is same-gender.

The finding that therapist body-confidence is important to ED clients further supports findings in the literature suggesting therapists who have a healthy outlook provide hope and a positive experience of therapy (Hoogerwerf, 2013). The implications for clinical practice are important in the context of observations that therapists in ED services embody striking homogeneity not representative of the wider population (Murray, 2010). Treatment settings could take advantage of upward social comparison processes by providing ED clients with greater opportunity to view body-confident comparators perhaps achieved by increased focus in therapist training upon projecting body-confidence and a healthy outlook toward diet. One participant's experience demonstrates the importance of projecting such attitudes:

[103] "I have had three encounters with female therapists that I have found personally very distressing due to them exhibiting disordered views and clearly not being comfortable with themselves. On the other hand, I have had therapists who have been wonderful at promoting positive body image."

For further discussion, please see Extended Paper – Extended Discussion

Recovery

The literature hosts debate about what criteria represent recovery from an ED. Some argue weight-related criteria are sufficient (Morgan & Hayward, 1988) whilst others argue that psychosocial aspects are crucial, since rates of remission are reduced when these criteria are used (Bachner-Melman et al., 2006; Strober et al., 1997). The current study highlighted

that individuals who have an ED may go through a cycle comprised of three main stages: restricted by the ED; reconciling social and cultural pressure for thinness with ideals about themselves; before finally developing resilience sufficient to maintain a fulfilling and healthy lifestyle.

Objective criteria, such as not engaging in ED behaviours, were important to advance from the restricted stage. . This theme, and the theme *maintaining healthy weight* in the resilience stage, lends support to the use of the weight-restoration criteria proposed by Morgan and Hayward (1988). However, the importance of considering other factors in recovery is also supported by the current study. Participants described the necessity of *overcoming fear of food*, developing *self-compassion*, learning *not to compare themselves to others* and being *happy in their own skin*. These themes demonstrate that broader criteria encompassing improvement in psychological and social functioning provide more comprehensive criteria for recovery.

The current study contributes the voice of ED clients to understandings of recovery. Further support is given to arguments against use of weight-related criteria, which *just scratches the tip on the iceberg in terms of recovery*. Psychosocial aspects should be incorporated into definitions of recovery. By highlighting the importance of both sets of criteria to individuals who have an ED, clarity is given to previous, apparently contradictory, findings that ED clients viewed weight-related criteria as crucial (Noordenbos & Seubring, 2006) but did not mention weight in relation to recovery (Keski-Rahkonen & Tozzi, 2005).

Further, the role of social comparison for maintaining ED is underlined. Individuals who have an ED have low self-esteem (Fairburn et al., 2000) which is associated with elevated levels of social comparison (Bailey & Ricciardelli, 2010; David & Johnson, 1998). The recovery cycle elucidated themes indicative of improving self-esteem, such as *treating body as important* and *personal worth not related to size*, developing alongside

themes indicating reduced social comparison, such as *stop comparing myself to others*.

Implications for service delivery are evident. Current treatment guidelines recommend provision of cognitive-behavioural therapy for AN and interpersonal therapy for BN (NICE, 2004). The themes indicated milestones that individuals who have an ED considered vital for recovery. Prior to treatment, services could assess what milestones have yet to be achieved to tailor treatment to facilitate recovery from the most relevant stage for the individual. For this purpose, the recovery map could be used as a clinical interview tool or converted into a checklist of behaviours representative of each recovery stage. The current study's findings indicate that increased access to therapies that encourage development of self-compassion and acceptance, such as Compassion Focused Therapy (Gilbert, 2009) may help individuals to develop self-acceptance, reconcile cultural pressures and be happy in their own skin. Nevertheless, it is also clear that skills-focused approaches that enable an individual to manage the ED remain valuable.

For further discussion of service design, please see Extended Paper – Extended Discussion

Limitations

Despite high response to the survey, there was insufficient power for statistical analysis. Therefore findings should be regarded as preliminary and interpreted with caution. However, the study aimed to explore importance of therapist body-confidence. Trends in the data emerged, which, alongside rich qualitative descriptions, suggest this area warrants further exploration.

Participants completed the survey based upon recollections of past experiences of therapy. Retrospective accounts rely on the assumption that the event is recalled in the same way as it was experienced. However, the possibility that participants had re-interpreted past

experience cannot be ruled out. Additionally, recovered individuals may have answered based upon how they felt whilst receiving treatment and not upon current feelings. Indeed, one recovered participant stated she used her 'ED brain' to answer questions. This may account for the lack of significant findings between recovered and unrecovered individuals. Future research should more carefully word questions to clarify what perspective participants should take.

For further discussion please see Extended Paper – Extended Discussion.

Future research

The study aimed to communicate views of individuals who have an ED. Therefore, areas for future research have been largely informed by participant feedback. Several participants thought it would be important to explore reasons for preferring same-gender, body-confident therapists, as well as indicators they might use to ascertain whether their therapist was body-confident.

[44] "How clients could know how body-confident a therapist is"

[63] "How one would know whether they were body-confident or not regardless of their size."

Similarly, there was suggestion that age of the therapist might determine how important gender or body-confidence was.

[33] "I think age can also make a difference"

[9] "I would rather have a young man than a young woman, but would have no real gender preference for older therapists."

Several participants suggested exploring differences in views of recovered and unrecovered individuals about therapist body-confidence, or how an individual's views about their therapist might change during the recovery process.

[78] "Answers...depend on where you are in recovery."

[155] *“What the anorexic part of my brain felt was a 'body-confident' therapist and what the healthy part of my brain felt was a 'body-confident' therapist because there is a difference”.*

Finally, since many factors related to therapist appearance have been highlighted, it would be valuable to establish the relative importance of each factor in relation to client decisions to engage in therapy so causal links might be established and possible mediating variables identified.

Acknowledgements

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EXTENDED PAPER

Extended Background

Overview

This section is intended to provide further description of issues introduced in the journal paper and thus will follow broadly the same structure. In keeping with the current study only literature relevant to adults with an eating disorder (ED) is discussed. Each subsection is completed with conclusions about literature relevant to the design and rationale for the current study. An overall summary of these conclusions is provided in the study aims sub-section.

Treatment Efficacy

Recently, the UK government announced plans to invest £150 million to radically reform treatment of eating disorders in young people (GOV.UK). Part of this investment includes extending access to evidence-based talking therapies. Current treatment guidelines outlined by the National Institute of Clinical Excellence (NICE, 2004) recommend cognitive behavioural therapy (CBT) and interpersonal therapy (IPT) for the treatment of bulimia nervosa (BN). In addition to these therapies, cognitive analytic therapy (Cogley & Keel, 2003) and family therapy are recommended for the treatment of anorexia nervosa (AN). These guidelines are informed by extensive review of treatment efficacy literature. Notably, recommendations for treatment of AN are categorised as grade C, indicating they are based upon expert opinion in the absence of empirical evidence. The journal paper referred to low treatment satisfaction in at least one third of the ED population (Clinton et al., 2004), often resulting in poor engagement (Leavey et al., 2011) and low treatment efficacy. Alongside limited empirical evidence for treatment of ED, low treatment satisfaction implies the necessity of more research investigating efficacious treatments.

Several reviews of treatment efficacy underline this conclusion (Hay et al., 2009; Shapiro et al., 2007; Wilson et al., 2007). The reviews highlight that

as well as being limited, existing literature is constrained by small sample sizes, high attrition rate and variable trial quality. For example, though CBT has been included in 6 randomised control trial (RCT) designs (Wilson et al., 2007), the results are often difficult to interpret due to poor study design (Richard, 2005). Nevertheless, some evidence exists to suggest that psychological intervention is better than other treatment approaches such as weight recovery, nutritional counselling and behavioural programmes targeting eating habits (Hay et al., 2009; Shapiro et al., 2007). Since explanatory models of ED are primarily psychological, there is a need for further research to highlight mechanisms of efficacious treatment.

Yet, despite the chronic nature of ED, the current literature largely neglects long term treatment outcome (Shapiro et al., 2007), with most studies focusing on immediate treatment gains (Hay et al., 2009). Emerging evidence suggests how treatment contributes to recovery from an ED, however studies tend to focus on early processes present in psychological intervention (de la Rie et al., 2006; Sly, Morgan, Mountford, & Lacey, 2013; Zeeck & Hartmann, 2005). Little research exists to suggest why individuals who have an ED are difficult to engage in treatment. In particular, the perspective of these individuals has rarely been considered (Vanderlinden et al., 2007).

More complete understanding of poor treatment efficacy may be facilitated by convergence of all knowledge about treatment; efficacy evidence, therapist and ED clients' views (de la Rie, Noordenbos, Donker, & van Furth, 2008). The current study hopes that by exploring engagement from the perspective of the ED client, further insight into limited treatment efficacy may be developed. Such knowledge has important implications for healthcare services, particularly the design of specialist ED community teams targeted by the new government funding, intended to reduce necessity for hospital admissions.

Premature Treatment Drop-out

The journal paper highlighted high treatment dropout rate amongst individuals who have an ED. Dropout rates may be as high as 70% (Fassino et al., 2009). Certainly, outcomes are unlikely to improve if individuals do not wish to engage in treatment. Importantly, dropout from therapy has been associated with higher need for re-hospitalisation, more ED symptoms at follow up (Baran, Weltzin, & Kaye, 1995), greater likelihood of relapse (Bjork, Bjorck, Clinton, Sohlberg, & Noring, 2009) and more chronic course of illness (Killaspy, Banerjee, King, & Lloyd, 2000). Commonly treatment dropout is discussed as a confounding factor rather than a variable in its own right.

The treatment efficacy literature lacks a consensus definition of dropout. Terminology varies across studies; terms such as premature treatment termination, dropout and attrition are used interchangeably (Mahon, 2000). Further, some studies investigate only individuals who chose to end treatment themselves (Bell, 2001; Bjork et al., 2009), whereas others investigate all instances of dropout whether initiated by client or therapist (Walsh et al., 2004). Failure to agree upon what constitutes dropout, alongside failure to isolate factors that lead individuals choose to end treatment, significantly affects how poor engagement is understood.

Further, there is lack of clarity across studies regarding the timing of treatment dropout. Some evidence suggests motivation for ending treatment may differ with treatment stage. Dropout early in treatment may be due to impulsivity (Wallier et al., 2009), fear of relinquishing symptoms (Leavey et al., 2011) and ambivalence regarding change (Wilson et al., 2007). Conversely, dropout later in treatment may be related to the individual feeling dissatisfied with treatment or therapist (Bjork et al., 2009; Walsh et al., 2004), or feeling sufficiently recovered to manage alone (Bjork, Bjork, Clinton, Sohlberg, & Noring, 2008)

Additional difficulties arise from stringent exclusion criteria applied by efficacy studies, likely limiting how findings might be generalised to the

clinical population. When carried out, studies of the clinical population analysed data gathered pre-treatment for general purposes, in an atheoretical way, using many comparisons (Mahon, 2000). These methods limit the applicability of data to a wider population, as well as increasing the chance of statistical error through use of multiple comparisons. Generalisation of findings is further complicated by variation in sample composition. Studies vary widely; participants differ on body mass index, ED subtype, duration of illness and age. Further, although family environment may impact upon dropout amongst adolescents, studies often include mixed adult and adolescent samples (Shapiro et al., 2007; Wallier et al., 2009).

Despite these limitations, investigations of patient characteristics have provided some evidence in support of effective treatment. Although demographic features have been found largely unrelated to dropout (Bell, 2001; Mahon, 2000), studies have shown other characteristics may contribute. High levels of pre-treatment depression, external locus of control (Steel et al., 2000) and higher levels of interpersonal difficulties (Franzen, Backmund, & Gerlinghoff, 2004) have been associated with dropout. However, these findings are rarely strongly significant and frequently un-replicated (Mahon, 2000).

Nevertheless, dropout is largely believed to be associated with intra-personal factors of the individual who has an ED. In particular, it is widely held that symptoms of an ED are ego-syntonic and therefore difficult to abandon (Waller, 2012). Although evidence for this supposition has not been consistently replicated (Leavey et al., 2011), motivational components, designed to increase the individual's readiness to change, are frequently incorporated into treatment (Treasure & Schmidt, 2001). Despite lack of significant findings in support of motivational approaches (Waller, 2012), they continue to be investigated in treatment efficacy literature. This may be due to belief that ED symptoms are ego-syntonic, coupled with the fact that dropout occurs early in treatment. Therefore, an approach designed to increase engagement in and motivation for treatment may appear ideal to address both of these factors.

Overall, evidence for characteristics that might predict dropout is patchy at best. Many more factors are likely involved, including characteristics of individuals who have an ED, treatment setting and treatment itself (Walsh et al., 2004). Though all factors are likely to be underpinned by interpersonal context they have rarely been examined within an empirically valid interpersonal theory (Bjork et al., 2008). The current study aims to address this. Further, understanding of treatment dropout is unlikely to be improved by continued investigation of factors that have yielded inconsistent and or weakly significant findings. Ultimately, ED clients need to feel safe to return to treatment (Leavey et al., 2011); therefore the current study aims to investigate factors related to the therapist that might influence how they appear to individuals who have an ED.

Treatment outcome and recovery

The journal paper highlighted difficulty caused by the lack of a consensus definition of recovery from an ED. Since this is highly relevant to measurement of treatment outcome as well as to the current study, this topic warrants further discussion here.

The concept of recovery has been defined as a personal process of changing one's attitude, values, goals and skills in order to live a satisfying and contributing life, despite limitations due to illness (Anthony, 1993). As such, recovery is a multi-dimensional and time-consuming process that enables the individual to live with their illness; recovery does not indicate all symptoms and suffering have been removed (Andresen, Caputi, & Oades, 2006; Anthony, 1993; Corrigan, Giffort, Rashid, Leary, & Okeke, 1999). This has had an important impact on the approach of services to working with individuals who have long-term mental health difficulties. NHS services have been organised to support individuals in the recovery process, evident in numerous policy documents encouraging increased personalisation and choice in service provision and putting service-users at the centre of their care (Department of Health, 2009; Sainsbury Centre for Mental Health, 2010). Such models of service delivery envision

supporting individuals to build resilience, a life beyond illness (Department of Health, 2011), and empowerment through greater service-user led involvement, education and training (Sainsbury Centre for Mental Health, 2010; Watkins, 2007).

Within the wider literature, personal accounts of recovery from service-users have proliferated, providing valuable insight into the complex nature of learning to live with a mental health difficulty. Many accounts describe how recovery changes the frequency and duration of symptoms. In early stages of the process, symptom intensity may be as high as previously experienced (Anthony, 1993) and even after recovery has been attained, relapse remains possible (Andresen et al., 2006; Watkins, 2007). This complexity renders definition of recovery from severe, long-term mental health difficulties problematic. The wider literature has hosted debate about what criteria should exist in terms of symptom improvement, psychosocial functioning and time-frame. A general consensus has been reached for depression (Keller, 2003; Nierenberg & M., 2001) and psychosis (Ahern & Fisher, 2001; Albert et al., 2011).

Similar debate is rife within the ED literature, though conclusion about components vital for remission and recovery has yet to be reached. Nevertheless, criteria against which to measure treatment outcome and recovery do exist. One of the earliest set of criteria to be developed are the Morgan-Russell criteria (Morgan & Hayward, 1988), used widely in outcome studies to define good, intermediate and poor treatment outcome (Bardone-Cone et al., 2010; Couturier & Lock, 2006b). These criteria are largely based upon weight gain and restoration of menses, thus have received criticism for being narrow and simplistic in focus and lacking generalisability across different ages (healthy weight range varies depending upon age) and gender.

Nevertheless, the Morgan-Russell criteria represent the argument for considering recovery from an ED in terms of behavioural symptom remission. Such categorisation is favoured due to practicality and ease of

measurement (Couturier & Lock, 2006b). Studies have shown both therapists and individuals who have an ED agree weight restoration and absence of ED related behaviours are important for recovery (Noordenbos & Seubring, 2006; Vanderlinden et al., 2007). However, one study analysing 'recovery talk' on a web forum for individuals who have an ED found weight restoration rarely associated with references to recovery (Keski-Rahkonen & Tozzi, 2005). Further, findings suggest lingering concerns about body weight and shape are risk factors for relapse (Cogley & Keel, 2003; Keel et al., 2005). Bachner-Melman et al. (2006) argue overlooking psychological factors in recovery leads to individuals who 'walk the walk' but still 'talk the ED talk'. Objective outcome measurement provides information for clinical treatment and improvement is often presented as approximation to cure (Roberts, 2004). Yet simple, objective measurement of symptom remission fails to fit with autobiographical accounts of the complex process of recovery. Therefore, although recovery of eating behaviour is important, improvement in psychological and social functioning must not be overlooked (Noordenbos & Seubring, 2006).

An alternative set of criteria were proposed by Strober et al. (1997). They suggest that an individual might be considered 'recovered' when they are within the healthy weight bracket and indistinguishable from healthy controls on measures of psychosocial functioning. Many studies have demonstrated differences between current and former ED clients on such measures. Body dissatisfaction (BD) and its influence on the individual's self-esteem is lower in recovered individuals when compared to unrecovered individuals and at a similar level to healthy controls (Bardone-Cone et al., 2010; Cogley & Keel, 2003; Keel et al., 2005). Recovered individuals have been found to have higher perceived level of interpersonal support, suggesting improvement in social functioning (Cogley & Keel, 2003; Keski-Rahkonen & Tozzi, 2005; Noordenbos & Seubring, 2006).

Rather than defining recovery as a definitive state characterised by absence of behavioural or cognitive ED symptoms, some authors have adopted the idea of recovery as a process wherein there may be differences in symptoms and symptom intensity at different stages. For example, Bachner-Melman et al. (2006) and Bardone-Cone et al. (2010) identified partially- and fully-recovered individuals and assessed differences in ED symptoms between each group and between each group and healthy controls. Partially recovered individuals were those who no longer performed ED related behaviours but still scored within the clinical range on psychological measures of BD, self-esteem and drive for thinness. Fully recovered individuals were indistinguishable from healthy controls on all measures.

All studies investigating what constitutes recovery from an ED have limitations. Most employ retrospective measures that require the individual to self-report about how they have managed post-treatment. Some have asked individuals to compare their level of functioning at the time of their final therapy session and their current level of functioning, which may be up to 2 years later (Bachner-Melman et al., 2006; Bardone-Cone et al., 2010; Noordenbos & Seubring, 2006). Further, many studies use small samples, limiting how findings might be generalised to the wider ED population. Though measurement of psychological functioning has begun to be included in research, it is rarely done in a standardised way. Some measures, such as the Eating Disorder Examination, include psychological aspects, though no clinical cut-off for remission exists and how much change constitutes clinically significant improvement remains unclear (Couturier & Lock, 2006a). Similarly, the time-frame required for remission of symptoms to be considered indicative of recovery varies. Typically, studies suggest between 8 weeks to one year (Bardone-Cone et al., 2010), however, some suggest up to 24 months (Bachner-Melman et al., 2006).

Clearly a consensus definition of recovery in the field would address many limitations within the ED recovery literature. Clarifying the concept of

recovery would enable comparison of treatment outcomes across studies and greater understanding of how symptoms, psychological aspects and recovery are related. The distinction between partial or behavioural recovery and full or behavioural and cognitive recovery may help clarify the concept as well as providing clinical utility. There is evidence to suggest remission of behavioural symptoms and weight restoration does indeed occur earlier than remission of cognitive symptoms (Fennig, Fennig, & Roe, 2002; Fichter, Quadflieg, & Hedlund, 2006; Strober et al., 1997). Therefore if key components of change for partial and full recovery can be identified and criteria to indicate when each stage of recovery has been attained can be agreed upon, services may be better able to design treatment programmes to support individuals throughout the recovery process. The current study aims to contribute to the current literature by asking both individuals who have an ED and recovered individuals about their experience in order to explore possible differences in how they might define the concept and what is important in the process.

Views of individuals who have an ED

The journal paper highlighted that views of individuals who have an ED are frequently absent in the literature. Given its relevance to the current study, this issue warrants further discussion. Although advances have been made in the understanding of ED aetiology and development, there has been relatively little improvement in treatment and service provision for individuals who have an ED (Nishizono-Maher et al., 2011). The views of ED clients about treatment are likely to influence key variables such as treatment uptake and outcomes (Swain-Campbell, Surgenor, & Snell, 2001). In the past decade, studies have been conducted investigating the preferences of individuals who have an ED with regard to treatment. Although such studies are relatively sparse within the ED literature, some common themes have emerged.

Amongst aspects of treatment identified as helpful by individuals who have an ED are those common to broader psychotherapy literature. Individuals who have an ED prefer a treatment environment that is empathic, non-

judgmental, accepting and offers understanding (Cockell, Zaitsoff, & Geller, 2004; Colton & Pistrang, 2004; Escobar-Koch et al., 2010; Halvorsen & Heyerdahl, 2007; Reid, Burr, Williams, & Hammersley, 2008; Tierney, 2008; Timulak et al., 2013). Indeed, a recent study that surveyed the top five essential features for a high quality ED service found that, in the UK, individuals who have an ED ranked the personal qualities of therapists most important (Nishizono-Maher et al., 2011). Nevertheless, these qualities alone are insufficient; the most helpful treatments also offered practical help and clear guidance (Reid et al., 2008).

More specific to ED treatment are interventions focused upon weight gain. Several studies have found a focus upon eating is largely viewed as unhelpful by individuals who have an ED (Emanuelli, Waller, Jones-Chester, & Ostuzzi, 2012; Timulak et al., 2013). However, weight gain is not seen as unimportant. A recent meta-synthesis identified preference for treatment that includes education about nutrition (Espindola & Blay, 2009). Many individuals who have an ED identified fear of loss of control central to their difficulties and treatments focused on weight gain overlooked their needs and increased their sense of helplessness (Cockell et al., 2004; Reid et al., 2008; Timulak et al., 2013). Preferred treatments enabled collaboration, allowed the individual to form an identity separate from the disorder (Pettersen & Rosenvinge, 2002) and increased self-esteem (Cockell et al., 2004). Individuals who have an ED expressed preference for psychological over medical interventions, particularly interventions incorporating psychological, emotional and social elements of an ED and recovery (Emanuelli et al., 2012; Reid et al., 2008; Tierney, 2008; Timulak et al., 2013). Further, treatments in which the individual felt they had social support were valued (Colton & Pistrang, 2004; Reid et al., 2008; Timulak et al., 2013), since this increased feelings of connectedness (Offord, Turner, & Cooper, 2006).

These findings highlight aspects of treatment programmes likely to be accepted by and helpful for individuals who have an ED. Further, they indicate areas of improvement important for recovery. Such information is

valuable and may be used in design of services and to inform clinical decision making (Newton, 2001). Indeed, there is a current emphasis upon service-user involvement in the development of treatment programmes. The Department of Health (2001, 2006) recognises such input as necessary and important for implementation of effective healthcare. Nonetheless, it is also vital to consider the strength of the research findings.

It is important to recognise only a small number of studies have explored views of treatment from the perspectives of those who experience ED (Offord et al., 2006). Of these, many use quantitative data collected from self-report questionnaires. This method likely limits responses given by participants, causing important variables to be overlooked. Additionally, description of samples is poor; participant demographics, treatment setting and contexts often lack clarification, which impacts upon how findings might be generalised. Also important is that samples are often recruited from ED associations or patient groups and likely to be members of self-help groups (Newton, 2001). Consequently, views of treatment may be skewed since such membership may strongly influence an individual's opinions about treatment and therapists.

Where qualitative data collection methods have been used, the quality of data has been moderate; a recent meta-synthesis rated the majority of qualitative studies as category B (Espindola & Blay, 2009). Data collection and analysis procedures were frequently poorly defined. Procedures to ensure methodological rigour, such as use of inter-rater reliability, were often not employed. Additionally, epistemological stance of researchers was poorly defined or not discussed. Such omission neglects consideration of how researcher's values might have influenced data analysis and what other interpretations might be possible.

Although the current literature exploring the views of individuals who have an ED has significant limitations, it does highlight the importance of combining methods of data collection to provide greater understanding of

experience and to strengthen conclusions. Consideration of these issues led the current study to adopt a mixed methods approach to exploring the views of individuals who have an ED in order to complement existing qualitative and quantitative findings.

Cultural Norms

The journal paper briefly discussed the supposed association of Western cultural norms for thinness with disordered eating. Since the current study is exploring attitudes toward body and appearance, further discussion about how such ideals might develop is warranted here.

BD has become so prevalent amongst women in Western society that it has reached normative levels in the population (Grabe et al., 2008; Thompson & Stice, 2001). This is concerning in the context of evidence to suggest that BD prospectively predicts development of an ED (Stice, 2001). Research has highlighted an association between high levels of thin-ideal internalisation and high levels of BD (Anschutz et al., 2008; Grabe et al., 2008; Thompson & Stice, 2001). Stice (2001) demonstrated thin-ideal internalisation predicted BD, which in turn predicted increased bulimic behaviours and negative affect amongst American high-school students. Pressure to attain thin-ideal causes discrepancy between women's ideal body-size and actual body-size, thought to lead to changes in health related behaviours, such as diet and exercise (Lowery et al., 2005).

Thin-ideal internalisation occurs due to internalising attitudes of significant or respected others (Thompson & Stice, 2001), most likely through processes of social learning and behavioural reinforcement. For example, Stice (1994) highlights how individuals who have BN are more likely to come from families concerned with food and appearance. Social pressure may come from family, peers or the media; in fact these sources of influence have been associated with clinical and non-clinical levels of eating disturbance (Young et al., 2004).

Research into the relationship between media exposure and eating has been prolific. Studies have focused on media content, medium and exposure frequency or upon individual differences that influence how a person responds to media exposure, such as self-esteem. A review of media and eating concluded women who internalise social standards of beauty have greater adverse reaction to appearance-related media and low self-esteem increases the likelihood of thin-ideal internalisation (Berel & Irving, 1998). However, since most studies used correlations the direction of associations is not clear. A more recent meta-analysis concluded experimental studies have demonstrated media portrayal of thin-ideal has an adverse effect on women's body image (Grabe et al., 2008). It concluded this evidence, taken alongside studies highlighting a positive correlation between media consumption and BD, demonstrates exposure to thin-ideal media is related to higher levels of BD, stronger thin-ideal internalisation and more frequent ED behaviours.

Few studies have investigated impact of media influence upon males (Morgan, 2008). Historically, there has been less cultural pressure upon males to achieve a particular body-ideal. Therefore values related to eating and body-size may be less prevalent in the male population (Lowery et al., 2005). Recently, the media increasingly portrays thin and muscular physique as desirable, leading to an increase in the number of males dissatisfied with their body who strive to lose weight or increase muscle tone (Harvey & Robinson, 2003; McCabe & Ricciardelli, 2004). Despite the literature's focus on females, some studies have investigated impact of media portrayal of thin-ideal upon males. Overall, findings indicate men share the same susceptibility as females; exposure to thin-ideal media leads to greater levels of BD (Blond, 2008; Leit, Pope, & Gray, 2001). Nevertheless, only 15% of BN and 10% of AN populations are male. Some authors have speculated this is due to ED being conceptualised as a female disorder (Strother, Lemberg, Stanford, & Turberville, 2012; Weltzin et al., 2005) and therefore males do not present to services unless there are comorbid issues (Bramon-Bosch, Troop, & Treasure, 2000).

Across the literature, evidence indicates people tend to associate weight with 'positive appearance' (Hesse-Biber, Leavy, Quinn, & Zoino, 2006), for example appearance-related compliments are associated with weight and body satisfaction (Bailey & Ricciardelli, 2010). As well as in media, this attitude may be proliferated and modelled to individuals by family and peers. Family attitudes promoting thin-ideal may be communicated via pressure to lose weight or a family association of weight and attractiveness (Anschutz et al., 2008; Stice, 2001). Similarly, suggestions from peers to lose weight, or dieting behaviour in friendship groups have been associated with ED behaviours (Anschutz et al., 2008; Stice, 2001).

Though the relationship between media, thin-ideal internalisation and eating disturbance has been widely investigated in the literature, many studies have important limitations. Most utilise a sample of White females, usually high-school, college or university students in English speaking countries, which limits how far findings might be generalised. Additionally, studies are often cross-sectional. More prospective and longitudinal designs are required to provide evidence of a causal role of media in BD. Studies investigating social pressures from family and peers also have limitations. Many have relied upon retrospective self-report from individuals who have an ED which could reduce the reliability of the data. Thus conclusions should be cautious. Further, many such studies have used case-series. Though data yielded from these studies is rich, small samples limit how widely findings might be generalised.

Finally, it is important to note proliferation of thin-ideal and positive association of weight with attractiveness are very much situated within Western culture. Occurrence of EDs is relatively low in non-Westernised countries (Furnham & Adam-Saib, 2001) and less common among minority groups in the US (Gluck & Geliebter, 2002). The low proportion of ethnic minorities in the ED literature has been highlighted (Stice, 2001), so it is unclear whether the same influences are associated with development of ED in individuals with different cultural backgrounds. Nevertheless,

researchers have hypothesised that being a member of an ethnic minority group may protect individuals when exposed to thin-ideal media. A study of South-African university students found females had more realistic views concerning their weight status and body shape than a similar study conducted in the UK (Senekal, Steyn, Mashego, & Nel, 2001). For example, South-African females who were 'normal' weight thought their weight was normal in contrast to British students who were more likely to state they were overweight.

Nevertheless, studies of eating disturbance in ethnic minority populations have found mixed results. Some findings indicate lower levels of perceived pressure to conform to thin-ideal amongst ethnic minorities compared to White populations, some have found greater perceived pressure and some have found no difference (Gluck & Geliebter, 2002). Shaw, Ramirez, Trost, Randall, and Stice (2004) have highlighted studies conducted during the 1980s reported significantly lower susceptibility to thin-ideal in non-Western cultures whereas more recent studies tend to note no significant differences. As more individuals from ethnic minority populations become acculturated to dominant Western culture, there appears to be an increase in the risk of developing ED attitudes and behaviours (Furnham & Adam-Saib, 2001). Indeed, after controlling for actual weight of participants from African-American, Asian-American and White-American backgrounds, one study found no difference between perceived or ideal body-size endorsed (Gluck & Geliebter, 2002). It would appear that the more involved ethnic minority populations become in Western culture the more individuals assimilate to mainstream cultural values espoused by media and members of Western society (Shaw et al., 2004).

Overall, the evidence suggests that thin-ideal endorsed by Western cultural standards for attractiveness is strongly associated with high levels of BD amongst females and, increasingly, males. Further, prospective studies have highlighted high BD predicts development of an ED. Individuals may be subject to social pressure to attain thin-ideal from

family, peers and the media (Berel & Irving, 1998; Stice, 2001; Thompson & Stice, 2001). Additionally, these effects appear to be becoming more widespread, with the 'protective' effect of being a member of a minority population apparently waning (Shaw et al., 2004). Nevertheless, only a small minority of the population exposed to thin-ideal actually develops an ED. Therefore, whilst they play an important role, cultural norms and social pressure cannot fully explain the development of disordered eating. Individual differences may be the determinant of who is most at risk of developing an ED (McGee, Hewitt, Sherry, Parkin, & Flett, 2005)

Social Comparison Theory

The journal paper made brief reference to social comparison theory in relation to ED. Since the current study is exploratory, it is important that theories guiding the research be stated prior to undertaking the study (Barker, Pistrang, & Elliott, 2002). Therefore deeper discussion of how social comparison theory might explain potential relevance of therapist body-confidence and gender is presented here. The decision to focus on social comparison theory was informed by theoretical prominence of socio-cultural models in conceptualisation of ED (Fitzsimmons-Craft, 2011). As discussed above, such models suggest individuals who have an ED have internalised Western cultural norms for thinness (Strahan, Wilson, Cressman, & Buote, 2006). Socio-cultural models afford an explanation for development of an ED that does not divorce individuals from their cultural context (Hesse-Biber et al., 2006).

Social comparison theory (Festinger, 1954) proposes people draw comparisons of themselves with similar others in order to evaluate skills and abilities. In general, comparisons may be either upward or downward. When upward comparisons are made, superior others are used to provide standards with which to drive self-improvement. Additionally, upward comparisons are made in order that an individual may judge their self-worth. Individuals who have an ED have a tendency to make upward comparisons of themselves with negative consequences to their self-worth (Ferreira, Pinto-Gouveia, & Duarte, 2013; Vocks et al., 2010). Conversely,

downward comparison facilitates self-enhancement; for example comparing oneself to an inferior other boosts self view. However, comparisons are not made indiscriminately. Individuals do not evaluate themselves against others whom they view as divergent (Festinger, 1954). Rather, individuals are driven to compare with others most similar or relevant to themselves (Fitzsimmons-Craft et al., 2012) and from whom they can attain the most useful information for assessing their ability. Overall, downward comparisons are preferred since they serve self-enhancing function. However, individuals will engage in upward comparison if the superior other is relevant and if the other's achievements are considered attainable (Strahan et al., 2006). With regards to ED, women pay attention to other women's bodies, so physical appearance becomes a relevant domain for comparison (Corning et al., 2006). Indeed, evidence suggests individuals who have high BD pay attention to others' bodies for longer (Cho & Lee, 2013) and women who have an ED are more likely to engage in social comparison than their peers (Corning et al., 2006; Tiggemann & McGill, 2004).

Hypotheses about how an individual might behave as a consequence of making upward or downward comparisons are unclear. Upward comparison may lead an individual to adjust behaviour to be closer to that of the superior other, thus maintaining proximity (Ferreira et al., 2013). However, other evidence suggests the superior other may be deemed too threatening to remain in close proximity, so the individual distances themselves (Buunk & Gibbons, 2007). Downward comparisons are unlikely to induce such behaviour as the inferior other is likely to be deemed irrelevant (Buunk & Gibbons, 2007; Corcoran, Crusius, & Mussweiler, 2011).

Women who have an ED have been found to have a tendency to engage in upward comparisons on appearance-related dimensions (Blechert et al., 2009; Fitzsimmons-Craft et al., 2012; Trottier, Polivy, & Herman, 2007). In the case of ED, how comparison might impact upon the individual is somewhat clearer. Upward comparison has a deleterious effect.

Neurologic evidence revealed enhanced activity in the amygdala of AN participants when they viewed photographs of another woman's body and they reported stronger negative affective reactions compared to healthy controls (Vocks et al., 2010). Women who more commonly compare appearance to others feel worse about their body (Blechert et al., 2009; Trottier et al., 2007), experience greater drive for thinness (Ferreira et al., 2013) and report more ED behaviours (Lindner et al., 2012). Thus social comparison is shaped by cognition, behaviour, affect and motivational factors as well as having impact upon the same.

Critique has been levelled toward social comparison theory; however this has largely been resolved through modifications to the theory (Corcoran et al., 2011; Wood, 1996). Nevertheless, an important criticism remains unaddressed. The theory posits that people make comparisons spontaneously and possibly unconsciously (Morrison et al., 2003). Therefore the possibility remains that individuals are not aware of their tendency to make comparisons with others. The issue of addressing this criticism remains unresolved. However, it seems unlikely an individual might be completely unaware they make social comparisons, since comparisons tend to be made along dimensions of importance to the individual. It is perhaps more likely that comparison upon important dimensions, such as appearance, become automatic and unconscious over time.

In relation to literature about how social comparison might explain development and maintenance of ED there are greater limitations. Most studies have used female samples (Arcelus, Haslam, Farrow, & Meyer, 2013) making it difficult to conclude whether males who have an ED have the same tendency for higher levels of social comparison. Samples used in such studies have often been drawn from non-clinical populations and findings extrapolated. The current study aims to address these issues by recruiting participants from the clinical population and including males in the sample.

Social comparison and self-esteem

The discussion about impact of media presentation of Western cultural thin-ideal highlighted individual differences may play a mediating role in how an individual responds to idealised images. Social comparison theory posits that upward comparisons play a role in how the individual judges their self-worth; therefore the construct of self-esteem seems particularly relevant. Low levels of self-esteem are well documented within the ED population (Fairburn et al., 2000; Olivardia, Pope Jr, Borowiecki III, & Cohane, 2004; Pastore et al., 1996). Evidence suggests low self-esteem may predispose an individual to frequently engage in social comparison (Stice, 1994). Low levels of certainty about personality and functioning (Morrison et al., 2003) and lower levels of self-esteem (David & Johnson, 1998) have been found in high social comparers. Self esteem may be contingent; that is, conditional on how far one meets internally or externally imposed criteria (Bailey & Ricciardelli, 2010). Individuals who have an ED are thought to have internalised cultural norms of appearance (Strahan et al., 2006). Therefore, they may engage in comparisons against these cultural standards in order to assess their own self-worth. Contingent self-esteem has been found to predict BD (Bailey & Ricciardelli, 2010). The same study also found social comparison was more important for maintenance of BD than self-esteem (Bailey & Ricciardelli, 2010).

In fact, individuals who engage in high levels of social comparison are more reactive to others' behaviours and have unstable self-concept (Corning et al., 2006; Gilbert & Meyer, 2003). Women with unstable self-concept are more likely to seek external points of reference for defining their identity and therefore are more likely to engage in social comparison (Vartanian & Dey, 2013). To the author's knowledge there is no research indicating whether this is also true for men. In the context of therapy, low self-esteem and a poor concept of self may cause ED clients to focus on their therapist to provide standards to guide their behaviour, rather than attempt to identify solutions for themselves (DeLucia-Waack, 1999). Recovered individuals have stated improved self-esteem is important for

recovery (D'Abundo & Chally, 2004) and have been found to have higher levels of self-esteem than unrecovered individuals (Bachner-Melman et al., 2006; Cogley & Keel, 2003; Keel et al., 2005). Perhaps improved levels of self-esteem serve to reduce ED clients' tendency to engage in social comparison and increase their ability to trust their own resources.

Social comparison and therapist gender

Salient and easy to process features are particularly influential in comparison processes. Therefore, therapist gender may be important since it is their most salient feature (DeHeer, Wampold, & Freund, 1992). Some evidence from psychotherapy literature suggests a gender-same therapist may improve their client's therapeutic engagement (Cottone, Drucker, & Javier, 2002). Males and females with high BD differ on characteristics they find attractive (muscular and thin respectively) and pay attention for longer to images of bodies that possess these features (Cho & Lee, 2013).

Social comparison theory suggests if therapist is gender-opposite, they may be considered irrelevant for comparison. Therefore the ED client would not engage in potential self-esteem boosting comparisons with their body-confident therapist if they were gender-opposite. Conversely, a same-gender therapist is more likely to possess physical characteristics the ED client values, so they are more likely to attend to the therapist and engage in comparison upon valued physical characteristics.

However, there is little consideration in the literature about how therapist gender influences therapeutic relationship (TR) from an ED client's perspective. Evidence suggests clients consider gender-matched therapeutic dyads (i.e. male client, male therapist; female client, female therapist) as most facilitative of TR and most likely to increase engagement in treatment (Wintersteen, Mensinger, & Diamond, 2005). From a social comparison perspective, it is likely same-gender therapists improve engagement since they provide a salient and relevant source of information about appearance to the client. As discussed above,

exposure to realistic information about appearance can have a positive impact upon an individual who has an ED. If the same-gender therapist has qualities that the ED client perceives as attainable, such as body-confidence, then they may be rendered more relevant due to the high saliency of shared gender.

Research exploring whether male or female therapists are preferential to ED clients has tended to focus upon therapist perspective (Bilker, 1993; Waller & Katzman, 1998). Further limitation in the therapist gender literature is the omission of male ED clients (Stein et al., 2001). Thus it is difficult to conclude whether preference for gender-matched therapeutic dyads applies to both male and female ED clients. The current study aims to address these limitations by asking a mixed gender sample of ED clients about therapist gender.

Social comparison and therapist body-confidence

Social comparison theory would suggest ED clients perform social comparisons with their therapist. Female therapists working with ED clients share many socio-cultural characteristics with their client group (Bilker, 1993; Satir et al., 2009; Crisafulli, 2009) and thus provide a relevant other with whom to compare. Consequently these comparisons may impact upon therapy. Research upon how comparison to others might affect TR has tended to focus on therapist perspective, through consideration of transference and counter-transference (Satir et al., 2009). Such investigation has found therapists can feel scrutinised by their ED clients (Kaplan & Garfinkel, 1999; Warren et al., 2009) and become driven to change exercise and eating habits due to increased attention on body image and physical condition (DeLucia-Waack, 1999). Therapist sensitivity to scrutiny from ED clients clearly impacts their experience of the TR. However, the literature has given little consideration about whether ED clients might engage in comparisons with their therapist. Since eating disturbance has been associated with greater tendency to make frequent social comparisons, whether up or down, it is reasonable to

assume that ED clients do make comparisons to their therapist (O'Brien et al., 2009).

Some evidence exists to suggest therapist appearance may impact upon how the client experiences TR. Vocks (2007) surveyed female eating disorder clients and found therapist body-size highly relevant to TR. ED patients may assess therapist ability based upon appearance, for instance an overweight therapist may be concluded incompetent (Warren et al., 2009). In such instances the client may engage in downward comparison in order to boost self-worth in the presence of a perceived threat. Indeed, Hoogerwerf (2013) found ED clients felt an overweight therapist was conspiring to make them overweight. Thus it appears ED clients engage in comparisons of themselves in relation to the therapist. Clients declared a preference for 'body-confident' therapists over 'thin' or 'overweight' therapists (Hoogerwerf, 2013).

Findings for ED clients' preference for body-confident therapists suggest comparisons with such an individual may encourage development of self-esteem. Further, in order for an individual to strive toward attaining the achievements of a superior other, the achievements must be considered relevant and attractive (Festinger, 1954). Thus if a therapist projects body-confidence, it may appear more realistic to the ED client. Further, body-confidence may indicate high self-esteem which may be considered an attractive trait. Research into how ED clients conceptualise body-confidence would be helpful to indicate why it may be considered an important therapist quality and therefore how it may impact upon the TR.

The current study aimed to explore how ED clients conceptualise body-confidence and how important it would be for their therapist to possess this quality. If males who have an ED share the same cultural risk factors as females who have an ED then the role of social comparison in maintaining BD and eating disturbance will gain support (Carlat et al., 1997). Therefore, both females and males are included in order to explore

whether male ED clients consider the same factors as females as important for the TR.

Sensitivity of discussing therapist appearance

Finally, it is important to acknowledge the potential sensitivity of the topic of therapist appearance. This is no doubt one reason it is largely neglected within the literature. The rationale for exploring how a therapist's body-confidence may impact upon their ED client has been highlighted. The particular issue of body-confidence was raised in previous research relating to therapist body-size (Hoogerwerf, 2013), although it was unclear whether participants associated body-confidence with body-size.

With regards to therapist body-size, the topic produces heated debate within the literature. Some highlight the rarely acknowledged homogeneity of staff in ED services not representative of the wider population (Murray, 2010). However, others determine our colleagues' bodies should not be our business unless there is a related impairment in professional functioning (Adamitis, 2000) and, further, question whether a therapist's size is related to competence (McGilley, 2010). Certainly there are ethical questions to be addressed regarding the potential impact of therapist size upon their client. However, there are also important legal issues to consider and certainly from this particular standpoint, it is uniformly discouraged to address a colleague's size or weight (McGilley, 2010).

Although the topic of body-confidence arose from research about therapist body-size, it remains unclear whether this concept is related to size or weight. The current study hopes to explore further what ED clients imagine body-confidence to mean. Previous research has highlighted therapist body-size has an important impact upon therapeutic engagement, with the suggestion that 'too thin' therapists may trigger competition with the ED client and 'overweight' therapists are considered untrustworthy (Hoogerwerf, 2013; Jacobs & Nye, 2010). The concept of body-confidence calls attention to another dimension in how a therapist's

appearance might impact upon their ED client. How we, as therapists, feel about our body is always in the room (Hornstein, 2010) and by the nature of our physical presence we communicate something to our clients (Picot, McClanahan, & Conviser, 2010). Though the topic of therapist appearance activates personal, professional and ethical considerations, it is important to undertake research regarding difficult topics concerning therapy, particularly those not yet fully addressed (Levine, 2010; McGilley, 2010). As therapists, we must be aware of the potentially profound effect our influence might impose upon our clients (Levine, 2010).

Study Aims

The study aims to address the current gap in the literature and utilises a mixed methods design to explore the meaning of body-confidence and recovery to the ED client, from the client's perspective. Additionally, if body-confidence is important to the ED client, the study hopes to indicate whether therapist body confidence and gender may impact upon therapeutic engagement and whether body-confidence may relate to recovery.

Extended Method

Overview

This section expands on information provided in the method section of the journal article, specifically detailing design rationale and procedure for this study. The rationale for mixed methods research (MMR) will first be addressed, followed by a description and rationale for adopting a critical realist epistemological position. A brief overview of qualitative approaches considered for the study will be provided, before rationale for using Thematic Analysis (Braun & Clarke, 2006) is provided. Finally, an outline of the development of study design, questionnaire, sampling, inclusion and exclusion criteria, ethical considerations, data collection and measures for quality assurance is provided.

Quantitative and Qualitative Research

Quantitative research is founded in positivist frameworks which hold scientific attention should be limited to observable facts (Bechtel, 2013). Positivism takes a hypothetico-deductive approach; the researcher knows the hypothesised relationship they wish to find between variables and test predictions using statistical models of inference (Barker et al., 2002). As such, findings of quantitative approaches are considered to be easily generalised to a wider population than was sampled.

In contrast, qualitative research is grounded in constructivist frameworks which attempt to provide rich description of experience (Hammersley, 1996). The approach comprises interpretive practices to make the world visible and interpret phenomena in the context of meanings that people may bring to them (Denzin & Lincoln, 2011). Data collected using such approaches is arguably richer and more detailed than quantitative approaches, but may be less easily generalised to a wider population than sampled. The active role of the researcher in interpretation of data at all phases of research leaves qualitative approaches vulnerable to researcher bias. However, all forms of research are open to such bias (Barker et al., 2002).

The key elements of quantitative and qualitative approaches present a range of strengths and limitations. Rather than placing each set of approaches in opposition, it may be advantageous to integrate them to enable richer explanation when approaching complex issues (Denscombe, 2008). Indeed, Creswell (2011) argues distinguishing between qualitative and quantitative methodology creates a division that does not exist in practice. For example, context can often be inferred from quantitative numerical data and qualitative judgements are often required during statistical analysis procedures (Sandelowski, Voils, & Knafl, 2009).

Mixed Methods Research

MMR synthesises ideas from qualitative and quantitative research approaches for the purpose of breadth and depth of understanding (Johnson, Onuegbuzie, & Turner, 2007). As a methodological approach, MMR focuses on collecting, analysing, and mixing both quantitative and qualitative data in a single study. The central premise is combining approaches enables better understanding of complex issues than either approach alone (Sale, Lohfeld, & Brazil, 2002). MMR is commonly used in applied human sciences since it casts a wide lens, utilising all available data sources to answer a question (Teddlie & Tashakkori, 2011). It may be applied at all levels of the research endeavour, simultaneously addressing confirmatory and exploratory questions (Teddlie & Tashakkori, 2011). Core characteristics of the approach are collection and analysis of both qualitative and quantitative data, mixing the two concurrently, either through combining them or sequentially building one upon the other (Bryman, 2006).

MMR is advantageous for investigating research problems where one method of enquiry would be insufficient. For example, when quantitative results might be explained by a qualitative element to enhance study findings, or qualitative, exploratory findings might be generalized by addition of a quantitative element to study design (Creswell, 2011). Further, when the area of research is new or there is a paucity of knowledge about a population being studied, qualitative exploration of

what questions should be asked, variables examined and theories applied is illuminating. Addition of a quantitative element to this exploration may enable identification of a population subset to which findings are most relevant (Creswell & Plano Clark, 2011).

Rationale for using MMR

Mixed methods approaches enable researchers to locate numbers in the context of participant experience and the same experience to be situated within trends and statistical findings (Creswell & Plano Clark, 2011). The current study elected to employ a mixed methods approach for two reasons. First, to the author's knowledge, the topic of body-confidence has not been researched before in the ED literature. Thus inclusion of a qualitative component to explore and give voice to individuals who have an ED seemed particularly important. Second, if a difference exists in importance of therapist body-confidence between genders or between individuals at different stages of recovery, then there would be important implications for treatment engagement and service delivery. Therefore the quantitative element was added in order to allow identification of clinically significant differences.

Further, there has been widespread discussion in the ED literature about whether therapist gender may impact upon the relationship between therapist and ED client. A second quantitative element was included to allow participants to indicate whether they had a preference for therapist gender, in order to clarify the importance of this factor from the perspective of individuals who have an ED. It was hoped the addition of this data would enhance understanding of qualitative exploration of body-confidence, for example by indicating that body-confidence was most important in therapists of the individual's preferred gender.

Critique of MMR

As outlined above, different methodologies have traditionally been linked to particular worldviews. One major criticism of MMR is combination of qualitative and quantitative methods may be incommensurable due to

opposing epistemological stances. However, some authors argue paradigm boundaries are not fixed and definite (Morgan, 2007) and epistemology and method are not synonymously linked (Johnson & Onuegbuzie, 2004). Though Lincoln, Lynham and Guba (2011) argue that elements of paradigms may be blended in a single study, most authors agree methods may be mixed so long as paradigms are not (Bryman, 2006; Johnson & Gray, 2010; Morgan, 2007)

Another key criticism is that MMR undervalues the qualitative, using it as a subordinate element to the quantitative component (Teddlie & Tashakkori, 2011) and thereby propagating positivist approaches (Giddings, 2006). However, the qualitative element is viewed as extremely important, particularly in research seeking to advocate for an under-represented group (Sweetman, Badiie, & Creswell, 2010). Further to this concern is the argument that it is more time consuming to analyze two types of data. Rather than being utilized to truly expand and enhance understanding of the topic under study, two types of data are analyzed inadequately (Creswell, 2011). Thus results presented as a unified and complex explanation are in fact fragmented (Freshwater, 2007).

MMR has been further criticised for the claim it has overcome the dualism of the competing paradigms debate and reduced researcher bias (Freshwater, 2007). In fact, many mixed methods researchers conflate practical methods with theoretical assumptions so what has been mixed is unclear and internal inconsistency is increased (Giddings & Grant, 2007). In response to these criticisms, many mixed methods researchers have recommended greater specificity about how both methods have been integrated and which method, if any, has been given priority (Hanson, Creswell, Clark, Petska, & Creswell, 2005; Tashakkori, 2009)

Limitations of MMR

The current study acknowledges the incommensurability issue in mixing methods. It is not the authors' intention to create a one to one correspondence between ideas of opposing paradigms. The aim of the

study is a pragmatic one in that the findings sought are in pursuit of giving voice to ED clients, to expand understanding about how to improve treatment success. Thus qualitative and quantitative methods are integrated, with emphasis on qualitative data, in order to yield a richer description of these individuals' experiences. The author's epistemological stance in relation to this design is further discussed in a later section.

Furthermore, the current study acknowledges that both qualitative and quantitative approaches share some limitations. Both rely upon observations which are implicitly or explicitly based upon pre-existing theory (Barker et al., 2002). Thus all knowledge is theory dependent (Danermark, Ekstrom, Jakobson, & Karlsson, 2002). Therefore, pre-existing theories that may influence interpretation have been acknowledged within the extended background section.

Finally, although the mixed methods design was implemented in order to elucidate detail about the impact on the ED client of therapist body-confidence and gender, the fallibility of this explanation is acknowledged. Frequent observation of a phenomenon does not conclusively verify its existence (Barker et al., 2002). Therefore, in line with the epistemological position of the current study, all conclusions made are tentative and probabilistic.

Epistemological Position

Epistemology is concerned with the philosophical nature of knowledge, including context and contingency in social knowing (Greene, 2008). It addresses questions about how we know what we know and how reliable this knowledge is (Thompson & Harper, 2012). Every research study involves such assumptions, thus explicit statements about the researcher's position on knowledge, truth and reality are informative (Danermark et al., 2002; Hanson et al., 2005). As stated in the journal paper, the current study adopted a critical realist stance. Epistemological positions are rife with contradiction due to the influence of styles of

reasoning which set criteria for assessment of truth (Sugarman, 2009). Thus the author's interpretation of the critical realist stance will be explained in order to clarify how this position informed the current study.

First, alternative epistemological positions of positivism and constructivism will briefly be summarized to locate the argument for adopting a critical realist stance. Further, an overview of pragmatism will be presented since MMR commonly adopts this methodological stance. This overview is presented here since it is relevant to the argument for a critical realist position. Finally, implications and limitations of the chosen stance are acknowledged.

Overview of positivism, constructivism, pragmatism and critical realism

Much empirical research is informed by positivism and its assumption that an objective reality independent of human perception exists. Knowledge about objective truth may be obtained via a series of neutral observations (Danermark et al., 2002). Broadly, positivism cites researchers may study phenomena without influencing them or being influenced by them (Sale et al., 2002). Therefore, what is observed represents truth and reality.

Conversely, constructivist approaches believe there is no reality free from interpretation. Thus individuals construct their own perceptions of the world (Harper, 2012). Constructivist approaches present a multifaceted view of the world, drawing attention to how language and reality are related in such a way that facts are seldom objective in a definite sense (Danermark et al., 2002). In its most radical forms, constructivism holds language is used to order the world and is not necessarily representative of individual experience (Lincoln et al., 2011). Researchers cannot study phenomena in a neutral or objective fashion since their observations are coloured by personal history, social background and cultural assumptions (Morgan, 2007).

Critical realism takes a stance midway along the positivist-constructivist continuum, arguing that reality is affected by how it is experienced but also has an ongoing structure independent of how it is known (Olsen, 2004). Theories about the world are influenced by perspective and all knowledge is partial, incomplete and fallible (Maxwell & Mittapalli, 2010). This stance indicates research is focused upon the relationship between the real world and its interpretation (Danermark et al., 2002). Therefore, research cannot be useful unless there is reflection upon how empirical data was constructed (Harper, 2012).

Thus, quantitative approaches are usually underscored by positivism and qualitative approaches by constructivism. By combining two seemingly opposing methodologies, mixed methods research challenges how differences in epistemological stance might be reconciled. Pragmatism offers one answer to this debate, citing knowledge might be obtained only via a combination of action and reflection (Biesta, 2010). As such, focus is upon the relationship between action and consequences rather than existence of an explanatory theoretical framework (Morgan, 2007). In general, the pragmatist stance focuses upon the practical to decide what action will advance understanding of phenomena (Johnson & Onuegbuzie, 2004). Pragmatists argue that debate about epistemological stance prevents researchers from utilising the best and most practical methods for answering research questions (Bryman, 2006). Therefore, under pragmatic assumptions, researchers may combine different methodologies claiming that, in practical terms, the distinction between epistemological stances is meaningless.

Pragmatism seeks a middle ground between philosophical dualisms with a focus on negotiating workable solutions to conceptual disputes. The either-or dichotomy of explanatory or exploratory questions is replaced by a continuum describing a range of options (Teddlie & Tashakkori, 2011). Polarising qualitative and quantitative methodologies, as in the incommensurability debate, neglects the fact that, in the practical research process, elements of both are often combined (Danermark et al., 2002).

However, critics argue that pragmatism lacks principles that provide rationale for a particular course of action (Denscombe, 2008). Since no research can be void of theoretical concepts, lack of specificity about theoretical lens through which data is interpreted confers a major limitation and introduces greater risk of researcher bias (Sandelowski, 2010; Sweetman et al., 2010).

For these reasons, many proponents of MMR argue that it is both possible and important to take an epistemological stance within such a study (Danermark et al., 2002; Hanson et al., 2005; Sweetman et al., 2010). Indeed, if MMR is viewed strictly as a method, then researchers may take any philosophical stance as foundation for justifying the chosen approach (Creswell, 2011). In particular, if the phenomenon investigated by each method is clearly labelled then methods may be combined in a single study (Sale et al., 2002).

From this argument it should be clear why the authors have chosen to adopt a philosophical stance for the current study. The following section will further outline the rationale for choosing critical realism. First, since there is a proliferation of realist positions (Maxwell & Mittapalli, 2010), it is important to clarify the authors' interpretation of this stance.

Straightforwardly, most observations can accurately represent objects and are necessary for understanding. However, some observations are influenced by personal, social and cultural background and therefore do not provide accurate understanding. Importantly for the current study, wherein participants communicate in writing, the authors believe the participants' language represents their experience but interpretation of their language is coloured by the authors' background.

Rationale for critical realism

Critical realism incorporates some elements from the constructivist approach by acknowledging importance of language in constructing reality. Additionally, elements of the positivist approach are acknowledged in assertion that some aspects of reality might be accurately understood

through observation. Mainly, the constructivist stance was rejected due to its view that language does not represent experience and the process of construction should be the focus of research. The adoption of an epistemological position focused on interpretation rather than experience would be counter-intuitive to the current study's aim; to give ED clients a voice. The positivist stance was rejected most importantly due to the position that subjective experience would be excluded from study. Again, this seemed counter-intuitive to the current study's aims. Further, the assertion that researchers might observe phenomena without influencing them was concerning. The authors acknowledge that data will be interpreted through our experiences of being therapists and women in the Western world.

Adopting a critical realist stance allows maintained awareness of the constructed nature of research whilst acknowledging how this construction might influence interpretation, without rejecting the importance of subjective experience as worthy of study.

Alternative methods of qualitative enquiry

The journal paper states participant responses to the open-ended survey questions were analysed using thematic analysis (TA). Other approaches to analysing qualitative data were considered. The following sections are intended to outline these approaches with reference to how they perceive truth and reality as well as to provide rationale for the decision to use TA. The limitations and implications of this decision are also discussed.

Grounded Theory (GT)

GT was developed by Glaser and Strauss in order to provide an iterative process for systematic analysis of unstructured qualitative data (Pidgeon, 1996). By utilising a detailed inspection of data about a particular issue, GT states new developments and new theories may be generated (Henwood, 1996). GT was not considered an appropriate approach for the current study since the aim was to explore experience of individuals who have an ED. Development of new theory is not necessary in relation

to this aim and may dilute the voice of the individual by imposing interpretative viewpoint of the researcher on data.

Discourse Analysis (DA)

DA focuses upon how phenomena are constructed and used in social interactions (Potter, 1996), taking a constructionist view of language (Henwood, 1996). That is, mental processes do not translate directly into action, rather they are used to construct and direct social interaction (Potter, 1996). DA was rejected for the current study for two reasons. Firstly, it would be difficult to align constructionist principles of DA with the current study's critical realist perspective. Secondly, it was felt the interpretation of language used by participants was in direct opposition to the aim of facilitating individuals who have an ED to express their opinions.

Interpretive Phenomenological Analysis (IPA)

IPA is concerned with human understanding and emphasises importance of lived experience (Smith, Jarman, & Osborn, 1999). 'Phenomenological' refers to the purpose of gaining individual perspectives about experience and 'interpretive' acknowledges influence of the researcher's own perspective upon data (Fade, 2007). Although the current study aimed to understand ED clients' perspectives, IPA was rejected due to the emphasis placed upon experience and bias of the researcher. This particular approach limited the lenses through which data might be considered. Thus utilising TA allowed the current study to view data from multiple perspectives, including the perspective the researchers shared with most participants; being women in the Western world.

Thematic Analysis

Broadly, TA aims to identify patterns or themes in data that then form categories for analysis (Fereday & Muir-Cochrane, 2006). In many ways, TA is similar to content analysis (CA), which involves counting the frequency of established categories in a text (Silverman, 2011). Though valued for efficiency and reliability, CA is considered to be constrained and

limited since it removes the category from the wider context (Namey, Guest, Thairu, & Johnson, 2008). TA is a more nuanced approach that aims to capture something important about the data. Themes are identified that represent either explicit and implicit meaning within the data set (Braun & Clarke, 2006). Boyatzis (1998) describes themes as, at minimum, organising observations and, at maximum, interpreting aspects of the phenomenon. Due to the element of interpretation involved in TA, reliability is less certain than in CA since different researchers may vary in their analysis of the same data (Namey et al., 2008). Nevertheless, precautions can be taken to ensure rigour and reliability. The current study takes the recommended actions of stating the author's epistemological position (Braun & Clarke, 2006) and developing a template for coding in order to evidence the analytic process (Fereday & Muir-Cochrane, 2006).

Rationale for TA

There are several reasons TA was chosen for the current study. Firstly, it is suitable for use within any epistemological framework (Braun & Clarke, 2006), so fits with this study's critical realist stance. Secondly, Boyatzis (1998) states TA allows findings to be more easily communicated than other approaches. Since the current study aimed to explore importance of body-confidence, greater accessibility of findings should allow recommendations to be followed up more readily by further research. Thirdly, TA enabled an external framework, informed by social comparison theory, to structure analysis whilst avoiding imposition of pre-determined categories upon data that might limit analysis. Thus identification of themes inductively from data remained possible.

Finally and most importantly for the current study's aims, TA enables identification of salient themes in data that represent how participants conceptualise the issue under study (Fereday & Muir-Cochrane, 2006). Thus the current study is able to emphasise experience of ED clients rather than researcher-constructed reality. Though this is perfectly in line with the study aims, the limitations of TA are acknowledged.

Critique of TA

One major criticism of TA is that identification of themes within a dataset risks fragmenting data and the loss of meaning for an individual (Hollway & Jefferson, 2013). However, the aim of TA is not to perform a deep analysis of one individual's experience but to identify meanings valid across a group of people. Additionally, TA has been criticised for its lack of consideration about how researcher bias impacts upon interpretation and analysis of themes (Silverman, 2011). However, the current study has emphasised systematic and transparent analysis so the process may be followed or challenged by other researchers. Importantly, few explicit biases are likely since the first author has no history of ED and does not work clinically with the ED population. Therefore it was not deemed necessary to utilise an approach to accommodate researcher bias.

Study Design Rationale

The study design was outlined in the journal article. This section provides further description and rationale for each element of design, including participant inclusion and exclusion criteria, sample size, questionnaire design and online data collection. Finally, ethical considerations are discussed.

Inclusion Criteria Rationale

The online research environment does not allow the application of stringent exclusion criteria (Jones, 1999). Including only those participants aged 16 years and over was a practical and ethical decision. Further, as outlined in the journal article, social comparison is most likely to occur with similar others (Festinger, 1954; Fitzsimmons-Craft, 2011). Therefore, exclusion of participants younger than 16 years of age was designed to provide a sample more likely to share similar characteristics with their therapist. The exclusion of participants with co-morbid psychiatric diagnoses was not considered necessary since the majority of ED clients are diagnosed with an Axis I or Axis II disorder (Wardle & Chadwick, 2007). Finally, the decision to include individuals at all stages of an ED

was intellectual, informed in part by lack of consensus in the literature regarding what constitutes good treatment outcome and recovery from an ED (Fassino et al., 2009; Mahon, 2000).

The decision to include all ED subtypes warrants more in depth discussion. The debate surrounding the diagnostic criteria for ED seems important to consider. A consensus definition of what constitutes ED has yet to be reached in the literature. This difficulty is further exacerbated by the fact that many individuals classified as having an ED move between diagnostic categories, for example BN may develop following a history of AN (NICE, 2004). Fairburn & Cooper (2003) argue this movement across categories reflects a poorly defined single disorder rather than recovery from one disorder and development of another.

Indeed, individuals who have an ED are known to share characteristics such as weight control by manipulation of food intake and fear of losing control over eating behaviour, as well as high correlation between weight and body shape with self-esteem (Fairburn et al., 2003; Vitousek & Watson, 1998). Characteristics comparable across ED perhaps contribute to difficulty in reaching a consensus definition across the literature and certainly inform the rationale for adopting a transdiagnostic approach (Fairburn et al., 2003).

The transdiagnostic approach posits that all ED subtypes are maintained by common psychopathological processes and maintaining mechanisms (Fairburn et al., 2003) and is widely used in treatment of individuals who have an ED. Therefore, adoption of this approach in the current study seemed sensible. Firstly, knowledge that all individuals across ED subtypes share the same psychopathological processes suggests they are likely to engage in similar social comparisons. Secondly, the transdiagnostic model is commonly used in ED treatment services. By adopting the same model the current study hoped that findings would be directly applicable and informative to these services.

Sample Size Justification

The sample size was originally informed by the research question and proposed methodology. A power calculation was carried out using G-power¹ software to ensure the sample size was large enough to provide sufficient power for repeated measures, within-between interactions MANOVA.

Effect size = 0.30

α error probability = 0.05

1- β error probability (power) = 0.95

Number of groups = 2

Number of measurements = 6

It was expected some participants may wish to withdraw prior to their data being anonymised for analysis. Figures from the ED literature suggest the dropout rate of this population is between 29-73%. Recently, a study using the same method of recruitment as the current study experienced a drop-out rate of 0%. Since the strengths of recruitment using this methodology have been demonstrated, and participation in this study was voluntary, the dropout rate is estimated to be minimal. Therefore:

Sample size = 226

Assumed dropout rate of 29% = 65

Adjusted sample size = 291

Recruitment to the study was monitored in order to ascertain the success of advertising and recruitment strategies (see recruitment section below for further discussion). Few male and few recovered participants were recruited. An interim analysis of data undertaken to inform decisions about recruitment revealed a male vs. female participant views and recovered vs. unrecovered participant views of therapist body-confidence yielded a small effect size (Cohen's d = 0.04 and 0.06 respectively).

¹ See <http://www.psych.uni-duesseldorf.de/abteilungen/aap/gpower3/download-and-register> for information about the tool

Therefore, the decision was taken to analyse male and female participants as one group. Previous studies have suggested that since female and male ED clients are similar in clinical presentation, mixed gender analyses are valid (Bramon-Bosch et al., 2000; Carlat et al., 1997; Woodside et al., 2001). This necessitated change to the planned analysis. A power calculation was done to determine sample size necessary for the small effect size between recovered and un-recovered participants to reach significance for therapist body-confidence. This calculation yielded a necessary sample size of 8,724. Since the difference between male vs. female participants and recovered vs. un-recovered groups was minimal and likely to lack clinical meaning, continued effort to recruit a greater number of males and recovered individuals to the sample was not considered sufficiently important. Further, the sample size required to produce a clinically meaningful effect size with regards to recovered and un-recovered participants was not considered attainable within the time frame available.

Recruitment

As stated in the journal paper, awareness of the study was raised by advertising on websites and mailing lists of the ED charities BEAT, Men Get Eating Disorders Too and First Steps Derby as well as on the Rethink Mental Health website and a landing page on a website for advertising research studies, "Call for Participants". Due to the challenges outlined above, recruitment warrants further discussion here.

The study was first advertised on websites and mailing lists of ED charities BEAT and First Steps Derby. Following low recruitment rates via this advertising strategy, an amendment to ethical approval was sought to allow advertising through additional charities, including a charity specifically aimed at supporting men who have an ED; Men Get Eating Disorders Too. Permission to advertise the study more widely resulted in an increase in number of participants recruited. Further, male participants were recruited following the advert being published by Men Get Eating Disorders Too.

During the period of recruitment, the first author made regular contact with charities to update them on progress. In particular, Men Get Eating Disorders Too was contacted to request the advert was sent to their mailing list again, since this had been effective in eliciting participation from males. Nevertheless, recruitment of male participants remained low. This is not unusual within ED research; a recent review highlighted male participants often formed a negligible proportion of mixed gender samples, i.e. between 0 and 2% (Fassino et al., 2009). Indeed, one study found 220 out of 334 in a potential sample of male ED clients declined to participate in research (Weltzin et al., 2012).

Many authors have speculated about why males are less likely to present for treatment or participate in research about ED. One common explanation is males must cope with a great deal of stigma since ED is viewed as a typically female disorder (Carlat et al., 1997; Strother et al., 2012; Weltzin et al., 2005). Further, due to this particular bias, males may not be aware of issues associated with disordered eating and therefore remain unaware they have an ED unless other co-morbid issues arise that bring them into contact with services (Bramon-Bosch et al., 2000). The current study attempted to address this by also recruiting through charities that deal with wider mental health issues, such as Rethink.

Alternative methods of recruitment were considered to increase the number of recovered ED individuals recruited to the study, such as advertising the study via social media platforms. However, following interim analysis, it was decided further expanding advertising of the study was unlikely to meet the sample size required within the time constraints of the project. Further, sufficient qualitative data had been collected to begin thematic analysis. Recruitment to the study was kept open during the initial coding of the themes, in order to allow maximum collection of quantitative data.

Questionnaire Description and Rationale

As stated in the journal paper, data was collected using a web-based questionnaire accessed via a web-link. The first author designed the first version of the questionnaire. The structure was informed by questionnaires in the literature (Hoogerwerf, 2013; Vocks, 2007). The instrument incorporates the Contour Drawing Rating Scale (Thompson & Gray, 1995), developed to assess BD. The CDRS has recently been used to elicit preferred therapist body-size (Vocks, 2007) demonstrating its appropriateness for use in assessing ED clients' perception of others. Estimation of body-size is related to an individual's attitude towards their body (Skrzypek, Wehmeier, & Remschmidt, 2001). The current study chose to use a measure of body-size estimation to investigate attitudes of ED individuals towards the body of their therapist. Responses on the CDRS could be compared to participants' responses to the qualitative section of the questionnaire to explore whether or not perceived body-confidence appears to be related to perceived body-size.

The first version of the questionnaire was revised in collaboration with University of Nottingham researchers to ensure structure and questions were not too suggestive. Finally, feedback was obtained from members of First Steps Derby (FSD), a charitable Eating Disorders support group. Revisions were made according to all feedback before the final version of the questionnaire was produced².

The questionnaire opened with definitions of terms used, such as 'therapy', 'therapist' and 'eating disorder'³ to increase clarity and specificity of language in the questionnaire (Barker et al., 2002). Additionally, promoting a shared understanding of these terms between participants increased validity of responses. As stated in the journal paper, the first section of the questionnaire asked participants to provide information about themselves, their ED and their experience of therapy. The final two

² Copies of the questionnaire, with and without design commentary, are provided in Appendices C.1 & C.2 respectively

³ NHS website definitions of Eating Disorders and a link to the DSM-IV diagnostic criteria were provided. Please refer to Appendix C

questions in this section were intentionally broad, designed to allow participants to express their opinions and feelings with regard to recovery and body-confidence. With regards to recovery, the decision to invite an open answer was due to the lack of consensus definition of this process in the literature. Therefore, since the motivation for the study was to explore perspectives of individuals who have an ED, it seemed important to allow participants to share their own ideas about recovery.

The rationale with regards to body-confidence was similar. In a previous study (Hoogerwerf, 2013), individuals who have an ED expressed a body-confident therapist was preferable. To the author's knowledge there has been no research about what individuals who have an ED consider to constitute body-confidence. Further, the concept of body-confidence seems difficult to define, and may differ between individuals. Indeed, in Hoogerwerf's study, none of the participants provided an explanation of their use of the term. Therefore it felt important to allow participants to express their ideas about body-confidence, to explore what it may mean in relation to ED clients and their therapists.

The second section of the questionnaire was designed to obtain quantitative data about importance of therapist gender and body-confidence. In order to establish whether ED clients equate body-confidence with body-size, participants were shown the CDRS. Two questions asked participant to choose which female and male therapist they would rate as most or least body-confident. The CDRS was chosen for this purpose, since participants' judgments about therapist body-confidence would be based solely upon information about the therapist's body-size. Therefore the CDRS was used for the sole purpose of testing whether participants conflated body-confidence and body-size. Participants were not asked whether they considered the CDRS to be a valid measure of body confidence. The section closed with a question asking participants to rate, on a Likert scale from 1-9, how important it would be to have a body-confident therapist to quantify ED clients' previously stated preference for this type of therapist.

Finally, the questionnaire closed by requesting feedback from participants about the appropriateness and usefulness of the questionnaire. The questions used in this section are replicated from Hoogerwerf's previous study and their retention reflects the author's recognition of the importance of service-user involvement in research design. Feedback from Hoogerwerf's participants was used in the design of this study's questionnaire. Similarly, any comments or feedback from participants in this study could be used in future research design. Further, whilst it was hoped that any significant problems with the questionnaire would have been highlighted by feedback during the study design phase, the possibility that experience of participants may differ was acknowledged. Since evidence suggests the ED population may be difficult to engage, the authors wanted to be as responsive as possible to participant feedback. Indeed, an amendment to the questionnaire structure was made following feedback that participants had found it difficult to fully express their opinion about importance of therapist body-confidence. Participant feedback also provided valuable information about potential limitations of one of the screening questions⁴.

The use of a web-based questionnaire tool meant the unique ability to present material depending on how participants answered particular questions. For example, if a participant answered they were under 16 or did not consider themselves to suffer with an ED, they received a message thanking them for their interest in the study, explaining they were not suitable for this research and directing them to resources for further support. Similarly, those participants who had not received formal psychological therapy for their ED were presented with a message requesting they complete the questions hypothetically, considering what thoughts they might have should they be undergoing therapy. The decision to include a population who had no direct experience of therapy

⁴ Copies of the University of Nottingham, Faculty of Medicine approval for this amendment is provided in Appendix A.

was informed by literature suggesting that males with an ED are less likely to present for treatment (Bramon-Bosch et al., 2000; Strother et al., 2012)

Online Design Rationale

Particular benefits of online research were considered of relevance to the current study. The internet provides a cost-effective method of recruiting participants from a large geographical area. Thus data collected may be from a more heterogeneous population (Mann & Stewart, 2002) as well as potentially increasing access to a greater number of individuals from the target population. This was relevant for two reasons: firstly, the current study required a large sample size in order to provide sufficient power for statistical analysis and secondly, the current study aimed to recruit males who have an ED so access to a more heterogeneous population was advantageous.

Of further relevance is the fact that online data collection allows participants to complete the questionnaire in the absence of the researcher. Although this approach has limitations, such as preventing the researcher from gauging participants' reactions to materials presented, there are also important advantages. Participants are afforded anonymity and are able to complete the survey in relative privacy. Thus responses are unlikely to be influenced by presence of the researcher. This advantage was considered particularly important because poor engagement of the ED population is widely cited (Fassino et al., 2009; Wilson et al., 2007). It was hoped that the opportunity to complete the survey anonymously would increase participants' willingness to engage with the study. Additionally, the area under research is of a sensitive nature, so absence of a researcher may facilitate more open responses from participants.

Limitations of the Design

Despite advantages of researching online, potential limitations that arise from such designs cannot be overlooked. Online data collection renders enforcement of strict exclusion criteria impossible. Therefore, despite use

of screening questions as part of the consent process, the authors cannot be certain all participants are members of the target population. Further, there are issues surrounding integrity of responses. The decision not to identify participant IP addresses was taken to preserve true anonymity of responses. However, this means certain considerations must be taken. Since it was not possible to identify the participant, it was difficult to prevent the same person from submitting the survey more than once. Contingencies were introduced by to reduce possibility of multiple responses; all participants were asked to create a unique study code prior to completing the questionnaire. Another issue regarding integrity of responses is that it is possible for a person who does not meet inclusion criteria to enter the survey by altering responses to the exclusion questions. Therefore, before analysing the data the authors screened responses for signs the survey may not have been completed by an individual who has an ED.

Ethical Considerations

The study followed British Psychological Society (BPS, 2007) recommendations for ethical practice in online research (BPS, 2007) and was conducted in accordance with ethical principles originating from the Declaration of Helsinki (World Medical Organisation, 2013) and the Department of Health Research Governance Framework (Department of Health, 2005). The study received approval from the University of Nottingham, Faculty of Medicine Research Ethics Committee⁵.

It is unlikely the study caused participants any harm. The study required completion of an anonymous, online survey and thus participants were free to choose what they felt comfortable to disclose in their responses. Nonetheless, due to the method of data collection, participants' reaction to material was impossible to observe. Therefore, details of available support services were provided on both the information and debriefing pages.

⁵ Copies are provided in Appendix A

Reaction to materials

Since there was no contact between researchers and participants it was not possible to observe motivation for taking part or reactions to the materials. Therefore, as a minimum strategy to ensure participant protection, links to support services, such as their GP and local support groups, were provided. Further, recruitment via charitable organisations such as BEAT ensured participants were well supported when completing the questionnaire. Additionally, the recruitment process was governed by the ethical standards and requirements of these ED services as well as by the University of Nottingham, Faculty of Medicine Research and Ethics Committee.

Participants were required to answer screening questions regarding age and ED diagnosis for the survey to continue. No other questions on the survey were mandatory, thus protecting the participants' right to refuse to disclose information (BPS, 2007).

Despite best efforts to ensure participants would not be distressed by study materials via provision of study details in information and debriefing pages, the researchers were contacted by one participant who had been upset. The distress was related to the apparent conflation of body-size and appearance by using of the CDRS to rate therapist body-confidence. Indeed, this comment was made by several other participants in survey feedback. The first author (ER) and LB responded to the participant who made contact in order to provide more detail about the rationale for using the CDRS in this study and apologise for the distress caused. The wider implications of these comments about the relation between body-confidence and size are addressed in the extended discussion.

Participant information and informed consent

To ensure participants had sufficient information about the study in order to consent, an information page⁶ was displayed prior to study entry. Both

⁶ A copy is provided in Appendix B.1

information and consent pages adhere to BPS (2007) guidelines for obtaining consent online. The information page provided participants with a brief outline of study aims and a description of study procedure. Right to withdraw, potential risks and signposts to support were provided. The researchers' contact details were included should the participant have any questions or concerns. Following the information page, participants were required to confirm they had read and understood the study procedure and potential risks from taking part, before giving consent to participate. They were also required to indicate willingness to have their anonymised responses included in any dissemination of the research.

Participant withdrawal

Since there was no contact between researcher and participants, care was taken to ensure withdrawal procedures were made clear and simple. The information sheet underlined participants had the right to withdraw from completing the questionnaire at any time. To ensure participants were aware of their continued right to withdraw, the option was provided at the end of each questionnaire page. Participants were also made aware their right to withdraw remained for two weeks following submission of the completed questionnaire. The information made clear following this point, all data would be anonymous and untraceable.

Debriefing

A debriefing page⁷ was displayed once participants had completed the questionnaire. As well as fully outlining the purpose of the study, information was given about how participants might access a summary of the results, should they wish to. Participants who chose to withdraw part-way through completing the questionnaire were also presented with this page. Finally, a message thanking participants for their time was displayed.

⁷ A copy is provided in Appendix B.2

Data protection and storage

Organisation, storage and analysis of data were important issues due to the electronic procedure for data gathering. The online survey tool and secure website where data were submitted were managed by the technical department at 'surveygizmo'. As is standard practice, all data was backed up regularly and copies were stored in a secure, locked cupboard on university premises.

All data generated by this study will be retained for 7 years by the University of Nottingham. It will also be available for inspection upon request to any regulatory authorities.

Audit Trail

The critical realist framework that informed study procedures required transparency about collection and analysis of data to ensure possibility of research replication (Barker et al., 2002). Therefore, a personal research journal was kept from ethical clearance to study completion. This record detailed development of thought processes and reactions to the research as the study progressed. Additionally, copies of all versions of study documents and all correspondence with the Research Ethics Committee and charities advertising the study were kept so the development and process of the study could be tracked.

Extended Analysis

Overview

The process of Thematic Analysis (TA) and Saliency Analysis (SA) undertaken on the qualitative survey data is more fully outlined in the following section. The journal paper highlighted non-parametric tests were chosen for analysis of quantitative data. This section describes in more detail how this decision was reached.

Qualitative Analysis

In keeping with Braun and Clarke's (2006) guidelines for conducting TA, a priori decisions regarding coding of the data are described below.

Rich description of the data set or detailed description of one aspect?

Rich description of the whole data set highlights predominant themes and is a particularly useful method for research in an area where the participants' views are unknown (Braun & Clarke, 2006). Rather than undertaking a detailed analysis of one aspect, the decision to analyse the entire data set was taken. This is in keeping with the study aim to represent the views of the participants. Further to this aim, steps were taken to reduce researcher bias and remain faithful to participants' views. Detailed analysis of one aspect of the data set risks selection of sections of data that support arguments the researcher wishes to make (Joffe, 2012) and as such is not necessarily data-driven (Namey et al., 2008). Therefore, data from each question was analysed together. Although this risks some loss of depth and complexity an overall rich description is maintained.

Inductive or theoretical analysis?

According to Braun and Clarke (2006), TA should be undertaken in either an inductive "bottom-up" way or a theory-driven "top-down" way. The current authors take the position that this distinction is unnecessary; indeed data cannot be analysed in a purely inductive manner due to researchers' pre-existing knowledge of the literature as well as individual pre-conceptions. Indeed, Braun and Clarke acknowledge data cannot be analysed in a theoretical vacuum. Consequently, the current study

followed guidelines recommended by Miles and Huberman (2014) for analysing data both inductively and deductively. This approach has been used successfully in previous studies utilising TA (Fereday & Muir-Cochrane, 2006) and enabled researchers in the current study to acknowledge awareness of previous literature whilst consciously avoiding searching for explicit themes in the data that had been identified by previous studies.

Semantic or latent themes?

Braun and Clarke suggest coding should be done at either the semantic and explicit level or the latent and interpretive level. As above, the authors of the current study argue this distinction is unnecessary. The rationale for this stance is that if analysis focuses on the semantic level, the aim is nevertheless to understand the meaning observable in the data, which implies a latent and interpretive level of analysis (Joffe, 2012). Further, guidelines recommended by Miles and Huberman (2014) for dual inductive-deductive and semantic-latent coding are in keeping with recommendations for high quality TA (Joffe, 2012).

Process of Analysis

For ease of description, the process of analysis is grouped here into three stages of data reduction, data display and verification. Nevertheless, it is acknowledged these stages are ongoing rather than discrete and overlap to some extent in an interactive process (Miles et al., 2014).

Data Reduction

The process of coding data was done over a period of 4 months in order to prevent damaging the robustness of the data through researcher fatigue or sloppiness (Guest, MacQueen, & Namey, 2011). Initially, the large amount of data provided by participants was reduced by reading the text data and applying initial codes. The survey instrument allowed the printing of responses with space for writing codes in the margins⁸. Participants' responses were specific to the question that had been asked; therefore

⁸ An example is provided in appendix E.1

codes could be applied to large units of text. Nevertheless, codes were kept as semantically close as possible to the terms they represented. Table 9 shows an example of semantic and latent coding.

Table 9. Examples of semantic and latent coding

Quote	Code (semantic)
Being happy and content in your own skin	Happy in my own skin
Quote	Code (latent)
To wear what you want, do what you want and go where you want or not be afraid to eat what you want in front of others.	Unrestricted

Identifying Themes

Although analysis of individual responses was undertaken, many participants used the same words or phrases, making it difficult not to recognise the same ideas occurring across responses. Repetition is recognised as one of the easiest ways to recognise themes (Boyatzis, 1998). Marking repeated words or phrases became a useful way to generate codes from the data.

Another useful way of recognising themes is noticing contradiction or difference in responses across data (Joffe, 2012). An example from the current study is in participants' descriptions of body-confidence. Some participants clearly stated body-confidence was only possible if one was thin, whereas others stated body-confidence was unrelated to body-size. These dichotomous responses allowed observation of two distinct groups amongst participants. Eventually they were represented using a continuum demonstrating the overarching theme of body-confidence. This decision was taken following observation that participants who stated body-confidence required thinness had shorter illness duration compared to those who stated body-confidence was possible at any size.

Data Display

Guest, MacQueen and Namey (2011) recommend information is organised into an accessible and compact form in order to facilitate observations and conclusions. In line with this, text from individual responses was cut and pasted under the relevant code in a specifically constructed table⁹. Though primary conclusions were made throughout this process, reading of new responses often resulted in an additional code being added to the table. New codes were created throughout the data analysis process, until the reading of a new response did not provide new information and fitted within existing codes. This process indicates a point of data saturation (Elliott, 2012) and may be taken as evidence of systematic and rigorous analysis (Miles et al., 2014).

Nevertheless, the researchers acknowledge the concept of data saturation is difficult within the critical realist perspective, with its emphasis on each individual bringing their own experience. Thus each new response has the potential to add different themes. Further, different researchers who hold different values and worldviews may identify different themes from the same dataset.

The data in the table was considered to ensure the code labels assigned were coherent and their key properties defined. A 'codebook' containing definitions of the initial codes was produced by the primary researcher¹⁰. Miles and Huberman (2014) advise employing methods to guard against premature conclusion drawing and analytic tunnel-vision. Therefore, the codebook and a sample of survey responses were reviewed by the third author to check whether other conclusions could be drawn from the data.

During the coding process, code reoccurrence commonly occurred. Code reoccurrence is defined as the application of two or more codes to a discrete section of text (Guest et al., 2011). The ascription of multiple codes to the same text is possible and may occur when separate ideas

⁹ Appendix E.2

¹⁰ Appendix E.3

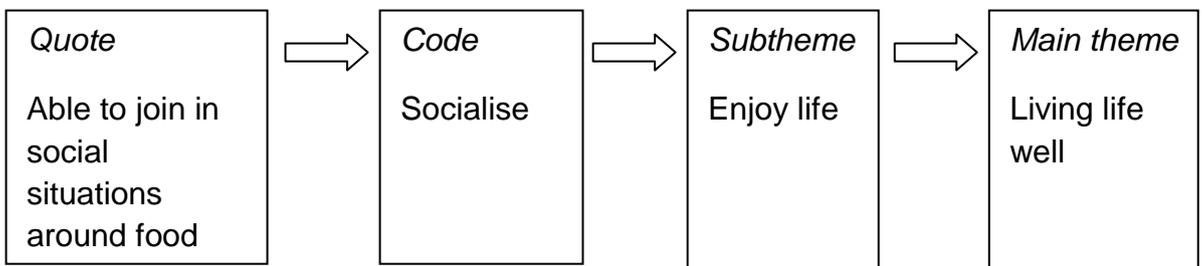
are expressed together, indicating they are related in some way (Joffe, 2012). An example of code reoccurrence in the current study is provided in table 10.

Table 10. An example of code reoccurrence

Quote	Codes
Healthy body weight, no longer obsessional about food, decent level of self esteem, ability to cope with social situations involving expectations about appearance, ability to deal with obsessional behaviours, not dealing with emotions through food	‘Healthy weight’ ‘Not using disorder to cope’ ‘Not engaging in ED thoughts or behaviours’

Once good reliability of codes was established, consideration was given to how they might be grouped under overarching themes. This process required identifying repetitions, exceptions and where necessary changing the code from a descriptive to an analytic label. During this process, the guidelines outlined by Patton (2002) were used to review and collapse subthemes under main themes. These guidelines state themes should have internal homogeneity (i.e. that they should cohere within a main theme) as well as external homogeneity (i.e. that there should be a clear distinction between themes). A worked example of this process is provided in figure 3.

Figure 3. Example of tracking a quote to a theme



Having identified themes in the data, the process of drawing conclusions and verifying themes was undertaken. This involved noticing patterns and regularities amongst themes as well as considering explanations. The

primary researcher developed a thematic map to depict participants' experience of recovery and body-confidence. The map was reviewed and verified by all researchers through a process of asking critical questions, such as whether the map provided a good enough representation of participants' experiences and whether any omissions or contradictions were present.

Further verification was achieved by comparing the map with original survey responses. Minor amendments to the initial map were made as a result of this process. For example, the theme 'control disorder' had been depicted as linked to the theme 'overcome fear of food' during the interpretation process. However upon returning to the data, it became clear participants had not linked these two ideas in their responses. In fact, they had associated 'overcome fear of food' with ideas that fell within the theme 'treat body as important'. This process of revision continued to be made until no further revisions were necessary¹¹.

Saliency analysis

As outlined in the journal paper, the initial codes were subjected to a saliency analysis. This process is afforded further discussion here.

The decision to utilise saliency analysis was taken since it allows identification and sustained visibility of important themes from qualitative data, aiming to facilitate production of clear and salient conclusions (Buetow, 2010). Saliency analysis assigns each code one of four categories:

1. Highly important and recurrent;
2. Highly important but not recurrent;
3. Not highly important but recurrent;
4. Not highly important and not recurrent (Buetow, 2010)

¹¹ Initial draft of thematic map in appendix E.6

Codes were considered highly important if participants explicitly stated importance in the text or if the code was in line with the study aims. Frequency of code occurrence was determined by number of participant responses that contained the code, rather than total number of times it appeared in the text¹². This decision was informed by assumption that the number of different individuals expressing the same idea provides a more accurate indication of importance than total number of times the idea appears overall (Namey et al., 2008).

Final analysis of themes

Following the development of themes and prior to arranging them in a thematic map, analysis was undertaken to ascertain whether change arose in the occurrence of themes pertaining to body-confidence and recovery according to the recovery status of participants¹³. This analysis revealed particular themes occurred more often in recovered participant responses. Consequently, the decision was taken to use a cycle of recovery and a continuum of perspectives about body-confidence in order to represent change in themes that occurred in recovered versus unrecovered participants.

In the final version of the thematic map the decision was made to situate the recovery cycle and body-confidence continuum developed from participant responses within a model of recovery from mental illness (Andresen, Oades, & Caputi, 2003). This was done to demonstrate that although there are specific processes important in recovery from an ED, the process of recovery shares broad themes present in Andresen et al's model. Since the current study did not produce a model of recovery that might have clinical utility, situating participants' experience of recovery within an existing model enabled emphasis of broad skills and processes necessary for recovery and subsequent treatment implications highlighted (please see Extended Discussion for further discussion).

¹² Appendix E.4

¹³ Appendix E.5

Quantitative Analysis

In order to ensure the validity of statistical conclusions, exploration of data was undertaken prior to analysis and consideration given to appropriate methods of analysis.

Assumptions

The use of parametric tests requires the assumption that data is normally distributed (Dancey & Reidy, 2007). To test for normal distribution, two methods were used. First, histograms with normality curves were produced. A bell curve would indicate normal distribution. To reinforce conclusions drawn from visual inspection of histograms, the values of skewness and kurtosis may be divided by their associated standard error to produce a z-score. A z-score within the range of -1.96 to +1.96 indicates the data is likely to approximate a normal distribution.

Application of both methods to the data indicated the variables of age, illness duration and length of therapy were not normally distributed (table 11). The non-normal distribution of data in addition to unequal sample sizes (recovered N = 20; unrecovered N = 114) informed the decision to use non-parametric tests for data analysis.

Table 11. Values of skewness and kurtosis, associated standard error and the converted z-score for relevant variables

Variable	Skewness	Kurtosis	Z-score	
	(standard error)	(standard error)	Skewness	Kurtosis
Age	1.522 (0.203)	3.097 (0.403)	7.497	7.684
Illness duration	-0.121 (0.203)	-1.512 (0.403)	-0.596	-3.75
Length of therapy	1.504 (0.212)	2.125 (0.422)	7.09	5.03

Effect sizes

Any effect will become statistically significant given a large enough sample size and regardless of what value of p is used, since the null hypothesis is never entirely accurate (Meehl, 1978). Effect size is an objective and standardised measure of the magnitude of observed effect (Field, Miles, & Field, 2012). Therefore, effect sizes were calculated for all analyses to provide an estimate of clinical meaning of findings. Due to discrepancy in group sizes, Cohen's d was utilised since it is less sensitive to group differences than other measures (McGrath & Meyer, 2006).

Quality Assurance Measures

The journal paper briefly referred to quality assurance measures employed to ensure trustworthiness of the current findings. Quality in mixed methods research has not been widely considered in the literature (Dellinger & Leech, 2007); however in general there appears to be a preference for using different criteria for assessing the qualitative and quantitative components (Bryman, Becker, & Sempik, 2008).

Methods utilised to ensure validity of quantitative data were discussed above with regards to selecting appropriate statistical tests. Due to frameworks and approaches used by qualitative research, quality criteria used in quantitative research are not considered applicable (Kitto, Chesters, & Gbich, 2008). Therefore measures taken to assure quality in qualitative data are discussed here in greater detail. Whether a set of generic quality criteria may be applied to all qualitative research has been much debated, however a number of recurring principles may be identified (Spencer & Ritchie, 2012). Table 12 lists each of these principles and details how the current study has met the relevant criteria. This is presented with acknowledgement that epistemological position of any study will affect applicability of quality criteria (Silverman, 2011). The guidelines authored by Elliott, Fischer and Rennie (1999) were chosen since they were developed within a clinical psychology context and describe common guidance for both qualitative and quantitative

approaches as well as guidance specifically pertaining to qualitative designs.

Table 12. Guidelines for quantitative and qualitative research (Elliott et al., 1999) and how they are met by the current study

Criterion	Ways in which current study meets criterion
Guidelines shared by both quantitative and qualitative approaches	
Explicit scientific context and purpose	The principle researcher developed an understanding of epistemological positions and theoretical underpinnings of qualitative design. Overview of these understandings with regard to methodology and analysis is provided. Throughout, awareness is maintained of the methodological implications and potential limitations are identified. A thorough review, including quality appraisal, of the literature on therapeutic factors that impact upon positive outcome was undertaken in order to understand the context of the research. Therefore a coherent purpose and rationale for the study was provided with knowledge of the gap in the literature.
Appropriate methods	Inclusion criteria ensured that participants recruited to the study were appropriate. The use of an online survey instrument eliminated need for transcription, thus ensuring participant responses were not altered through researcher influence. Thematic Analysis was undertaken systematically through immersion in the data. All responses could be included within a theme which indicates their accuracy, appropriateness and salience. Verbatim quotes taken proportionally from across participants are presented alongside themes. Corroboration of developing themes was provided through continuous review with the second and third

Respect for participants	<p>authors. The validity of the qualitative data is strengthened via triangulation with quantitative data.</p> <p>The study was given favourable permission by a research ethics committee. The lack of contact between researcher and participant enabled participants to reflect upon their experiences without researcher influence. However, a disadvantage of the lack of researcher-participant relationship was that the researcher was not available to provide support should the participant become upset. Therefore details of support agencies were provided in the information sheet and debriefing page. Fair representation of participants' realities was ensured through the use of open-ended questions in the survey instrument and provision of direct quotes to support interpretations. Throughout the study, participants are considered experts in their own experience.</p>
Specification of methods	<p>Consideration of study design and rationale for selection of methods is provided. Development of the survey instrument and stages of recruitment to the study are described. An overview of qualitative methods is provided as well as the rationale for using Thematic Analysis. The study maintains an awareness of the impact of using this method and the potential limitations. Detailed description of the process of analysis and examples of how the analysis developed are provided for clarity, in figures within the main text as well as in the appendices.</p>
Appropriate discussion	<p>Study findings are presented in the context of existing theory. Alternative explanations for all interpretations are acknowledged and considered. Discussion of clinical and theoretical implications of the findings is</p>

Clarity of presentation	<p>undertaken. In addition, the primary researcher's critical reflection upon theoretical, scientific and ethical elements is provided.</p> <p>Several drafts of the study have refined presentation. Review was undertaken with both the second and third authors to take advantage of differing perspectives. The integration of themes is illustrated in a clear map that also situates the current findings in an existing theoretical model. This illustrated map is accompanied by clear description.</p>
Contribution to knowledge	<p>The study has practical and theoretical utility. The implications of the findings are discussed with regard to existing literature, clinical practice and individuals who have an ED. Further, recommendations for future research are provided.</p>

Guidelines pertinent to qualitative research

Owning one's perspective	<p>The principle researcher developed an understanding of epistemological perspectives in scientific research. An overview of perspectives is provided in the Extended Methodology. Rationale for adopting a Critical Realist stance is emphasised throughout and the impact of this position on the study, including potential limitations, is acknowledged. Interpretation of the data in the context of the Critical Realist position and the researchers' personal and professional backgrounds is considered.</p>
Situating the sample	<p>Inclusion criteria ensured participants recruited to the study were appropriate. Description of participants, including age, ED diagnosis and experience of therapy is provided to give context to the sample.</p>
Grounding in examples	<p>Examples of the raw data are provided. Quotes taken from across the participant sample are presented alongside themes to demonstrate interpretation and</p>

Providing credibility checks	<p>how developing themes are grounded in the data. Exemplars of survey responses are provided in the appendices.</p> <p>Themes were developed through continuous discussion with the second and third authors. This took advantage of multiple perspectives and allowed consideration of different interpretations of the data. Examination of quantitative data provided an additional check of the credibility of the themes.</p>
Coherence	<p>Themes are presented in an illustrative map which demonstrates how an individual who has an ED might progress through recovery and how this impacts upon their view of body-confidence. The map depicts how particular themes are linked. Description of the themes is provided in text, including excerpts from the data to illustrate the theme.</p>
Accomplishing general vs. specific research tasks	<p>The study used a large sample of qualitative data to explore the experiences of individuals who have an ED. Inclusion criteria did not limit participants depending on ED diagnosis, so the sample may be thought of as broadly representative of this population. Nevertheless, limitations in the generalisability of this data are considered, including aspects such as the gender of the participants and site of data collection.</p>
Resonating with readers	<p>The analysis sought to accurately reflect participants' experience. Direct quotes from the data were used as theme titles and the use of over-arching themes created a narrative of recovery and perspectives of body-confidence. The thematic map was discussed with reference to an existing model of recovery in order to situate the findings in the wider context.</p>

Reflexivity

Preconceived ideas and biases held by researchers may impact interpretation of study findings (Braun & Clarke, 2006). Smith (1996) argues researcher reflexivity is an inevitable consequence of engaging in psychological research. Thus for quality assurance it is important for the author to assess impact of their presence and declare values and epistemological position (Spencer & Ritchie, 2012). Designs utilising TA within a critical realist framework do not usually include a statement about the researcher (Joffe, 2012). Nevertheless, such a statement is included here, in keeping with the above quality assurance guidelines, to maintain transparency and acknowledge the role of researchers in the current study. Reference to how critical realist stance may have impacted upon the study has been made throughout. Thus the statement below pertains to the personal history of the researchers, with a particular focus on the primary researcher.

At the time of conducting this study, the primary researcher (ER) was a 29 year old female Trainee Clinical Psychologist with no personal or family history of ED and no clinical experience working with this population. The two remaining researchers were female Clinical Psychologists with limited experience of ED. When designing the study, it was anticipated therapist body-confidence would be important to individuals who have an ED, particularly if they were at different stages of recovery. It was also anticipated individuals who have an ED would prefer a gender-same therapist.

Extended Results

Overview

The journal paper presented the study's main qualitative and quantitative findings. The following section first describes themes from recovery stage 1, 'restricted', recovery stage 2, 'reconciling self and culture' and recovery stage 3, 'resilience', that could not be included in the journal article. Further description of these themes should illustrate how participants viewed body-confidence and recovery as intertwining concepts. Second, description of secondary quantitative analyses that could not be included in the journal article is provided.

Findings from Qualitative Data

Recovery stage one: Restricted

Not engaging in ED thoughts or behaviours:

The main theme in this stage of recovery was a strong desire for ED related thoughts or behaviours to be absent and to be able to live a life free from their influence:

[140] *"Being able to function without being consumed with thoughts of ED."*

[200] *"No eating disorder thoughts about weight, body image etc. Also being able to eat any food without eating disorder thoughts or worries."*

Many participants viewed being free from both ED related thoughts and behaviours to be necessary for recovery; being able to abstain from ED behaviours was not considered sufficient by participants to view themselves as recovered.

[2] *"I have periods of abstinence from eating disorder behaviours, however still experience the same thoughts and feelings around food. I have also, more recently, gone through a period of not thinking too much about food"*

and my feelings around it, at which point I saw myself as 'pretty much recovered'..."

[197] *"However my therapy was purely down to physical actions and I still don't think I am mentally recovered? [sic] By this I mean I still experience negative thoughts relating to food, body image, and exercise."*

Not using the disorder to cope:

The use of ED behaviours was described as a means of coping at times of stress:

[92] *"...intentionally choosing not to eat for any reason is using the anorexia as a coping skill"*

[210] *"...able to cope with difficult situations and emotions without feeling the need to rely on food-related behaviours."*

Two participants acknowledged a desire to learn alternative ways of coping with stress:

[19] *"... (not) using destructive eating behaviours as a coping mechanism but use other more healthy ways to deal with stresses."*

[65] *"...learning new and healthy coping mechanisms rather than food."*

Coping with emotions

In addition to refraining from engaging in ED behaviours and being free from ED thoughts, participants spoke about the desire to be able to cope with emotional reactions to food or eating.

[17] *"Ability to eat and think about food without feeling direct emotions which affect behaviour, e.g. guilt leading to compulsion to exercise or restrict to compensate."*

[168] *“being able to stop disordered behaviours without feeling like I’m going to relapse every second. It (recovery) would mean...facing thoughts and feelings, but not being overwhelmed by them.”*

Recovery stage two: Reconciling self and culture

Control the disorder

The journal article outlined how an individual would begin to regain control over the ED. The sub-themes indicate how gaining control over the ED would impact upon participants’ lives.

Independence:

For participants, being independent had two elements. Firstly, they would no longer be supervised by others with regards to their weight and eating habits:

[25] *“I don’t require special support from professionals, friends and family around eating.”*

Secondly, they would be free from the influence that the ED exercised over their ability to make choices. Therefore, participants wrote about being able to care for themselves again:

[156] *“Ability to consistently make independent choices around food and exercise...Ability to maintain weight independently.”*

[170] *“Free from the constraints of the ED...nourishing my body, listening to its needs”*

Spontaneity:

By regaining control over the ED and feeling free to make their own choices participants re-learned spontaneity. They spoke about not having to plan their day so that they would know when, where and what they would eat or how they might compensate.

[86] *“ability to take part in social events that involve food largely free from obsessional thoughts about weight, food, calories and exercise, flexibility and spontaneity around meals, food and social events.”*

In order to gain more control over and freedom from the disorder, participants also spoke about particular skills and achievements that would be necessary.

Overcoming fear of food:

Due to the influence from the ED, participants had become afraid of food and how eating might impact their weight. Learning to once again *nourish my body* and continue progress towards full recovery necessitated facing this particular fear.

[134] *“...no longer feeling anxiety about what I am going to put in my body... I would no longer have a fear of specific foods”*

[141] *“I’m scared of food and scared of putting on weight. I don’t think I would count myself as recovered until I don’t feel scared of eating.”*

Treating body as important:

Closely linked to *overcoming fear of food* was learning to treat their body as important. These two skills appeared interlinked, though remained as separate themes since they represent two distinct processes.

[39] *“Being able to look in the mirror and saying ‘I’m OK...my body is deserving of care and nourishment’.”*

[148] *“Treating your body like an important part of yourself, which it is!”*

Learning to treat their body as important was an early manifestation of the development of an attitude of self-compassion and ability to accept themselves described by the other themes in this stage of recovery.

Self awareness

Although strongly linked to the development of self-compassion, this remained a separate theme since it pertained more to learning how to live with the ED. Participants wrote about how they were developing skills related to relapse prevention and learning more about themselves.

[86] *“Have awareness of vulnerabilities, triggers, emotional, family, personal and environmental stressors; the ability to recognise red flags, ask for support and troubleshoot.”*

[103] *“It is accepting that slips happen, but learning to see any slips in behaviour as a red flag for needing to take care of yourself and identify the problems in your life which you are trying to control with disordered eating.”*

Self Compassion

The journal article outlined participants' descriptions of developing self-compassion and acceptance of self. The subthemes further elucidate the meaning of developing such attitudes towards the self and how this might be achieved.

Stop comparing themselves to others.

Participants wrote about how they would not only compare themselves to others but how they would also try to perceive what others thought about them in order to ascertain whether they would be acceptable. One consequence of self-compassion was being able to refrain from this practice.

[56] *“Not comparing myself to everyone else.”*

[92] *“It means being completely ok with yourself even if it varies drastically from the people around you.”*

[124] *“Not to seek others' or societies approval of it (my body)”*

Body-confidence is difficult for everyone:

Finally, developing an attitude of self-compassion and being able to observe others without trying to perceive what they might think allowed the individual to come to a realisation that many people felt dissatisfied with their body.

[2] *“I don’t think that many people feel genuinely happy with themselves.”*

This realisation represented participants’ steps towards being able to reconcile societal and cultural pressures. By learning to become more accepting of themselves and make fewer comparisons based upon appearance, their attention was beginning to be drawn to the similarities they shared with those around them.

Not preoccupied with appearance

The development of self-awareness and self-compassion alongside the ability to refrain from comparing themselves to others enabled participants to feel less concerned about their appearance.

[25] *“Being able to wear what I want and not worrying excessively about how I look and how I might appear to others.”*

[161] *“Feeling like my body shape is no more important than my shoe size.”*

Recovery stage three: Resilience

Proud of body

This main theme was outlined in the journal article and demonstrated the evolution of self-compassion and being more accepting of one’s body into feeling proud about how you looked.

Clothes for expressing not hiding myself

This subtheme takes the sense of pride and freedom further and describes participants’ experience of feeling able to express their personality through

the way they dress; clothes were no longer worn for the sole purpose of disguising their shape.

[81] *“Dressing in what you want because you feel comfortable enough with yourself even though the clothes might be unusual, colourful, very fashionable or make you stand out.”*

[215] *“Dressing myself in a way that is appropriate for the weather or in a way that reflects my personality rather than choosing clothes purely on their ability to cover/disguise/hide parts of my body that cause me distress.”*

Personal worth is not related to size

This subtheme is related to the developing positive sense of self. It captured participants' growing realisation that there was more to themselves than the size of their body.

[86] *“The ability to “be” in one’s own skin but not devoted to a particular ideal, nor feel like body shape/size and physical attributes are primary to personal goals, relationships, achievement, growth, etc.”*

Coping with opinions of others

A consequence of developing a sense of being *proud of body* and *happy in their own skin* was participants' ability to be resilient to the opinions of others.

[51] *“Having the ability to see good and bad points with your body and being comfortable enough to handle compliments or criticisms without going to extreme emotions about it.”*

The skills that participants had learned in stage 2 of recovery and the impact that these changes had had on their perspective about themselves enabled them to further develop their approach to food and eating. At this

stage of recovery, they not were not only aiming to *overcome fear of food*, rather participants were aiming for *being normal* and *living life well*.

Healthy weight

In their simplest form, being normal and living life well meant the maintenance of a healthy weight.

[67] “*Regaining weight into healthy weight range... Feeling more confident about being in healthy weight range*”

[210] “*A healthy weight for you, i.e. not minimum BMI of 18-20, a weight that is easily maintained without counting calories/excess activity, and reasonably stable*”

Healthy relationship with food

In order to be able to maintain a healthy weight, participants felt that having a healthy relationship with food was necessary. The development of this relationship was the final manifestation of the skills learned during stage 2 of recovery: *spontaneity, independence and control the disorder*.

[63] “*Recovery for me would be equated with my being able to build a relationship with food in which restriction and bingeing were not an everyday part of life. There would no longer be forbidden foods and eating in public would be possible. Recovery would thus mean having a more ‘normal’ relationship with food.*”

[223] “*A normal relationship with food. Eating 3 meals a day with snacks, eating when hungry and stopping when full, eating whatever food you crave or would like, being spontaneous and unrestricted with food*”

Findings from Quantitative Data

Secondary Analysis:

Un-recovered and recovered individuals will differ in their ratings of most and least body-confident therapist.

In order to undertake this comparison, the nine therapist figures were grouped into 'thin' (therapist figures 1-3), 'average' (therapist figures 4-6) and 'overweight' (therapist figures 7-9). These groups were coded as -1, 0 and 1 respectively. Table 13 below demonstrates that, in comparison to recovered participants, unrecovered participants' ratings of therapist body-confidence skew toward rating 'thin' female therapists and 'average' male therapists as most body-confident.

Table 13. Percent of 'thin', 'average' and 'overweight' therapist body-confidence ratings with participant recovery status

		Un-recovered (%)	Recovered (%)
Most body-confident female therapist	'Thin'	25.4	20
	'Average'	64.0	70.0
	'Overweight'	10.5	10
Least body-confident female therapist	'Thin'	40.4	35
	'Average'	4.4	5
	'Overweight'	55.3	60
Most body-confident male therapist	'Thin'	5.4	0
	'Average'	92.9	95
	'Overweight'	1.8	5
Least body-confident male therapist	'Thin'	43.8	50
	'Average'	0.9	10
	'Overweight'	55.4	40

A 2 (recovered, unrecovered) x 3 (-1, 0, 1) Chi-Square was undertaken on female therapists rated most confident, female therapists rated least confident, male therapists rated most confident and male therapists rated least confident to investigate whether there was a relationship between recovery status and ratings of therapist body-confidence. Since expected frequency counts were <5, the most appropriate test was Fisher's Exact Probability (table 14). Due to the number of categories, Cohen's *d* was

not suitable for calculating effect size, as it assumes 1 degree of freedom. Therefore, Spearman's r was calculated using the ordered, categorical variable of importance of therapist body confidence with recovery status.

Table 14. Chi-Square analysis of therapist body-confidence ratings and recovery status

	Fisher's exact probability	p value	Effect Size r
MBCF	0.29	0.93	0.15
LBCF	0.45	0.92	0.09
MBCM	1.77	0.4	0.06
LBCM	5.63	0.06	0.02

Abbreviations in table: DF=degrees of freedom; MBCF=most body-confident female; LBCF=least body-confident female; MBCM=most body-confident male; LBCM=least body-confident male.

Therefore, recovered and unrecovered participants do not significantly differ in their ratings of high or low body-confidence in female therapists and high body-confidence in male therapists. There is some difference in the way that the two groups rate low body-confidence in male therapists. The effect size indicates that this difference is unlikely to convey any clinical value.

Extended Discussion

This section combines all elements of the study to provide an extended discussion of theoretical and clinical issues. Discussion of key themes and subthemes, including those not discussed within the journal article, is expanded and considered in relation to Social Comparison theory and one model of recovery. The impact upon findings and conclusions of the methodology employed is reflected upon. Suggestions for future research and implications for clinical practice and service organisation are described. Finally, this section concludes with critical and personal reflections upon the research process.

Proposed link to Social Comparison Theory

The journal paper indicated findings of the current study draw together literature and hypotheses regarding social comparison processes in individuals who have an ED, which were outlined in the Extended Background. Here, both qualitative and quantitative findings are discussed more deeply and support for social comparison processes considered.

Therapist gender

Social comparison theory posits that individuals are most likely to compare themselves to relevant others and salient features, such as gender, are most likely to be used to decide how relevant the comparison is (Fitzsimmons-Craft et al., 2012). The findings of the current study lend further support to these processes in ED clients.

First, the statistical findings indicated same-gender therapists were preferred by participants. Factors relating to survey instrument structure may have impacted findings for gender preference. For example, exploration of experiences of therapy was retrospective. Participants may have received effective therapy from a female therapist and prefer female therapists upon the basis of positive experience. This assumption is similar to the finding of DeHeer et al. (1992) that clients prefer therapists

on the basis of effectiveness rather than other characteristics. Alternatively, cultural norms may have some influence upon preference for same-gender therapists. In line with common gender stereotypes, male therapists are perceived as problem-focused and judgmental and female therapists as caring, easier to talk to and thus better able to form a TR (Gehart & Lyle, 2001; Johnson & Caldwell, 2011). Since the majority of the current study's participants were female and had difficulty *coping with opinions of others* the possibility that preference for a female therapist was influenced by these stereotypes rather than upon shared characteristics cannot be ruled out.

Further research is needed to elucidate whether findings for therapist gender preference have a significant impact upon therapeutic outcome and treatment dropout rates. Existing evidence regarding client preference and treatment dropout is discussed in more detail below. With regards to therapist gender, future research could measure therapeutic alliance between a client and their therapist throughout an episode of therapy to identify whether any clinically significant differences exist in therapeutic alliance between clients who have a therapist of the preferred gender and those who do not. Further, the outcome of therapy for clients who have a preferred gender therapist could be compared with that of clients whose therapist is not of the preferred gender.

Nevertheless, some support is provided for the idea that female therapists are deemed a more relevant source of information by their female clients. In particular, social comparison theory appears relevant in the TR when considered alongside evidence that same-gender therapists are associated with improved client engagement (Cottone et al., 2002) and female therapist body-size is relevant to TR with female ED clients (Hoogerwerf, 2013; Vocks, 2007). Further, themes from the qualitative data highlighted individuals who have an ED frequently engage in comparisons with others.

Second, female participants showed a slight skew towards rating 'thin' female therapists as most body-confident whilst they considered 'average' male therapists as most body-confident. This skew towards rating 'thin' females as most body-confident likely reflects internalisation of Western cultural norms for thinness in women. The fact that the same skew towards 'thin' males did not occur suggests cultural norms do influence the way in which ED clients perceive female therapists and provide further demonstration of the premise of relevance in social comparison theory. Due to the small number of male participants in the current study, further research investigating social comparison processes in males who have an ED would be useful. Further, exploration of ED clients' preference for same-gender therapists and whether it impacts upon outcome would also be of value.

Body-confidence

The major themes about body-confidence indicate that its perception by individuals who have an ED will evolve as they progress towards recovery. The development of numerous psychological components contributed to change in how body-confidence was defined. Development of self-compassion enabled participants to situate their body concerns within a wider social context and thus broaden their perspective, supporting an improvement in self-esteem. Further, aspects of self-presentation were important; for example, using clothes to express personality.

This change in perception fits with ideas about social comparison processes. Individuals who have low self-esteem and unstable self-concept are known to be high social comparers (Bailey & Ricciardelli, 2010; Corning et al., 2006; Morrison et al., 2003; Vartanian & Dey, 2013). These characteristics are well-documented amongst the ED population (Fairburn et al., 2000; Olivardia et al., 2004) and were reflected in themes from the qualitative data. Hypotheses about higher incidence of social comparison in individuals with low self-esteem suggest their low certainty about self leads to greater reliance upon external criteria (Bailey & Ricciardelli, 2010). The current study supports this hypothesis. Themes

indicated that as an individual develops greater self-compassion they feel less need to compare themselves to others. Ceasing to engage in frequent comparisons appeared to enable individuals to become more aware of cultural standards they had used to assess themselves and realise appearance had no relation to self-worth. This finding offers further support for literature suggesting that improving self-esteem is important in treatment of individuals who have an ED (Bachner-Melman et al., 2006; D'Abundo & Chally, 2004).

Additionally, body-confidence may include interactional processes. For example, an important step in achieving the belief that body-confidence is possible at any size was learning to cope with the opinions of others. The extended background outlined the importance of Western cultural ideals for thinness and how smaller body-size may be seen to convey positive personality characteristics. The themes indicated that, though participants learned to cope better with how others might perceive them, the fact that others might hold an opinion about their appearance remained important. Therefore, body-confidence may not reside entirely in the individual. Though there are individual components such as self-esteem and self-presentation, how these are perceived and received by others is likely to have an effect on how body-confidence is defined by the individual.

The statistical findings offer some suggestion about why therapist body-confidence might be important to ED clients. At the beginning of treatment, it may be assumed ED clients have low self-esteem and engage in more social comparisons. Therefore they are highly likely to engage in social comparison with their therapist. According to the theory outlined above, this tendency would be expected to reduce as the client progresses towards recovery. However, the hypothesis that recovered and unrecovered individuals would differ in their ratings of importance of therapist body-confidence was not supported.

Yet the body-confidence continuum provides further context to this finding. The continuum demonstrated body-confidence remains important

throughout the recovery process and is re-defined dependent upon recovery stage. In early stages, participants equated body-confidence with thinness whereas in latter stages, participants re-defined body-confidence as unrelated to body-size. This process is reflected in the statistical trend for unrecovered participants to select thinner female therapists from the CDRS than recovered participants. Future research could further explore this difference by asking individuals who have an ED at various stages of treatment and recovery to explain why therapist body-confidence is important and how they evaluate it.

As well as demonstrating changes in how participants defined body-confidence, preference for 'thin' therapists in unrecovered participants provides support for the hypothesis that individuals who have an ED internalise cultural norms for thinness (Grabe et al., 2008; Stice, 2001; Strahan et al., 2006). Further, the finding that recovered participants no longer demonstrate preference for thinness lends further support to evidence that social comparison is related to maintenance of BD (Bailey & Ricciardelli, 2010).

Contour Drawing Rating Scale

The lack of significant statistical difference in recovered and unrecovered participants' ratings of therapist body-confidence may be reflective of the validity of the CDRS to measure this concept. Participants were not asked whether they considered the CDRS to be a valid measure of body-confidence. As stated in the Extended Method, this was because the CDRS was chosen solely in order to establish whether participants might conflate body-confidence with body-size. However, the themes from the qualitative data revealed psychological components and interactional processes, vital for body-confidence, but not captured by the CDRS. If body-confidence is to be measured in future research, then these vital components must be captured by the instrument.

Modifications could be made to the CDRS, such as replacing the line drawings with fully fleshed-out figures to enable representation of some

aspects of self-presentation. Rather than presenting a scale from underweight to overweight, the figures could be arranged according to posture, for example from hunched and trying to appear small to standing tall and appearing proud. This may capture some elements of self-esteem as well as self-presentation. Further developments would be necessary to any measure of body-confidence so that interactional processes might also be captured. A second questionnaire could be administered alongside the adapted CDRS, which would ask individuals to identify what traits figures on the scale might possess, for example, that a figure standing tall might have high self-esteem,

Since the concept of body-confidence is multi-faceted, it may be impossible to produce a single, valid measure. Therefore, in order to develop a measure that represents all features, it would be helpful for future research to establish how judgements about a individual's body confidence might be made.

The argument that Western cultural norms for thinness and social comparison processes are influential in views about body-confidence is further supported by feedback from participants, in particular in the complaint that researchers received (see Extended Method). Some participants stated it was not possible to judge body-confidence based upon size alone. Inspection of responses that included this feedback revealed they were written by recovered individuals. Participants who questioned the use of a figure-size scale to rate body-confidence argued such judgements were impossible because "*body-confidence is not associated with weight*" and "*conflating body-confidence with body type is the type of thinking that is unhelpful for people who suffer from eating disorders*". This feedback illuminates the difficulties that individuals who have an ED face from idealisation of thinness and further underscores the current study's finding that the concept of body-confidence becomes redefined with progress toward recovery.

Interestingly, there was also feedback from some participants suggesting body-size might be related to body-confidence. Some participants highlighted difficulty in choosing between figures at either end of the CDRS, representing extremes of 'thin' and 'overweight'. They thought both figure 1 and figure 9 could be considered as least body confident. The author's chose to force this choice in order to ascertain whether body-confidence was particularly associated with thinness. Indeed, secondary analysis revealed a tendency to associate thinness with body-confidence when evaluating female figures.

These observations from participant feedback are noteworthy since they have important implications for theory and service delivery. Research to further explore ED clients' perception of body-confidence and how this might be explicitly related to the process of therapy would be valuable to highlight what might be important at different stages of therapeutic intervention.

Treatment dropout

The high rate of treatment dropout amongst the ED population was discussed in the Extended Background. Understandings about why individuals leave therapy prematurely are largely based upon intra-personal and illness characteristics, despite scant evidence to support them (Mahon, 2000). The current study investigated therapist characteristics in order to determine whether they may impact upon the client and therefore their decision to engage in therapy. Within a social comparison framework, the findings demonstrate therapist gender may be important to clients since it is a salient characteristic upon which to base comparisons. Within wider literature this idea is reinforced by findings regarding impact of therapist body-size upon ED client engagement, with 'thin' therapists being considered competition and 'overweight' therapists being considered untrustworthy (Hoogerwerf, 2013; Vocks, 2007).

The suggestion is tentatively made that preference for same-gender therapists may indicate an ED client's desire for a role model with whom

they might make upward or meaningful self-improving comparisons. Importance of therapist body-confidence was high indicating comparison with a body-confident role model may facilitate the process of recovery. Further, participants demonstrated different perceptions of same- and different-gender therapists. Judgements about female therapist body-confidence appeared influenced by Western cultural norms for thinness, perhaps demonstrating ED clients identify more closely with their female therapist. It would be useful for future research to ask ED clients about these preferences in order to determine whether differences exist within the TR and outcome of therapy with a same- or different-gender therapist.

The wider literature has investigated impact of therapist gender upon treatment efficacy and dropout. The number of studies is relatively small, with only three exploring the client's perspective (Swift, Callahan, & Vollmer, 2011). Findings indicate therapist gender is a weak predictor of therapeutic outcome; that male and female therapists appear equally effective (Bowman, Scogin, Floyd, & McKendree-Smith, 2001). However, client preference for therapist gender has been found to be related to treatment satisfaction (Johnson & Caldwell, 2011; Lam & Sue, 2001). This is important since one third of ED clients report low treatment satisfaction (Clinton et al., 2004). Further, alliance in early stages of treatment is significantly improved by same-gender therapeutic dyads (Wintersteen et al., 2005). Since ED clients are most likely to dropout during early stages of treatment (Mahon, 2000), their apparent preference for a same-gender therapist could impact upon these decisions. Indeed, two recent meta-analyses found clients whose preferences for therapist characteristics were met are less likely to dropout from treatment and more likely to show improved outcomes (Swift & Callahan, 2009; Swift et al., 2011).

Therefore, future research should aim to clarify whether therapist gender predicts outcome of ED treatment as well as identifying the impact of therapist gender upon treatment satisfaction for ED clients. If therapist gender does in fact impact upon treatment satisfaction and outcome for ED clients, then, in light of Wintersteen et al.'s findings, further research

would be of benefit to highlight whether the impact of therapist gender varies depending upon stage of treatment. These findings will be of value in service design and delivery and will usefully contribute to the training of professionals who work in ED services.

Recovery

As indicated in the journal paper, the findings of the current study further contribute to debate within the literature about what constitutes recovery from an ED. The Extended Background outlined this debate and two sets of criteria currently used to define recovery; the weight- and symptom-related Morgan-Russell criteria (Morgan & Hayward, 1988) and the broader set of psychosocial criteria proposed by Strober et al. (1997). In general, the concept of recovery is considered to be a complex process, involving a change of attitude, values, goals and skills (Anthony, 1993). This view of recovery fits better with the criteria proposed by Strober et al. (1997) and is supported by the current study's findings.

The major themes pertaining to recovery highlighted participants progressed through three distinct stages; restricted, reconciling self and culture and resilience. The sub-themes further demonstrated moving from one stage to another necessitated the individual changed values and developed new skills. For example, individuals changed to a more self-compassionate outlook that valued the importance of their body and was less concerned with appearance. Skills necessary for this change in attitude included learning independence, self-expression and how to manage a healthy lifestyle.

Despite providing evidence in support of psychosocial criteria, participants also supported importance of measuring weight- and symptom-related criteria. Participants identified that one of the most important tasks of recovery was overcoming the urge to engage in ED behaviours. However, many also endorsed the argument within the literature that ED thoughts must also be addressed (Bachner-Melman et al., 2006). The findings support the idea that there may be some value in differentiating between

partial and full recovery; partial recovery would indicate ED behaviours have ceased and full recovery would indicate the individual no longer engaged in ED behaviours or thoughts (Bachner-Melman et al., 2006; Bardone-Cone et al., 2010).

Finally, the current study provided further evidence in support of broader recovery literature and the view that recovery does not indicate all symptoms have been removed; rather the individual has learned to live with their illness. This is reflected in sub-themes such as learning to 'control the disorder' and 'not using the disorder to cope'. Nevertheless, once recovery has been attained, relapse remains a possibility (Andresen et al., 2006; Watkins, 2007). This idea was reflected in participant comments that although most days they would succeed at *not listening to the ED thoughts* there might be some days when they might *slip back into old habits*.

The themes were represented as a cycle rather than a static collection of ideas in order to illustrate the process of recovery participants had described. In keeping with the critical realist perspective of the study, it must be considered whether participants would recognise their description of recovery as it is represented in this cycle. Although the thematic map has not been shared with study participants, evidence from wider literature indicates illustration of recovery in different stages does indeed fit with experience of those who have recovered from mental health difficulties.

Andresen et al. (2003) propose a five stage model of recovery developed following extensive analysis of description in literature about recovering from schizophrenia and other severe mental health difficulties. Their model was verified by development of an empirically validated 'stages of recovery instrument' (Andresen et al., 2006). Table 15 presents a description of each stage of Andresen et al.'s model alongside key themes within the major recovery themes highlighted by the current study.

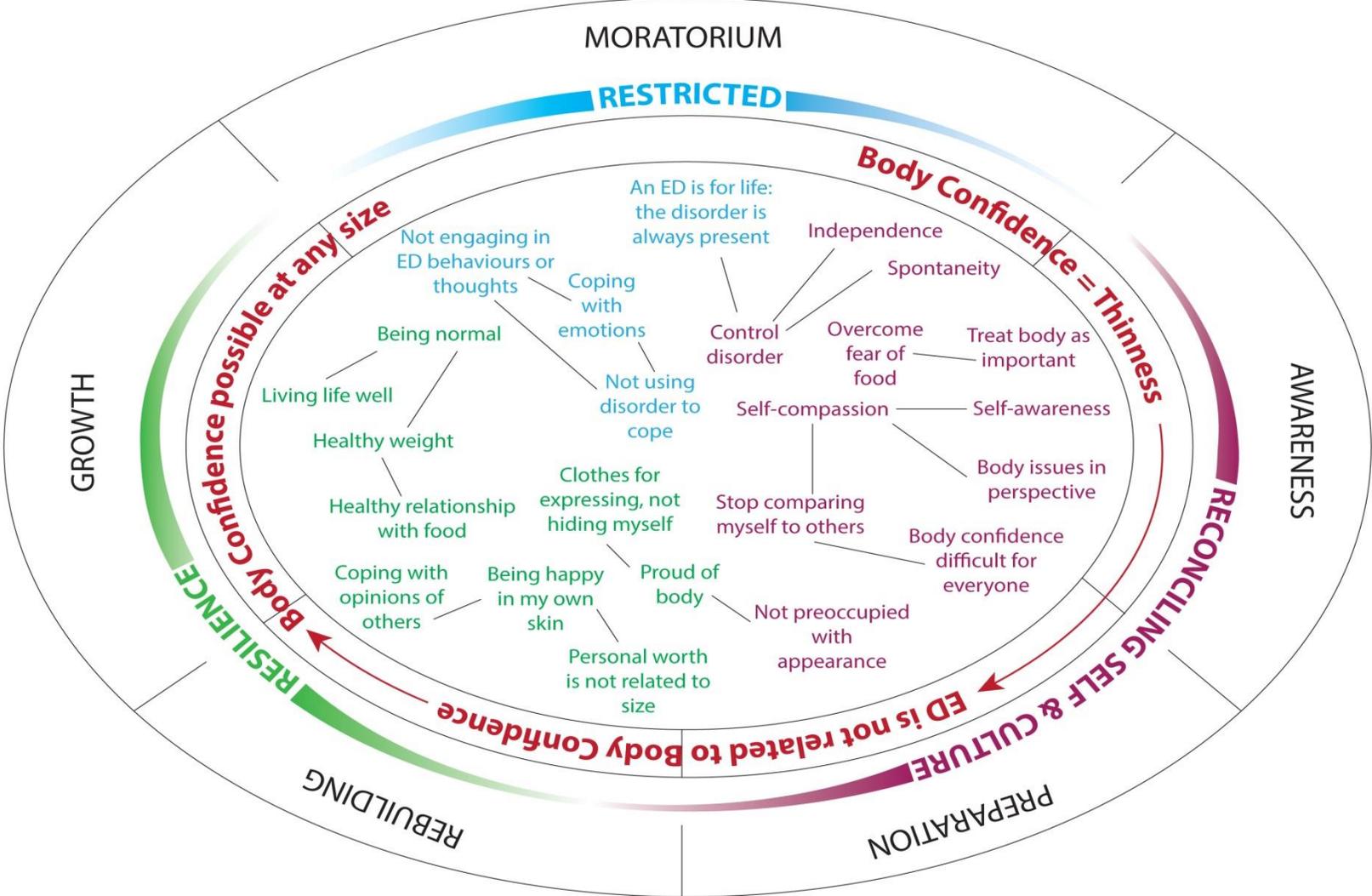
Table 15. Andresen et al.'s stage model of recovery alongside recovery stages from current study

Stage Model of Recovery	Major recovery themes
<p><i>Moratorium</i> Withdrawal, loss, hopelessness</p>	<p><i>Restricted</i> An ED is for life, you cannot unlearn what you know</p>
<p><i>Awareness</i> Realisation that a fulfilling life remains possible</p>	<p><i>Reconciling self and culture</i> Control the disorder, self-compassion and self-awareness, not preoccupied with appearance, proud of body, personal worth not related to size</p>
<p><i>Preparation</i> Identify strengths and weaknesses, develop skills</p>	
<p><i>Rebuilding</i> Work towards a positive identity, take control of life</p>	<p><i>Resilience</i> Coping with opinions of others, being happy in own skin, healthy relationship with food, living life well and being normal</p>
<p><i>Growth</i> Live a meaningful life and with a positive sense of self</p>	

Table 15 demonstrates the recovery cycle used to represent the current study's findings may be mapped onto Andresen et al.'s model. This is further illustrated by Figure 4. Thereby, some confirmation that the thematic map represents participant experience is achieved.

Nevertheless, the current study's findings add to literature about recovery by extending understanding about attitudes, goals and skills that individuals recovering from an ED consider to be most important at different stages.

Figure 4. ED recovery cycle situated within Andresen et al.'s stage model of recovery



Implications

Although the current study did not aim to recommend therapeutic intervention, particular areas of importance highlighted by the findings aligned with existing therapeutic models and treatments. Therefore, implications for theoretical models, therapeutic intervention and service planning and delivery cannot be overlooked. This is of particular importance given that the timing of the current study coincides with UK government provision of £150 million to develop specialist ED community services to make inpatient treatment a last resort (GOV.UK). Nevertheless, in the context of the current study's limitations, in particular lack of statistical power, all recommendations are made tentatively. Therapeutic intervention and service delivery were discussed in the journal paper. The other areas are addressed here.

Theoretical implications

The findings have further strengthened the link between social comparisons and therapist appearance that has received little attention by the literature. The current study reinforces these ideas, further highlighting that this topic warrants greater exploration. These ideas may have a wider impact upon theory regarding therapeutic processes than initially expected. In particular, the finding that individual's perspectives about body-confidence change from being associated with body-size to being a reflection of personality provides further insight into how ED clients might evaluate therapists based upon appearance.

With regards to models of recovery, the current study demonstrated a broad definition encompassing biological, psychological and social processes is most appropriate for accurately reflecting an individual's experience of overcoming an ED. Thus it might be further understood why criteria focused upon weight gain and symptom reduction are associated with higher rates of relapse than broader criteria. The study extends knowledge by contributing the voice of individuals who have an ED to current understandings of recovering from an ED and highlighting

the explicit link between social comparison processes and role of cultural norms in the process.

Service planning implications

Though not captured by the findings, the process of undertaking the current study highlighted important areas relevant to service planning, particularly in context of current mental health service focus upon early interventions and prevention. There were a high number of exclusions from the study as a result of pre-screening questions regarding age. Numerous 15 year olds attempted to complete the survey. As explained in the Extended Method, the decision was taken to exclude participants under the age of 16. Nevertheless, the high level of interest from individuals under 16 years old has important implications for service organisation and planning. There is a clear need to ensure that services are available to this age group. Further, the broad age range of the participant sample indicates the importance of continuing to offer services to adults.

This particular range of ages, spanning adolescence, early- and mid-adulthood, covers important points of transition pertinent to service organisation. ED clients are likely to undergo a transition from child and adolescent to adult mental health services, as well as a transition from services near their home to those at the place of higher education (Treasure, Schmidt, & Hugo, 2005). Unfortunately, transition between child and adolescent and adult mental health services is poorly defined (Treasure et al., 2005) and has been described as a 'cliff-edge' (GOV.UK). Further, services near ED clients' homes are often unable to offer support for individuals during academic holidays. As a consequence, many ED clients experience disruption of care and disruption of TR (O'Loughlin, 2012) which may lead to lower levels of self-esteem and fears about increased responsibility (Arcelus, Bouman, & Morgan, 2008). In light of the current findings regarding the process of recovery, ED clients approaching transitions may benefit from assessment to ascertain their stage of recovery and thus how

relationships they have within services might be planned to best support continued progress.

Further, as new specialist community services are designed, the current study's findings highlight it will be important to consider what therapists will be involved in service delivery. Appearance related characteristics such as body-confidence and, as highlighted by previous research, body-size will also be important to consider. The journal paper discussed how these considerations might impact upon training of therapists who work with the ED population.

Finally, service design should take into account findings regarding stages of recovery. The journal paper suggested that services could assess an individual prior to treatment to ascertain at what stage of recovery they are, using either the recovery map as a clinical interview tool or a checklist of behaviours informed by the stages demonstrated within the recovery map. This assessment would determine what type of treatment the individual received. For example, a person in the restricted stage could be provided with support to manage the ED and develop coping skills, whereas a person in the reconciling self and culture stage may benefit more from therapies to enhance self-acceptance and self-compassion and improve self-esteem. Therefore, when designing ED services it will be important to consider how tailored treatments can be best supported and which professionals might be most involved at delivering care at each recovery stage. The recovery cycle outlined by the current study indicates that weight-restoration interventions may be most beneficial as a focus in the early stages of recovery, whereas psychotherapeutic intervention maybe most beneficial in the middle and latter stages. Nevertheless, it is important that all interventions continue to a greater or lesser extent throughout all stages.

Males who have an ED

The participant group in the current study was heavily skewed toward female gender, with only four males having completed the survey. As

discussed in the Extended Method, males who have an ED are commonly difficult to recruit to research studies and often do not present to services. Explanations as to why this occurs remain speculative. Therefore this issue warrants further discussion.

The decision to keep male participant data in the current study was made to highlight the existence of this group within the ED population and to again underscore the difficulties in encouraging this group to voice their experience. The current study used an online anonymous survey that offered a private forum to express opinion, yet despite repeated attempts to increase recruitment, the number of male participants remained small.

Since the number was so small, it was considered the additional quantitative data was unlikely to skew statistical analysis. Further, some authors have suggested male and female ED populations share many characteristics, so mixed-gender analyses are acceptable (Bramon-Bosch et al., 2000; Carlat et al., 1997; Woodside et al., 2001). Indeed, inspection of qualitative data from the male participants did not reveal differences in themes regarding recovery or body-confidence. The only notable difference was that mean illness duration was slightly above the sample mean (8.5 years and 6.97 years respectively).

Therefore it is clear that although males who have an ED very much remain a silent group. Inspection of demographic information collected by the current study suggests males may live with an ED for longer than females, possibly as a consequence of failing to recognise symptoms or hesitation to access treatment. Speculation as to why this occurs has considered the possible stigma for males who have what is commonly conceptualised a 'female disorder' (Strother et al., 2012; Weltzin et al., 2005). If this is true, then there are important implications for services. At a time when the government has provided additional funding for provision of community ED services, such considerations are crucial. Thought should be given to how services are promoted, in particular to

highlighting that ED is not exclusively a ‘female disorder’. If males do indeed live with ED for longer than their female counterparts then it is important to tailor advertising of services to target this population. It may be beneficial to offer males who have an ED a more private forum in which to access treatment; perhaps a dedicated clinic or male only groups.

Finally, further research to elicit the voice of males who have an ED that might help to elucidate the reasons that they tend not to access treatment would be valuable to inform future service design.

Generalisability of findings

The broad inclusion criteria employed by the current study go some way to addressing critique regarding generalisability of findings. Demographic information obtained about participants reveals a wide age range, reasonable variation in ED duration, diagnosis and differing experience of treatment. Since average length of illness duration in the ED population is 8 years (Hoek & van Hoeken, 2003) and most adults present for ED treatment in their twenties and early thirties (Fairburn & Cooper, 2007), the current study’s sample may be considered broadly representative of the adult ED population.

However, the study aimed to recruit a mixed gender sample in order to establish whether males place the same importance upon therapist characteristics as females. As previously discussed, recruitment of male participants proved challenging. Therefore, conclusions from the current findings may be applied confidently to only the female ED population. Further, the demographic information collected about participants did not include details about cultural background. As discussed in the Extended Background, experience of ED differs across cultures; therefore, the current study cannot be certain how the findings might be generalised to individuals living outside of the UK.

The findings are based upon accounts provided by 143 participants whom are assumed to have personal experience of an ED. Nevertheless, the possibility remains that some or all participants did not have personal experience of an ED or they completed the survey more than once. However, there were indications this was not the case. First, the language used in answering the open-ended questions was indicative of individuals sharing the same experience; the uniformity of the final themes across data was evident and many participants used specific words and phrases typical of the ED population, referring to 'BMI' and 'ED thoughts'. Second, since completion of open-ended questions is time-consuming and demanding, it may be assumed those who completed the survey were motivated to do so by their experience of ED. Finally, themes identified from the data are in line with previous research with this population, which lends further support to the veracity to participants' assumed identities.

Study Critique

Strengths

The ED population is often difficult to engage (Fassino et al., 2009), therefore employing a methodology enabling participant anonymity is considered a strength of the current study's design. Further, the online survey included a section to elicit feedback about the experience of completing the questionnaire. This enabled the researchers to respond to feedback from participants during the study as well as providing participants the opportunity to share thoughts about future areas for research. Indeed, this method was employed in a previous study (Hoogerwerf, 2013). Participant feedback from this previous study informed the current study's aims with regards to exploring therapist body-confidence. Involving service-users in the research process is recommended by the Department of Health (2004). In addition to the area of research, service-user opinion was elicited with regards to questionnaire design and areas for future research. This is also considered a strength of the current study's design; utilising both

researcher knowledge and service-user expertise and experience contributes to increasing the robustness of the research.

Limitations

All participants who completed the online survey volunteered to do so. Therefore it is uncertain whether therapist body-confidence is important to the ED population as a whole, or just individuals in the current study. However, such an outcome would result in an uncharacteristically skewed sample and is deemed unlikely due to the high number of responses to the survey.

Another limitation was failure to obtain information about ethnic and cultural background of participants. This is perhaps an artefact of the chosen methodology which ensures participant anonymity. However, since cultural and ethnic background impacts upon how an ED is experienced, such information would have provided an additional dimension to the findings. Since the survey was advertised via UK charities it might be assumed that participants have similar cultural backgrounds. Nevertheless, the internet enables wider access to resources and the possibility participants from different backgrounds completed the research cannot be ruled out. It has been argued that importance of therapist body-confidence is a consequence of internalisation of thin-ideal propagated by Western media. Therefore individuals from different cultural backgrounds may not perceive therapist characteristics as important for TR. Further research is needed to clarify whether this issue is specific to particular cultures or ethnic backgrounds

Finally, the current study could be criticised for adopting a simplistic understanding of the function of language and assuming that participants' responses reflect their experience. This is a consequence of the epistemological position and chosen methodology. However it remains important to acknowledge participants may have sought to persuade the researcher rather than simply sharing their experience.

Future Research

The current study adopted a critical realist framework that acknowledges the multifaceted nature of experience and therefore endorses a comprehensive approach to research so that the truth of experience may be accurately represented. Therefore, as suggested in the journal paper, this area of research would benefit from employing different study designs. With regards to therapist gender, qualitative designs would enable the development of better understandings about why a same-gender therapist is important to the ED client. Therapist body-confidence remains a new topic within the literature, so would benefit both from deductive and quantitative designs to establish its importance in large and diverse samples, as well as qualitative designs to explore reasons for its importance to ED clients.

However, it is acknowledged producing quantitative statements about the complex phenomena of TR has limitations. The complexity of defining TR creates difficulties in operationalising qualities for investigation and a reductionist approach risks overlooking important aspects and large pools of data. Nonetheless, investigation of large and diverse samples would afford researchers a greater understanding of likely important themes warranting deeper exploration.

Conclusions

In conclusion, the participants in this study indicated a strong preference for a same-gender, body-confident therapist. Participants also demonstrated evolution of body-confidence was an important process in recovery. The aim of this study was not to reveal absolute truth. However, it has shown this group of participants have strong preference for therapist characteristics that may impact upon TR. Further, complexities of the process of recovery have been highlighted. Overall, the findings suggest these perspectives should be further explored by future research.

Critical Reflection

The first author's reflection upon the process of conducting the current study is presented here. Within mixed methods research, the core component determines theoretical base and approach (Morse, 2010). Therefore, since the core component of the current study was qualitative, guidelines for ensuring the rigor of qualitative research were followed. Reflective accounts contribute to the trustworthiness of qualitative data as well as facilitating critical thinking (Jasper, 2005). A research journal was kept from study inception to completion and used as a tool to manage possible researcher bias by making implicit assumptions explicit. The process of explicating assumptions to self and others enables biases to come into researcher awareness so they may be put aside or incorporated into analysis (Morrow, 2005). The process of keeping a research journal is also in keeping with the critical realist stance of the current study, which views the researcher as integral to interpretation of data (Morrow, 2005).

Reflection is a conscious and active process of focused thinking (Gelter, 2003). Through the process of considering various aspects of a situation, learning is gained (Coward, 2011). Reflection is crucial to demonstrate stance and integrity (Jasper, 2005) as well as providing an invaluable learning and ethical tool (Gelter, 2003). In line with this, the following section is structured using research journal entries considering theoretical, scientific and ethical aspects in relation to the current study. The decision not to use a reflective model is supported by literature that suggests structuring of reflection restricts thinking (Coward, 2011) and produces mechanistic responses to a pre-determined and therefore limiting set of stages (Ghaye & Lillyman, 2000).

Theoretical

The diary entry in Figure 5 demonstrates concerns I had about remaining true to my critical realist position. The mixed methods approach I chose meant I often moved between thinking along positivist lines of absolute

truth and constructivist ideas about context and individual experience. I found this difficult to reconcile and found myself revisiting design and research decisions in order to satisfy myself of their validity within the critical realist position. I think this process is evident in references throughout the thesis to how the study meets the critical realist position.

Figure 5. Research diary extract 1.

February 21st 2014

I am worrying about how the methods I have chosen fit with my critical realist position. There is so much debate about whether mixed methods approaches fit with a particular epistemology. There is even a school that talks about abandoning epistemological position since it opens up choice about what method to use. This is confusing and doesn't make sense to me...I do have ideas about what truth is and how knowledge is gained. I want to be honest about this because it will influence my interpretation of the data. But is this position at odds with using mixed methods – how do I run statistical tests with finite answers and then take a less absolute approach to analysing themes? I keep going back to the literature but the more I read, the more I come across different solutions to this problem. I know I have to synthesise it and reconcile it in my own way...I just don't want to get it wrong!

Following the decision in this excerpt about finding my own interpretation of epistemological positions in mixed methods research, I came up with an approach that made sense to me and helped me to understand how my position influenced my interpretations and conclusions. This process sensitised me to how planning and writing the research might influence the way I interpreted the participants' accounts of their experience. Figure 6 illustrates how this awareness led to decisions I took during thematic analysis.

Figure 6. Research diary extract 2.

June 6th 2014

Reviewing literature about cultural norms has really made me think about how society lauds appearance and how this comes across on TV and advertising. I have found myself getting angry and thinking about how difficult it must be to recover from an eating disorder when surrounded by this perspective. As I've gone back to thematic analysis, I've noticed I'm more sensitive to references to how participants monitor others. I spoke to my supervisor about my worries about influencing my interpretation. She advised me to go back to the original responses to check connections that I am making really are in the data. I've also decided not to return to the literature again until I have finalised the themes. I don't want to risk losing the participants' voice – that would undermine the point of this part of the study!

Through this process I have learned that there is not a single, correct way of approaching data analysis. In future I will remember a clear understanding of epistemological position and how it fits with study aims provides a valuable compass for navigating the process of data analysis.

Scientific

Figure 7. Research diary extract 3.

February 6th 2014

Despite widening advertising to include a landing page on Call for Participants the pace of new responses has not increased. So far I have around 40 responses so I am feeling disheartened and concerned about what I will be able to do in terms of statistical analysis when the time comes. I am hopeful that I will have 60 completed surveys by the time I take down the link – although that will still leave me short for sufficient power, at least it will give enough of a sample to do some basic exploratory analyses of.

Reflecting on this extract from my research diary, I recall how frustrated and worried I was about the rate of recruitment to the study. At this point, my timetable suggested I had three months remaining before I needed to begin analysis. I was disappointed because the quantitative part of the project that might have enabled me to make statements about the importance of therapist body-confidence was seriously lacking in power. I felt the study would not make the contribution I had envisaged when I designed it. Body-confidence had been highlighted by participants of a previous study as important and I wanted to help explore and share this. I met with my supervisor about how I might increase awareness of the study and consequently contacted advertising charities once again to request the link was sent to mailing lists. The results of these efforts are highlighted by the diary extract in figure 8.

Figure 8. Research diary extract 4.

March 8th 2014
Much better month in terms of recruitment; there was a real boost in numbers on Valentine's Day and during Eating Disorders Awareness Week. Now have over 100 responses 😊 Very pleased, although it does feel sad that these participants must find this time of year particularly challenging.

I learned two lessons from the ups and downs of recruitment. First, not to become despondent when things do not go as smoothly as hoped, but rather remain proactive in improving awareness of the research. Second, in designing a study it is important to remain realistic about the required sample size and timeframe within which data must be collected. In future, I would consider doing separate quantitative and qualitative studies since I have learned they require quite different approaches to recruitment.

Ethical

When I began this study, I had some awareness it was exploring a sensitive or controversial topic. Nevertheless, I was interested in finding out about body-confidence and whether it might be related to body-size for individuals who have an ED. This curiosity was the foundation for the decision to use figure line drawings in one of the questions about therapist body-confidence. Figure 9 demonstrates the dawning realisation about the impact this decision had upon the study participants.

Figure 9. Research diary extract 5.

March 15th 2014

We received an email from one of the participants complaining about the association of body-confidence and body-size in the questionnaire. This is something that some participants have commented on, but this person was particularly offended and upset. My supervisor and I met and considered our response to her. We decided to explain the aims of the study in more detail and to highlight that what we wanted to do was to investigate whether some people with an eating disorder do indeed conflate the two concepts. Some people in the questionnaire have! So far we have had no response from her to our reply. Hopefully this means that she was satisfied but there is a concern that she is still distressed but doesn't want to engage in the conversation. It makes me feel guilty since she spoke about how hard she had battled to overcome this association in order to feel recovered, but I suppose that is the point of the research: to highlight to professionals and services that this is what people with an ED need to overcome. I hope that we can get that message across with our data, it seems more important to share their voices when the distress has become so clear.

Reflecting upon this extract, I recall how distressed I felt that completing the survey so upset this participant. In my keenness to investigate an interesting topic I had overlooked the individuals whose experience I wished to explore. This experience strongly reminded me of the

struggles the participants might have been through and this made me more passionate about conveying this in our findings. I will take this lesson with me and use it to temper my curiosity with a greater consideration of individuals who might participate in the study. As Clinical Psychologists we are encouraged to hold an attitude of curiosity. Through this experience I have learned how that attitude might hurt the people with whom we work and that reflection is a valuable tool in mediating curiosity and ethical consideration.

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- Zunino, N., Agoos, E., & Davis, W. N. (1991). The impact of therapist gender on the treatment of bulimic women. *International Journal of Eating Disorders, 10*(3), 253-263.

APPENDICES

Appendix A: Systematic Review Search Strategy

The following search terms were entered into PsycINFO, Embase and Medline independently.

1. exp eating disorder\$
2. (therap\$ ingredients OR therap\$ factors OR interpersonal interaction OR therap\$ competence OR therap\$ trustworthiness OR therap\$ confidence OR therap\$ openness OR therap\$ empathy OR therap\$ encouragement OR therap\$ characteristics OR therap\$ experience OR therap\$ alliance OR working alliance OR therap\$ relationship)
3. treatment outcome\$
4. positive outcome\$
5. intervention outcome\$
6. Or 3-5
7. And 1,2,6
8. limit 7 to English language
9. limit 8 to year 2003-2013

Records retrieved:

PsycINFO: 135

Embase: 18

Medline: 6

The following search terms were entered into Web of Science with the search limits set to: Time-span: 2003-2013. Databases: SCI-EXPANDED, SSCI, CCR-EXPANDED, IC.

1. therap* ingredients OR therap* factors OR interpersonal interaction OR therap* competence OR therap* trustworthiness OR therap* confidence OR therap* openness OR therap* empathy OR therap* encouragement OR therap* characteristics OR therap* experience OR therap* alliance OR working alliance OR therap* relationship (topic)

2. AND positive outcom* OR treatment outcome* OR intervention outcome* (topic)
3. AND eating disorder OR eating disorders (topic)

Records retrieved: 49

The following search terms were entered into the Cochrane Library, with search limits set to: Year: 2003-2013

1. therap* ingredients OR therap* factors OR interpersonal interaction OR therap* competence OR therap* trustworthiness OR therap* confidence OR therap* openness OR therap* empathy OR therap* encouragement OR therap* characteristics OR therap* experience OR therap* alliance OR working alliance OR therap* relationship (title, abstract, keywords)
2. AND positive outcom* OR treatment outcome* OR intervention outcome* (title, abstract, keywords)
3. AND eating disorder OR eating disorders (title, abstract, keywords)

Records retrieved: 74

Appendix B: Systematic Review Quality Assessment Tool

Rater 1; Rater 2

de la Rie (2008)		
Good = 2; Fair = 1.5; Poor = 1; Very Poor = 0.5		
Criterion	Score	Comment
<p>Study aims:</p> <p>Good: Clear statement of aim AND objectives including research questions and PICO</p> <p>Fair: Research questions outlined and PICO included.</p> <p>Poor: aims and objectives/PICO inadequately outlined</p> <p>Very poor: no aims or objectives/PICO included</p>	2 2	<p>Clear statement of aims and objectives</p> <p><i>Aims and objectives clearly articulated</i></p>
<p>Sampling:</p> <p>Good:</p> <p>Details (age, gender, race, context) of who was studied and how they were recruited; Why this group was targeted; Sample size justified for the study; Response rates shown and explained</p> <p><i>Sampling cont.</i></p> <p>Fair:</p> <p>Sample size justified; Some missing about sample missing</p> <p>Poor:</p> <p>Sampling mentioned but few descriptive details</p> <p>Very poor:</p> <p>No details of sample</p>	2 1.5	<p>Recruitment method described.</p> <p>Sociodemographic characteristics of group described, response rates described</p> <p><i>Sample size not really discussed / defended. What is a specialised treatment centre? Number of participants not considered and limited details provided</i></p>
<p>Procedure:</p> <p>Good:</p> <p>Appropriate and described clearly, e.g. questionnaires/interview schedule included; Clear details of data collection and recording</p>	2	<p>Both screening and intervention procedures clearly described, questionnaires included, Analysis detailed clearly</p>

de la Rie (2008)		
Good = 2; Fair = 1.5; Poor = 1; Very Poor = 0.5		
Criterion	Score	Comment
No mention of issues		
<p>Results and Discussion</p> <p>Good: Findings explicit, easy to understand, and in logical progression; Tables, if present, are explained in text; Results relate directly to aims and sufficient data are presented to <i>Results and Discussion cont.</i> support findings; Confounding variables accounted for.</p> <p>Fair: Findings mentioned but more explanation could be given; Data presented relate directly to results AND/OR some account made for confounding variables.</p> <p>Poor: Findings presented haphazardly, not explained, and do not progress logically from results AND/OR no account for confounding variables.</p> <p>Very Poor: Findings not mentioned or do not relate to aims.</p>	<p>2</p> <p>2</p>	<p>Confounding variables not controlled for in the analysis but described and effect on data acknowledged in discussion</p> <p>Clearly explained; findings easy to understand and read; sufficient data provided. Results do relate to aims of study. Confounding variables not accounted for but considered.</p>
<p>Transferability and Generalisability</p> <p>Good: Context and setting of the study is described sufficiently to allow comparison with other <i>Transferability and Generalisability cont.</i> contexts and settings, plus high score in Question 2 (sampling).</p> <p>Fair: Some context and setting described, but more needed to replicate or compare the study with others, PLUS fair score or higher in Question 2 (sampling).</p>	<p>2</p> <p>2</p>	<p>Context and setting well described and sampling good</p> <p>Context and setting of the study is described sufficiently to allow comparison with other contexts and settings. Sampling clear.</p>

de la Rie (2008)		
Good = 2; Fair = 1.5; Poor = 1; Very Poor = 0.5		
Criterion	Score	Comment
Poor: Minimal description of context/setting. Very Poor: No description of context/setting.		

Summary Score: 14 13
Methodological Rigour Score: 7 6

Appendix C: Systematic Review Journal Guidelines

It is intended that this review will be submitted to the International Journal of Eating Disorders. This journal was selected because this review is relevant to its stated areas of interest and several of the studies in this review were published by the journal.

Guidelines for authors can be found at:

[http://onlinelibrary.wiley.com/journal/10.1002/\(ISSN\)1098-108X/homepage/ForAuthors.html](http://onlinelibrary.wiley.com/journal/10.1002/(ISSN)1098-108X/homepage/ForAuthors.html)

Appendix D: Ethics approval letters and amendments



Direct line/e-mail
+44 (0) 115 8232561
Louise.Sabir@nottingham.ac.uk

Faculty of Medicine and Health Sciences

24th October 2013

Emma Rodgers
Doctorate in Clinical Psychology Student
c/o Dr Louise Braham
Consultant Clinical Psychologist & Senior Clinical Tutor
Trent Doctorate in Clinical Psychology
Division of Psychiatry & Applied Psychology
Institute of Mental Health
Yang Fujia Building
Nottingham University Jubilee Campus
Nottingham
NG8 1BB

Research Ethics Committee
Division of Respiratory Medicine
D Floor, South Block
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham
NG7 2UH

Dear Emma

Ethics Reference No: K10102013 SoM Psychiat & App Psychol – please always quote.
Study Title: An Exploration of how therapist gender and body confidence impact upon the Eating Disordered client and recovery.
Academic Supervisor in Charge: Dr Louise Braham, Consultant Clinical Psychologist & Senior Clinical Tutor, Trent Doctorate in Clinical Psychology
Division of Psychiatry & Applied Psychology, School of Medicine.
Student Investigator: Emma Rodgers, Doctorate in Clinical Psychology.
Duration of Study: 01.10.13-30.09.14 12mths **No of Subjects:** 291

Thank you for your recent application which was considered by the Committee at its meeting on 10th October 2013 and the following documents were received:

1. UoN FMHS Med Sch Research Ethics Application form dated 10.09.2013.
2. Therapist Gender, Body Confidence and ED Client Protocol Final version 1.0, 09.09.2013.
3. Therapist Gender, Body Confidence and ED Client Appendix A1: Questionnaire with Commentary, Final version 1.0, date 09.09.2013
4. Therapist Gender, Body Confidence and ED Client Appendix AII: Questionnaire without Commentary, Final version 1.0, date 09.09.2013
5. Therapist Gender, Body Confidence and ED Client Appendix B1: Recruitment Message to BEAT and FSD, Final version 1.0, date 09.09.2013
6. Therapist Gender, Body Confidence and ED Client Appendix BII: Message to Participants, Final version 1.0, date 09.09.2013
7. Therapist Gender, Body Confidence and ED Client Appendix C: Information and Consent Page final version 1.1, 23.10.2013
8. Therapist Gender, Body Confidence and ED Client Appendix D: Participant Debriefing Page, Final version 1.0, date 09.09.2013.
9. Therapist Gender, Body Confidence and ED Client Appendix E: Breakdown of Potential Recruitment Figures version 1.0, date 09.09.2013
10. E-mail of Support from Jonathan Kelly, Research Officer, Beat, dated 1st March 2013.

These have been reviewed and are satisfactory and the study is approved.

- Please could you submit copies of posters and adverts to the Committee when these are available and have been approved by Beat.

Approval is given on the understanding that the Conditions of Approval set out below are followed.



1. You must follow the protocol agreed and inform the Committee of any changes using a notification of amendment form (please request a form).
2. You must notify the Chair of any serious or unexpected event.
3. This study is approved for the period of active recruitment requested. The Committee also provides a further 5 year approval for any necessary work to be performed on the study which may arise in the process of publication and peer review.
4. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

Dr Clodagh Dugdale
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

Approval of amendment



The University of
Nottingham

Direct line/e-mail
+44 (0) 115 8232561
Louise.Sabir@nottingham.ac.uk

25th November 2013

Emma Rodgers
Doctorate in Clinical Psychology Student
c/o Dr Louise Braham
Consultant Clinical Psychologist & Senior Clinical Tutor
Trent Doctorate in Clinical Psychology
Division of Psychiatry & Applied Psychology
Institute of Mental Health
Yang Fujia Building
Nottingham University Jubilee Campus
Nottingham
NG8 1BB

Faculty of Medicine and Health Sciences

Research Ethics Committee
Division of Respiratory Medicine
D Floor, South Block
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham
NG7 2UH

Dear Emma

Ethics Reference No: K10102013 SoM Psychiat & App Psychol – please always quote.
Study Title: An Exploration of how therapist gender and body confidence impact upon the Eating Disordered client and recovery.
Academic Supervisor in Charge: Dr Louise Braham, Consultant Clinical Psychologist & Senior Clinical Tutor, Trent Doctorate in Clinical Psychology' Division of Psychiatry & Applied Psychology, School of Medicine.
Student Investigator: Emma Rodgers, Doctorate in Clinical Psychology.
Duration of Study: 01.10.13-30.09.14 12mths **No of Subjects:** 291

Thank you for notifying the Committee of amendment no 1 20th November 2013 as follows:

- Amendment to advertising of study. The following organisations have been approached requesting that they advertise the study on their websites and other relevant promotional material e.g. Facebook, Twitter, newsletters:
 - No bodies Perfect
 - Body Charity
 - Men Get Eating Disorders Too
 - SYEDA (South Yorkshire Eating Disorders Association)
 - Rethink
 - Mind

Positive responses will be forwarded to the Committee when they have been received.

The following Positive responses were received:

1. Letter from Alexandra O'Brien, Founder and Director, No Bodies Perfect (Eating Disorders) 20.11.2013.
2. Letter from Rosa Reynolds, Policy Officer, Rethink Mental Illness. 10.11.2013.

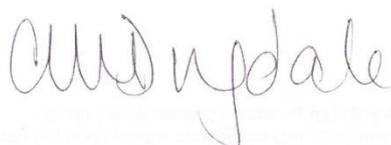
These have been reviewed and are satisfactory and the study amendment no 1 20th November 2013 is approved.

Approval is given on the understanding that the Conditions of Approval set out below are followed.



1. You must follow the protocol agreed and inform the Committee of any changes using a notification of amendment form (please request a form).
2. You must notify the Chair of any serious or unexpected event.
3. This study is approved for the period of active recruitment requested. The Committee also provides a further 5 year approval for any necessary work to be performed on the study which may arise in the process of publication and peer review.
4. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely



Dr Clodagh Dugdale
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

Appendix E.1: Participant information sheet and consent form

Title of Study: Therapist body-size, gender and the Eating Disordered client

Name of Researcher(s): Emma Rodgers, Louise Braham

You are being invited to take part in a research study. Before you decide whether or not you want to take part, we would like you to understand why the research is being done and what it would involve for you. Please take time to read the information below carefully. Talk to others about the study if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

Recent research has found that the body-size of female therapists has an important impact upon recovery for female clients suffering from an Eating Disorder.

The purpose of this study is to explore whether therapist body-size and gender is important to both male and female clients suffering from an Eating Disorder. The study will be included in a Clinical Psychology Doctoral thesis at the University of Nottingham.

Why have I been invited?

You have responded to our advert. We are looking for participants who are over the age of 16 and who have suffered/are suffering with an Eating Disorder of any subtype. You do not have to have sought therapy in order to participate, although that may be helpful. You must be able to read and write to an acceptable standard of English.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be asked for your consent. If you decide to take part you are

still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?

You will be asked to complete one online survey. The length of time the survey will take to complete will depend upon how much you choose to write. Some questions will ask you about you and your eating disorder and should not take more than 5 minutes to complete. The remaining questions will ask about your therapist's gender and body-size.

What are the possible disadvantages and risks of taking part?

There are no physical risks to you for taking part in this survey. However, completing the questionnaire will require you to give up some of your time. Additionally, some of the questions will ask you to think about your personal experience in therapy and some people may find thinking about these issues upsetting. If you are currently undergoing therapy, some of the questions may influence how you think about therapy and your therapist, so please think carefully before you decide to take part.

You do not have to discuss anything that makes you feel uncomfortable and the questions have been designed to be sensitive to your feelings and concerns. If you do become upset then we have provided contacts for help and support. Some people may not feel distressed at all. In the unlikely event that you are strongly distressed you can contact us for advice.

What are the possible benefits of taking part?

There is no individual benefit to you for taking part in this survey. However, this area of eating disorders literature has not been explored from the perspective of the person with an eating disorder. Therefore we hope that the information you provide will increase our knowledge and understanding of how relevant or important therapist gender and body-size is to eating disordered clients and their recovery.

What if there is a problem?

It is very unlikely that this study will cause you harm. However, if you do have any problems or any questions then please contact Emma Rodgers at the Institute of Work, Health and Organisations. The researchers' contact details are given at the end of this information sheet.

If you remain unhappy for any reason and wish to complain formally, you can do this through the Research Innovation Services, King's Meadow Campus, Lenton Lane, Nottingham, NG7 2NR. Telephone: +44 (0)115 8467408. In addition you will find contact numbers and links for psychological help-lines below.

Will my taking part in the study be kept confidential?

Yes. All information that you provide will be kept strictly confidential. You do not need to supply your name, address or any other information that could identify you. The written responses that you provide will be coded, anonymised and stored securely at the University of Nottingham. Only the researchers will have access to this data.

What will happen if I don't want to carry on with the study?

If you decide to withdraw you can do so at any time by selecting the withdraw button at the foot of the survey page. There will be no negative consequences to you if you decided to withdraw. You will be able to withdraw any submitted data for up to two weeks following completing the study. After this time, all anonymous data will be untraceable.

What will happen to the results of the research study?

The results of the study will be presented both as a Clinical Psychology doctoral thesis at the University of Nottingham and as paper(s) for publication in a scientific journal. Your individual responses or participation will not be personally identifiable in any way in any report. A summary of the findings will be reported on the BEAT website by October 2014. A copy of the study findings can be provided by Emma Rodgers, on request.

Who is organising and funding the research?

This research is being organised by the Institute of Work, Health and Organisations at the University of Nottingham.

Who has reviewed the study?

This study has been reviewed and given favourable opinion by the Faculty of Medicine and Health Science Research Ethics Committee at the University of Nottingham.

Further information and contact details

Emma Rodgers

Email: lwferro@nottingham.ac.uk

Supervised by: Dr Louise Braham

Chartered Clinical Psychologist

Email: Louise.Braham@nottingham.ac.uk

Institute of Work, Health and Organisations

Yang Fujia,

Jubilee Campus,

Wollaton Road

Nottingham

NG8 1BB

Support services and Help lines:

- BEAT (Eating Disorders Support Service) Helpline: **08456 341414**
Email: help@b-eat.co.uk
- Samaritans (24 hours a day): **08457 909090**: www.samaritans.org
- University of Nottingham Counselling Service: Tel: **(01159) 513695**:
Email: counselling.service@nottingham.ac.uk

Alternatively you may wish to speak to a member of a health care team or your GP.

CONSENT

1. I confirm that I have read and understand the information sheet provided for this research study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my legal rights being affected.
3. I understand that if I wish to withdraw after submitting the survey, I must contact the research team within two weeks. After that all anonymous data will be untraceable.
4. I understand that demographic information and data collected in the research may be viewed by authorised individuals from the University of Nottingham. I give permission for these individuals to have access to this data and to store, analyse and publish information obtained from my participation in this research.
5. I understand that direct quotes from the survey may be used in research reports, but will be made anonymous.
6. I agree to take part in the above study.

Yes

Appendix E.2.: Participant Debriefing page

Thank you for taking the time to complete this questionnaire. Your views are important to us and will be used to further our understanding of eating disorders.

All of your answers will be anonymised and therefore untraceable two weeks following you submitting this questionnaire. Therefore should you decide that you wish to withdraw your data please contact a member of the research team within two weeks from today's date.

If you have any queries or concerns as a result of completing this questionnaire, or you need someone to talk to, details are provided below of the principal researcher and further links where you may access support.

A summary of the study findings will be posted on the research website. You will be notified through BEAT when these are available.

Many thanks and best wishes

Emma Rodgers

Email: lwexerro@nottingham.ac.uk

Supervised by: Dr Louise Braham

Chartered Clinical Psychologist

Email: Louise.Braham@nottingham.ac.uk

Institute of Work, Health and Organisations

Yang Fujia Building,

Jubilee Campus,

Wollaton Road

Nottingham

NG8 1BB

Support services and Help lines:

BEAT (Eating Disorders Support Service) Helpline: 08456 341414

Email: help@b-eat.co.uk

Samaritans (24 hours a day): 08457 909090: www.samaritans.org

University of Nottingham Counselling Service: Tel: (01159) 513695:

Email: counselling.service@nottingham.ac.uk

Alternatively you may wish to speak to a member of a health care team or your GP.

Appendix F.1.: Questionnaire with commentary

Please create a unique study code by using the first 3 letters of your mother's maiden name and the last two digits of the year of your birth. For example, if your mother's maiden name is "Smith" and you were born in 2013 the code would be *smi13*.

Definitions

The terms below may be defined in several different ways. For the purposes of this study, please refer to the following definitions:

Therapy:

A process where a client speaks to a therapist as the main means of expressing and resolving issues

Therapist:

A healthcare professional whom you meet in a structured way for the purpose of discussing your difficulties

Eating Disorder:

"Eating disorders are characterised by an abnormal attitude towards food that causes someone to change their eating habits and behaviour. A person with an eating disorder may focus excessively on their weight and shape, leading them to make unhealthy choices about food with damaging results to their health." (NHS, 2013) The most common subtypes are:

Anorexia nervosa: when someone tries to keep their weight as low as possible, for example by starving themselves or exercising excessively

Bulimia: when someone tries to control their weight by binge eating and then deliberately being sick or using laxatives (medication to help empty their bowels)

Binge eating: when someone feels compelled to overeat

Eating disorders that do not fit with the above definitions may be described as:

Eating disorder not otherwise specified

(For more diagnostic criteria about each disorder, please click on the specific disorder)
(All definitions based upon information taken from www.nhs.uk)

Section 1

1. Age

(If the participant selects a number below 16 they will receive the message:

“Thank you for your interest in this study. However this survey can only be completed by participants aged 16 and over. If you feel you may be affected by some of the issues raised by this study, please contact the organisations listed for support and advice.”

Contact details of eating disorder charities and support services will be provided.)

2. Gender: Male/Female

3. Do you consider yourself to suffer/have suffered with an Eating Disorder? Yes/No

(If the person selects “NO” they will receive the message:

Thank you for your interest in this study. However this survey is designed for completion by participants who feel that they suffer/have suffered with an Eating Disorder. If you are the friend or relative of someone with an Eating Disorder, or are concerned about someone who you think may have an Eating Disorder, please contact the organisations listed for support and advice.”

Contact details of eating disorder charities and support services will be provided)

4. Have you received a formal diagnosis of an Eating Disorder? Yes/No

5: Which Eating Disorder subtype do you most closely identify with?

(Please refer to the definitions above. Some people identify with more than one subtype. If you identify with more than one subtype, please list in order of importance to you.)

6. For approximately how long have you suffered from an Eating Disorder?

7. Have you received any formal psychological therapy for your Eating Disorder? Yes/No

(If the person selects “NO” then they will receive the message:

We are still interested in your views. When completing the questionnaire, please imagine that you are seeing a therapist for your eating disorder and consider what thoughts you might have.

They will then be shown question 8.)

If the person selects “YES” then they will be asked to answer the following questions about their experience of therapy:

7a: What type of therapy did you receive for your Eating Disorder? CBT/IPT/Psychodynamic/Family/Systemic/Other (please specify)/Don't know

7b: What profession was your therapist?

Clinical Psychologist/ CBT therapist/ Counselling Psychologist/ Counsellor/ Nurse/Dietician/Support worker/Other (please specify)/Don't know

7c: For how long did you receive therapy?

(If you have had more than one experience of therapy, please state the length of time for each experience and whether you saw the same or a different therapist)

7d: Which of the following statements best describes the outcome of your therapy?

I am still undergoing therapy

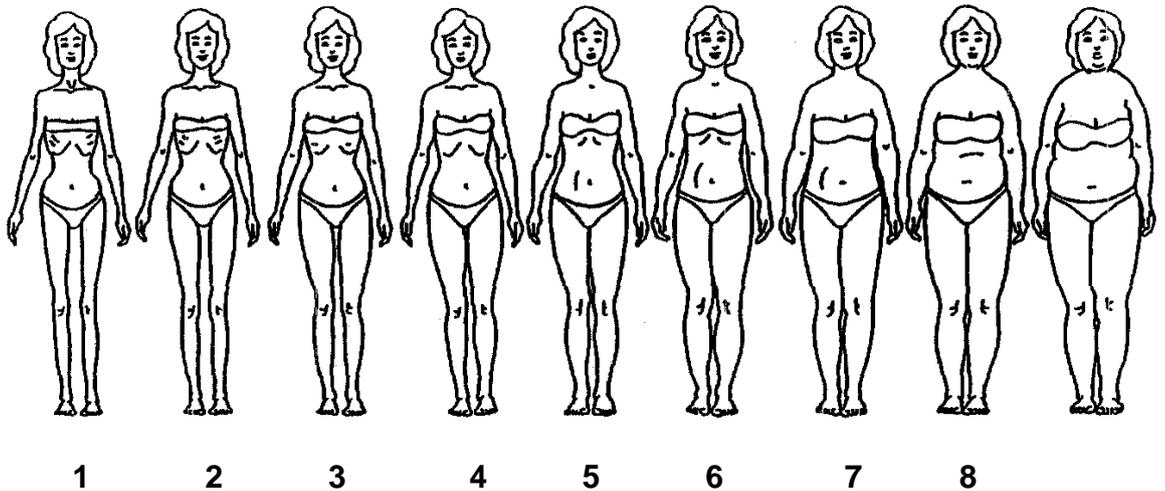
I am no longer undergoing therapy and consider myself to be recovered

I am no longer undergoing therapy but do not consider myself to be recovered

8. We are interested to find out what individuals with an Eating Disorder consider “recovered” to mean. Please could you describe what recovery from an Eating Disorder means to you?
9. Please tell us what “body-confidence” means to you?
10. If engaging in therapy, what gender would you prefer your therapist to be?
Male/Female

Section 2

You will now be shown some figures. The figures are shown without clothing so that you can view their body shape more easily. Please imagine engaging in therapy with a therapist represented by each of the figures when answering the following questions.



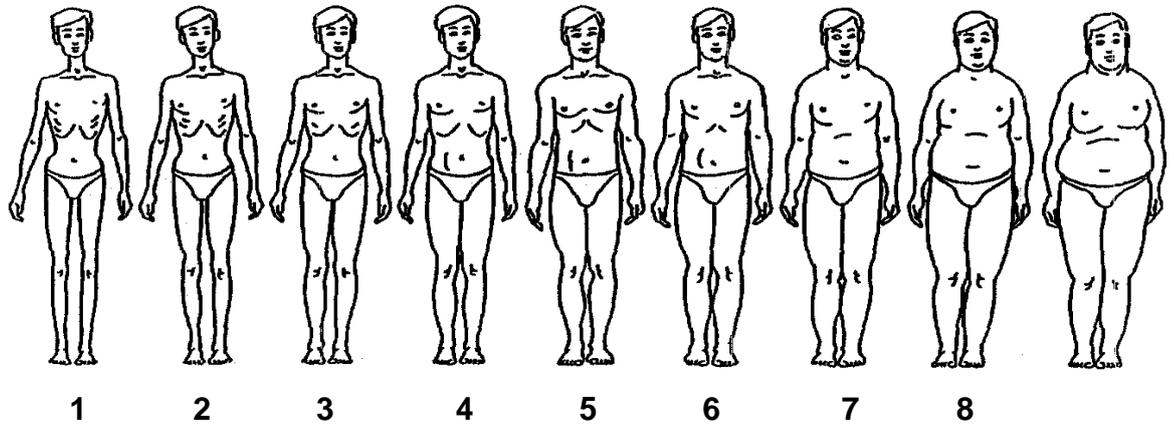
9

11. Which therapist would you consider to be most body-confident?

(Please select only one of the figures above)

12. Which therapist would you consider to be least body-confident?

(Please select only one of the figures above)



9

13. Which therapist would you consider to be most body-confident?

(Please select only one of the figures above)

14. Which therapist would you consider to be least body-confident?

(Please select only one of the figures above)

Thank you for taking the time to complete our questionnaire. In order to improve our questionnaire, we would appreciate your feedback and welcome any suggestions you may have. Please click [this link](#) for a blank copy of the questionnaire to appear in a new window that you may refer to. Please consider the following points in your feedback:

- How well did you feel the questions allowed you to express what you felt was important?
- Was there a question that felt inappropriate to ask?
- Is there a question you feel we should have asked?
- How successful was the structure of the questionnaire? (too broad/not broad enough?)

Appendix F.2.: Questionnaire without commentary

Please create a unique study code by using the first 3 letters of your mother's maiden name and the last two digits of the year of your birth. For example, if your mother's maiden name is "Smith" and you were born in 2013 the code would be *smi13*.

Definitions

The terms below may be defined in several different ways. For the purposes of this study, please refer to the following definitions:

Therapy:

A process where a client speaks to a therapist as the main means of expressing and resolving issues

Therapist:

A healthcare professional whom you meet in a structured way for the purpose of discussing your difficulties

Eating Disorder:

"Eating disorders are characterised by an abnormal attitude towards food that causes someone to change their eating habits and behaviour. A person with an eating disorder may focus excessively on their weight and shape, leading them to make unhealthy choices about food with damaging results to their health." (NHS, 2013) The most common subtypes are:

Anorexia nervosa: when someone tries to keep their weight as low as possible, for example by starving themselves or exercising excessively

Bulimia: when someone tries to control their weight by binge eating and then deliberately being sick or using laxatives (medication to help empty their bowels)

Binge eating: when someone feels compelled to overeat

Eating disorders that do not fit with the above definitions may be described as:

Eating disorder not otherwise specified

(For more diagnostic criteria about each disorder, please click on the specific disorder)
(All definitions based upon information taken from www.nhs.uk)

Section 1

1. Age

2. Gender: Male/Female

3. Do you consider yourself to suffer/have suffered with an Eating Disorder? Yes/No

4. Have you received a formal diagnosis of an Eating Disorder? Yes/No

5: Which Eating Disorder subtype do you most closely identify with?

(Please refer to the definitions above. Some people identify with more than one subtype. If you identify with more than one subtype, please list in order of importance to you)

6. For approximately how long have you suffered from an Eating Disorder?

7. Have you received any formal psychological therapy for your Eating Disorder? Yes/No

If no then participant will be shown question 8

If yes:

7a: What type of therapy did you receive for your Eating Disorder? CBT/IPT/Psychodynamic/Family/Systemic/Other (please specify)/ Don't know

7b: What profession was your therapist?

**Clinical Psychologist/CBT therapist/Counselling Psychologist/
Counsellor/ Nurse/Dietician/Support worker/Other (please specify)/
Don't know**

7c: For how long did you receive therapy?

(If you have more than one experience of therapy, please state the length of time for each experience and whether you saw the same or a different therapist)

7d: Which of the following statements best describes the outcome of your therapy?

I am still undergoing therapy

I am no longer undergoing therapy and consider myself to be recovered

I am no longer undergoing therapy but do not consider myself to be recovered

8. We are interested to find out what individuals with an Eating Disorder consider “recovered” to mean. Please could you describe what recovery from an Eating Disorder means to you?

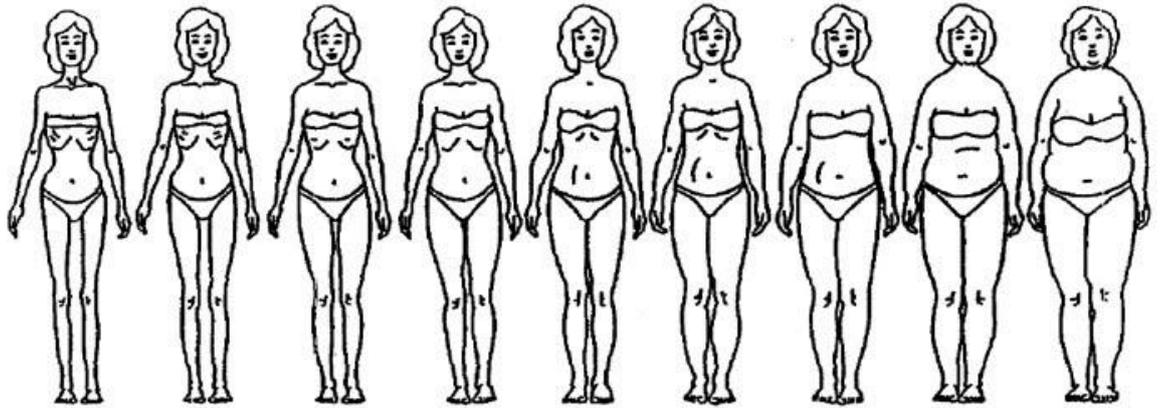
9. Please tell us what “body-confidence” means to you?

10. If engaging in therapy, what gender would you prefer your therapist to be?

Male/Female

Section 2

You will now be shown some figures. The figures are presented without clothing so that you can see their body shape more easily. Please imagine undergoing therapy with a therapist represented by each of the figures when answering the following questions.

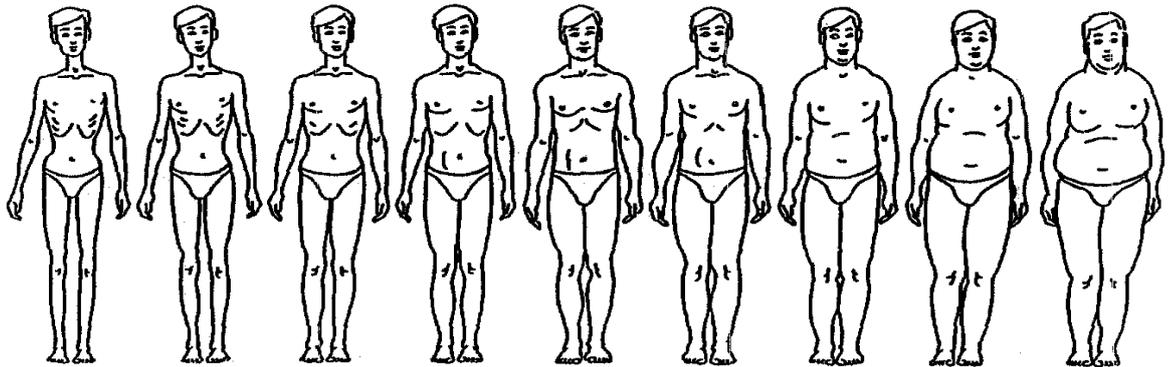


1 2 3 4 5 6 7 8

9

11. Which therapist would you consider to be most body-confident?

12. Which therapist would you consider to be least body-confident?



1 2 3 4 5 6 7 8

9

13. Which therapist would you consider to be most body-confident?

(Figures will be numbered)

14. Which therapist would you consider to be least body-confident?

(Figures will be numbered)

Thank you for taking the time to complete our questionnaire. In order to improve our questionnaire, we would appreciate your feedback and welcome any suggestions you may have. Please click [this link](#) for a blank copy of the questionnaire to appear in a new window that you may refer to. Please consider the following points in your feedback:

- How well did you feel the questions allowed you to express what you felt was important?
- Was there a question that felt inappropriate to ask?
- Is there a question you feel we should have asked?
- How successful was the structure of the questionnaire? (too broad/not broad enough?)

Appendix G: Email to websites and participant advert

Email to recruiting charities:

Dear

I am now looking for participants for my research. The study is open to both males and females aged 16 or over who have personal experience of an Eating Disorder, of any subtype, and who have access to a computer and the internet.

I'd be grateful if you would forward this email to anyone on your mailing list meeting these criteria,

Many thanks and best wishes

Emma Rodgers

Message to Participants:

Would you be interested in participating in a study exploring whether the gender and body-size of a therapist is important to their eating disordered client? There is very little research about these issues from the perspective of the individual with an eating disorder and so your views will be very important to us.

My name is Emma Rodgers and I'm a trainee clinical psychologist at the University of Nottingham. This study involves completing an anonymous online questionnaire. There are some short 'tick-box' questions and some questions that ask for more information about your choices. The time that it will take to complete depends upon how much you choose to write.

If you are interested or would like to find out more, please click on the link below to be taken to the study pages:

[Link]

If you have any queries please contact me by email

Many thanks and best wishes

Emma

Email: lwaxerro@nottingham.ac.uk

Supervised by: Dr Louise Braham

Chartered Clinical Psychologist

Email: Louise.Braham@nottingham.ac.uk

Institute of Work, Health and Organisations

Yang Fujia Building

Jubilee Campus,

Wollaton Road

Nottingham, NG8 1BB

Appendix H.1.: Example of initial coding procedure

7. Recovery

8. We are interested to find out what individuals with an Eating Disorder consider 'recovery' to mean. Please could you describe what recovery from an Eating Disorder means to you?

I believe 'recovery' to be when the individual has got to a point where they can lead a 'normal' life, or where activities of daily living are no longer governed or influenced by their eating disorder, to their own detriment. *live life*

healthy weight They maintain a healthy weight and any abnormalities in biochemistry caused as a result of malnutrition return to normal (not including abnormalities caused by the eating disorder that may have caused lasting damage), and

although they may still have negative thoughts which previously would have triggered eating disordered behaviours, the individual is now able to control/manage these influences in a more healthy way for the majority of the time. I don't think an individual will ever be completely free of their eating disorder but they learn to manage it and live a healthy and fulfilling life. *Controlling disorder*
ed always present

Withdraw?

8. Body Confidence

9. Please tell us what "body confidence" means to you.

acceptance of self.

Being able to be accepting and tolerant of my physical self. Being able to look at myself in a mirror and saying "there may be things about myself that I want to change, but for each thing I want to change, there are double as many things I like about myself, and I'm OK. My body is deserving of care and nourishment". Feeling like I am acceptable enough to be seen in public. Being able to go clothes shopping and try on clothes without hating myself. Being able to wear clothes I like and feel comfortable in them. Being comfortable with my body, and being confident enough to be comfortable with my body in spite of what others may (or may not) think. *enjoy clothes*

Withdraw?

feeling comfortable

coping opinions of others,

Appendix H.2.: Examples of codes (with quotes) transferred to tables

Living life	<p>4) Living a life in which I can function without the eating disorder dominating to the extent that I cant work, socialise, or gain fulfilment from life.</p> <p>14) To me recovery means being able to live my life without it revolving around food, exercise and weight. It means being able to make plans without them revolving around when I will eat, what I will eat and whether or not I will be able to either purge or exercise afterwards.</p> <p>38) Actually living rather than existing.</p> <p>39) I believe 'recovery' to be when the individual has got to a point where they can lead a 'normal' life, or where activities of daily living are no longer governed or influenced by their eating disorder, to their own detriment.</p> <p>76) To be able to live your life as best as possible</p> <p>94) able to get/keep a job, maintain friendships/relationships and, on the whole, do other 'normal' every day things essential to an adult life - including cooking, eating, opening mail, putting the rubbish out, etc etc...</p> <p>101) living fully engaged happy life</p> <p>110) able to live a normal life not controlled by food.</p> <p>145) Being able to live life</p> <p>160) be able to go about daily life while eating at normal times the right amount and not thinking about food and the next meal and wanting it all the time</p> <p>179) Recovery means having a life again, rather than missing out on thing due to my eating disorder</p> <p>186) Ability to work, socialise, participate in leisure activities without letting ED thoughts and behaviours dominate</p> <p>215) To go to university and complete my exams without agonising about how I can eat enough to get the most from my studies or perform my best in exams; without having to sacrifice hours to the gym rather than revision.</p>
Spontaneity	<p>77) Be able to be more spontaneous</p> <p>86) flexibility and spontaneity around meals, food, social events involving food</p> <p>182) When one can live everyday and living (and eating 'scary' foods) spontaneously</p> <p>189) Being able to eat spontaneously without panic, anxiety and guilt</p> <p>214) Being able to eat food spontaneously if offered</p> <p>37) able to have energy and motivation to do the things I want to</p>

<p>Self awareness and understanding</p>	<p>11) being conscious of my tendency to undereat when stressed</p> <p>124) with support, knowledge of self and time we can learn to live a normal life</p> <p>65) Addressing the reasons why I became ill</p> <p>225) I have great clinical insight into my illness</p> <p>21) being able to avoid and/or manage triggers</p> <p>55) to learn coping strategies for the times when the eating disorder may return</p> <p>65) recognising triggers and how to cope with them (relapse prevention)</p> <p>86) have awareness of vulnerabilities, triggers, emotional, family, personal and environmental stressors; the ability to recognize red flags, ask for support and troubleshoot.</p> <p>103) It is accepting slips happen, but learning to see any slips in behaviour as a red flag for needing to take care of yourself, and identify the problems in your life which you are trying to control with disordered eating.</p> <p>156) Ability to recognise disordered thoughts and compulsions. Ability to tolerate occasional changes to eating and exercise routine without needing to compensate later on.</p>
<p>Controlling disorder</p>	<p>3) I hate purging, but I seem to lack the willpower to not binge. I feel it's become more of an addiction to me than an eating disorder.</p> <p>4) a more realistic 'recovery' at this stage of my life is to be able to function sufficiently well that my life isn't entirely driven by my eating disorder.</p> <p>5) That my life no longer revolves around food and exercise.</p> <p>7) to have enough control in your life to rationalise those thoughts and recognise that they are not healthy. It is being able to understand that these thoughts do not control you and that you are allowed to eat whatever you like and enjoy it.</p> <p>20) Recovery means being able to enjoy my life without food or ED thoughts taking control and preventing me from doing things.</p> <p>21) Recovery for me means being able to manage the eating disorder until it does not affect my actions... It also means being able to control the thoughts.</p> <p>38) No longer being controlled by anorexic thoughts and feelings. Taking back control and not letting food and weight dictate mood, places I can/can't go, what I can/can't do etc.</p> <p>39) although may still have negative thoughts which previously would have triggered eating disordered behaviours, the individual is now able to control/manage these influences in a more healthy way for the</p>

	<p>majority of the time.</p> <p>44) Control over it and lost weight</p> <p>51) With skipping meals and it not being a concern, to overeat and it not be a concern, to sometimes feel like you've eaten 'bad' things and recognise the need to purge, but then being able to distract or move on from that feeling.</p> <p>55) Being able to manage my eating disorder effectively so that it doesn't impact on my daily life</p> <p>56) Getting to a situation whereby every decision I make is NOT dictated by how much food and exercise I have eaten/undertaken, and where my eating disorder is not always there in the background</p> <p>66) Recovery, in its most simplest term, would be to feel in control of my disorder, not that my disorder is controlling me.</p> <p>75) Not behaving in a disordered out of control manner around food.</p> <p>88) It does not mean that an individual becomes cured from an eating disorder but that they are able to find the strength to manage it and live life to the fullest (as much as possible)</p> <p>102) No longer feeling the need for previous behaviours, and feeling the ability to overcome the need for such behaviours, replacing negative thoughts with more positive ones</p> <p>114) I consider myself to be about 90% recovered. I don't say 100% because that would mean (to me) not experiencing thoughts/urges about engaging in behaviours, and not ever acting on them if they did occur</p> <p>150) When the disorder does not rule your life.</p> <p>177) I would describe recovery to mean a point at which I never listen to my eating disorder</p> <p>184) Being able to see food without feeling compelled to immediately eat it.</p> <p>194) I understand that the thoughts and feelings will always be there but as long as I am not acting on them and eating then I consider myself recovered</p> <p>197) I still 'think' in an eating disordered way however I no longer act on the thoughts (if that makes sense!)</p> <p>208) The majority of choices made in my life not dictated by eating disorder thoughts and food. Feeling free to choose the best option for myself.</p>
Healthy lifestyle	<p>7) Recovery is being able to live a healthy and happy life.</p> <p>43) Recovery therefore means healthy eating behaviour (not healthy as in veggie, but healthy as in 'feeling good while doing it'), healthy exercise behaviour (again, not healthy in terms of amount, yet healthy as in</p>

	<p>'feeling good before, while and after doing it') etc.</p> <p>65) eating a balanced diet... getting to a healthier weight</p> <p>66) Ideally, I would like to be able to maintain a lifestyle that involves set meals, healthy food and no intense urges to binge or over exercise.</p> <p>69) Being able to eat healthily, doing the right amount of exercise</p> <p>86) ability to eat variety of foods to meet nutrition needs, maintain health and wellness</p> <p>116) Feeling full, and satisfied on normal amounts. Being able to eat healthy and exercise without it becoming obsessive and compulsive, and not just a tool to control calories.</p> <p>137) eating in moderation/a balanced diet... not having health problems due to malnourishment</p> <p>144) Being able to eat a variety of foods in a balanced diet without guilt, anxiety and constant thinking about it</p> <p>146) To be able to eat and exercise healthily without counting calories. To be able to drink liquid calories.</p> <p>155) being able to be by myself and eat a regular diet. To know what 'normal' food portions are.</p> <p>166) Although I still struggle with body image and eating occupies a central point in my life, I now eat healthily</p> <p>199) To eat a regular diet without thinking about food all day and without thinking about what the impact of food has on my figure</p> <p>210) Able to eat anything you want without fear/guilt/'making up' for it, able to go into any situation without food/eating being a concern, acceptance of body shape/size, not counting calories, exercising in a normal way (i.e. able to take days off, exercise isn't no. 1 priority, exercise isn't unduly influencing weight)</p> <p>213) Being healthy</p> <p>228) Having healthy eating habits and a healthy body and feeling okay and content about it.</p>
<p>Good body image</p>	<p>15) Feeling comfortable with my body</p> <p>97) To me recovery means to have a healthy and nice relationship towards food, exercise and my body image.</p> <p>98) good body image, no body dis-morphia</p> <p>148) loving myself, reducing body dysmorphia,</p> <p>154) means just being happy with who I am and not having bad body image.</p> <p>156) Low(er) levels of BD, and ability to separate body image from eating behaviours.</p> <p>185) Good body image</p>

	<p>225) I can be quite positive about the way I look</p> <p>67) Improved body satisfaction</p>
Socialise	<p>14) It is being able to go to socialise without suffering from anxiety</p> <p>27) Being able to sit at lunch with my friends at sixth form college and be able to eat with them, not staring at other people all across the room eating.</p> <p>67) Being able to sit down and eat with other people.</p> <p>71) being able to enjoy food with my friends and family</p> <p>81) Being able to eat in front of other people and out in restaurants, cafes etc</p> <p>86) ability to participate in social events that include eating</p> <p>98) able to cope in social situations around food.</p> <p>144) To be able to socialise including situations that might involve eating with others.</p> <p>146) To not be cold all the time and be able to want to hangout with friends and socialize again</p> <p>199) To be able to eat normally with friends</p> <p>215) Socialising freely without undue concern about the calories in alcohol or being able to eat out with friends...</p> <p>223) I eat out and with friends</p> <p>202) Not having to check for people looking at you in a restaurant to check they don't think your greedy</p>
Relinquish control	<p>20) I see recovery as letting go of the control over food , and the restrictions</p> <p>56) Recovery would mean I didn't care about it all anymore!!</p> <p>103) Recovery is giving up all control over body-size, shape and weight. Recovery is having no food rules, or anxieties over food</p> <p>193) I've never wanted to be thin, just in control. I want to sort my control issues out and be fit and healthy.</p> <p>225) I am regimental in my food selection out of habit. I can get upset if what I was planning to have is not available. My panic safety food is cereal or fruit toast. I am fully aware this is not normal.</p> <p>228) Being happy with who I am and what I look like without trying to obtain control through my diet.</p>

Appendix H.3.: List of initial codes with description

Recovery

Theme	Definition
Good relationship with self	Participants talked about wanting to be able to separate their idea of self-worth from their weight, size and eating behaviour.
Absence of ED thoughts	Participants spoke about wanting to be free from thoughts about food, calorie intake and expenditure and weight which would allow them to make independent choices about what and when and with whom to eat. Absence of thoughts was seen as vital for recovery, not engaging in restriction or purging was not seen as sufficient if thoughts about it still occurred.
Not engaging in ED behaviours	Participants spoke about being able to eat without compensating, e.g. not engaging in purging and over-exercising. They also stressed the importance of being able to eat a 'normal' amount, i.e. no longer restricting or bingeing.
Freedom	Participants likened recovery to freedom. It would mean being free to live their life the way they wanted and being free of feeling judged or being controlled by the eating disorder. Some spoke about freedom from the shame of being ill and of being able to focus on the things that matter.
Coping with emotions	Participants described feeling overwhelmed by emotions, e.g. anxiety, depression, guilt. Sometimes this related to eating and sometimes this seemed a more general state which was controlled by restricting eating. They thought that recovery would mean being able to cope with emotions. Some participants linked being overwhelmed to experiencing a relapse from remised symptoms.
Living life	Participants spoke about merely existing and not being able to engage with a 'normal adult life' as a consequence of the ED. Recovery would mean being able to work, socialise, make plans for the future. Even keeping up with the mundane tasks of daily living such as opening letters or taking the bins out are prevented by the disorder.
Healthy weight	Participants stressed the importance of achieving and maintaining a healthy weight. Some specified that the weight should be healthy for their body type.
Enjoy life	Participants described being unable to enjoy life due to the eating disorder. Recovery would mean being able to experience enjoyment from their life.
Spontaneity	Participants spoke about wanting to be spontaneous. This related to broad categories such as eating, social events and daily

	activities that they would like to do, without concerns about food limiting or causing lack of motivation.
Self awareness and understanding	Participants stressed the importance of being aware of their behaviour patterns and tendencies, e.g. to under-eat when stressed. Understanding their illness was important so that they could learn strategies to cope with it and know when they may need to ask for support.
Exercising for fun	Participants considered recovery to mean that exercise could become a fun or social activity, rather than being used to compensate for calorie intake.
Acceptance of self	Participants highlighted that accepting themselves and their body at any shape or size would indicate recovery. This was both the most difficult and most fundamental aspect of recovery.
Controlling disorder	Participants stressed the importance of being able to live without being ruled by the disorder. They did not consider recovery to mean absence of ED thoughts, rather that they would have control over the decision about whether to act upon the thought.
Healthy lifestyle	Participants highlighted that recovery would mean a healthy lifestyle, e.g. eating a balanced diet, exercising to maintain fitness and doing both in moderation. They also stressed that for it to be 'healthy' they would also feel good after it.
Good body image	Participants spoke about the importance of having good body image to recovery, e.g. having no/less body dysmorphia and being positive about the way that they looked.
Socialise	Participants described how recovery would mean that they were able to eat with other people, not just at home but also in cafes and restaurants and that they would be able to do so without worrying about the calories or feeling anxious.
Regular periods	Participants highlighted that if they were recovered it would mean the return of menstruation.
Eat intuitively	Participants spoke about how recovery would mean being able to recognise the body's hunger cues so that they could eat when hungry and stop when full. They also talked about being tuned into cravings and being able to eat what they wanted without concern about whether or not they should eat.
Recovery = normal	Participants described recovery as being or feeling normal. This meant doing things that other people their age did and not feeling guilty or feeling limited by the eating disorder.
Disorder always present	Participants stressed that the disorder would always be present in their life. Some thought that recovery was not possible, only

	remission from symptoms. They spoke about the importance of being vigilant for the effects of the disorder and that this would have to be lifelong.
Treat yourself with kindness and respect	Participants thought that recovery would mean being kind to themselves and refraining from using derogatory terms to describe themselves.
Not using the disorder to cope	Participants talked about how they used control over eating and food as a way of coping with emotions. They described recovery as being able to cope with difficult emotions and being able to use alternative (healthy) ways of coping with stress.
Good relationships with others	Participants spoke about the importance of building relationships with other people, something that the disorder has prevented them from doing due to other's concerns and vigilance over eating behaviours.
Independence	Participants spoke about how recovery would mean independence from care and being able to listen to the needs of their body in order to care for it.
Maintenance over time	Participants stressed that to be 'recovered' they would have to maintain a healthy weight for a significant period of time.
Healthy relationship with food	Participants talked about having a healthy relationship with food being indicative of recovery. This meant eating 3 meals a day, not having 'forbidden' foods and no longer being obsessed by food.
Body issues in perspective	Participants recognised that many people had difficulties with accepting their body shape and size. Recovery was recognising that such issues are common and maybe normal.
Overcome fear of food	Participants described experiencing anxiety and fear about food and eating. Recovery would mean being able to eat without feeling afraid. Overcoming the fear may be even more important than whether or not they actually eat.
Happy	Participants talked about how recovery would mean being happy, both with themselves and with their life.

Body-confidence

Theme	Definition
Body-confidence means being thin	Participants describe body-confidence as being a particular (low) weight or being thin
Liking and accepting body	Participants talked about body-confidence as being a state in which one can accept one's body, see it as a whole with both good and bad parts and not constantly wish and strive to change it. They

	would know this feeling by being able to look in a mirror and not want to break the mirror or want to cry.
Happy in your own skin	Participants spoke about being happy with themselves both inside and out. Being happy in their own skin meant being able to like themselves and their body.
Good body image	Participants considered the presence of body dysmorphia as affecting one's self image. They thought that body-confidence meant feeling good about how one looks and as a result, looking good.
Not comparing with others	Participants talked about body-confidence as being able to accept what they looked like even if it was different from others. Body-confidence also meant not constantly comparing yourself to others.
Feeling confident	Participants said that body-confidence was feeling confident with your body. This meant many things, including being able to wear what you wanted, feeling confident in yourself and feeling confident that others would view you positively. They felt that body-confidence was about feeling a particular way, rather than looking a particular way.
Feeling comfortable	Participants talked about how body-confidence meant feeling comfortable with your body whatever its shape and size. It also meant feeling satisfied and ok with yourself.
Looking nice in and having fun with clothes	Participants spoke about the importance of clothes and body-confidence. Being body-confident would show by wearing clothes that are fashionable, that fit well and that are not designed to disguise body shape and size. Clothes would express personality and shopping for them would be enjoyable.
Not expecting to be perfect	Participants described body-confidence as giving up expectations of their body being perfect and no longer trying to control it to meet those standards.
Eating healthily	Participants thought that eating healthily reflected body-confidence.
Not preoccupied with appearance	Participants described over-scrutinising themselves and their bodies, e.g. always wondering how they looked to others or how they looked when they changed body position and body checking for weight gain. They talked about body-confidence as meaning that they would not engage in these behaviours.
OK to show off body	Participants talked about how being body-confident meant being able to show off your body in clothes that might make you stand out or by baring skin, e.g. wearing a bikini
Everything	Participants considered that having body-confidence would mean everything to them.

Not possible if you have an ED	Participants thought that having an eating disorder would preclude you from being body-confident.
Not related to having an ED	Participants thought that having an eating disorder was not related to body image.
Coping with the opinions of others	Participants talked about other people's opinions as being related to body-confidence. Body-confidence could mean not seeking other's approval, being able to cope with criticism or judgement or simply not caring what others thought or said about your appearance. This would mean not always trying to perceive what others thought about you and not defining yourself based on other's opinions.
Personal goals and worth are not related to size	Participants described body-confidence as recognising that size and appearance are not related to self-worth and that striving to look different was incongruent with their self.
Treating body as important	Participants spoke about body-confidence meaning that you treated your body as important
Not ashamed of body	Participants described feeling ashamed of how they looked and their body-size or shape. They felt that body-confidence did not mean loving your body, but being able to appreciate it as it is, not wanting to harm it and not wanting to apologise to others for how it looks.
Normal to find body-confidence difficult	Participants recognised that many people struggled to feel happy with themselves and that feeling unhappy with oneself was not necessarily exclusive to having an eating disorder
Respect and pride for body	Participants spoke about how feeling body-confident meant being able to appreciate and admire your body for the things that it could do. They also talked about being proud of their body, which meant carrying themselves in a way that expressed pride, e.g. walking tall.
Faith that body is ok	Participants described body-confidence as believing that one's body is ok the way it is.
Unrestricted	Participants described body-confidence as feeling free to express yourself, wearing what you want and doing what you want without fear.

Appendix H.4.: Initial saliency analysis, prior to collapsing subthemes

Freedom	22 + HI = 1
Recovery is being normal	9 + HI = 1
Recovery means not having an eating disorder	1 + LI = 4
Recovery is having regular periods	3 + LI = 4
Recovery lasts over time	3 + LI = 4
Not using the disorder to cope	9 + HI = 1
Requires self awareness and self understanding	9 + LI = 3
Not being overwhelmed by feelings	13 + LI = 3
Disorder always present	17 + HI = 1
Controlling disorder	23 + HI = 1
Relinquishing control	6 + LI = 4
Absence of eating disordered thoughts	50 + LI = 3
Mental stability	3 + LI = 4
Overcoming fear of food	10 + LI = 3
Not engaging in eating disordered behaviours	43 + LI = 3
Exercise for fun	3 + LI = 4
Moderation	3 + LI = 4
Good relationship with self	11 + HI = 1
Treat yourself with kindness and respect	4 + HI = 2
Good body image	9 + LI = 3
Body issues in perspective	2 + HI = 2
Happy	6 + LI = 4
Acceptance of self	15 + HI = 1
Healthy lifestyle	16 + LI = 4
Healthy weight	31 + LI = 3
Healthy relationship with food	10 + HI = 1
Being able to eat intuitively	21 + HI = 1
Living life	13 + HI = 1
Socialise	13 + HI = 1
Good relationships with others	3 + HI = 2
Spontaneity	7 + HI = 2
Independence	5 + HI = 2
Being body-confident would mean everything	3 + HI = 2
Being happy in my own skin	25 + LI = 3
No expectations of perfect	4 + LI = 4
Not preoccupied with appearance	17 + LI = 3
Feeling comfortable with myself	20 + LI = 3

Feeling confident	$12 + L = 3$
Looking nice in and having fun with clothes	$14 + HI = 1$
Feeling ok to show off my body	$3 + HI = 2$
Not comparing with others	$3 + HI = 2$
Coping with others opinions (real or imagined)	$15 + HI = 1$
Being unrestricted	$1 + HI = 2$
Treating my body as important	$1 + HI = 2$
Eating healthily	$1 + LI = 4$
Having respect and pride for my body	$10 + HI = 1$
Not being ashamed of my body	$20 + HI = 1$
Liking and accepting my body	$51 + LI = 3$
Faith that my body is ok	$1 + HI = 2$
Good body image	$6 + LI = 4$
Body-confidence means being thin	$3 + HI = 2$
It's normal to find being body-confident difficult	$2 + HI = 2$
Personal goals and worth not related to size	$3 + HI = 2$
Body-confidence not related to size or appearance	$1 + HI = 2$
Body-confidence is not related to my eating disorder	$1 + HI = 2$
Body-confidence is impossible if you have an eating disorder	$1 + LI = 2$

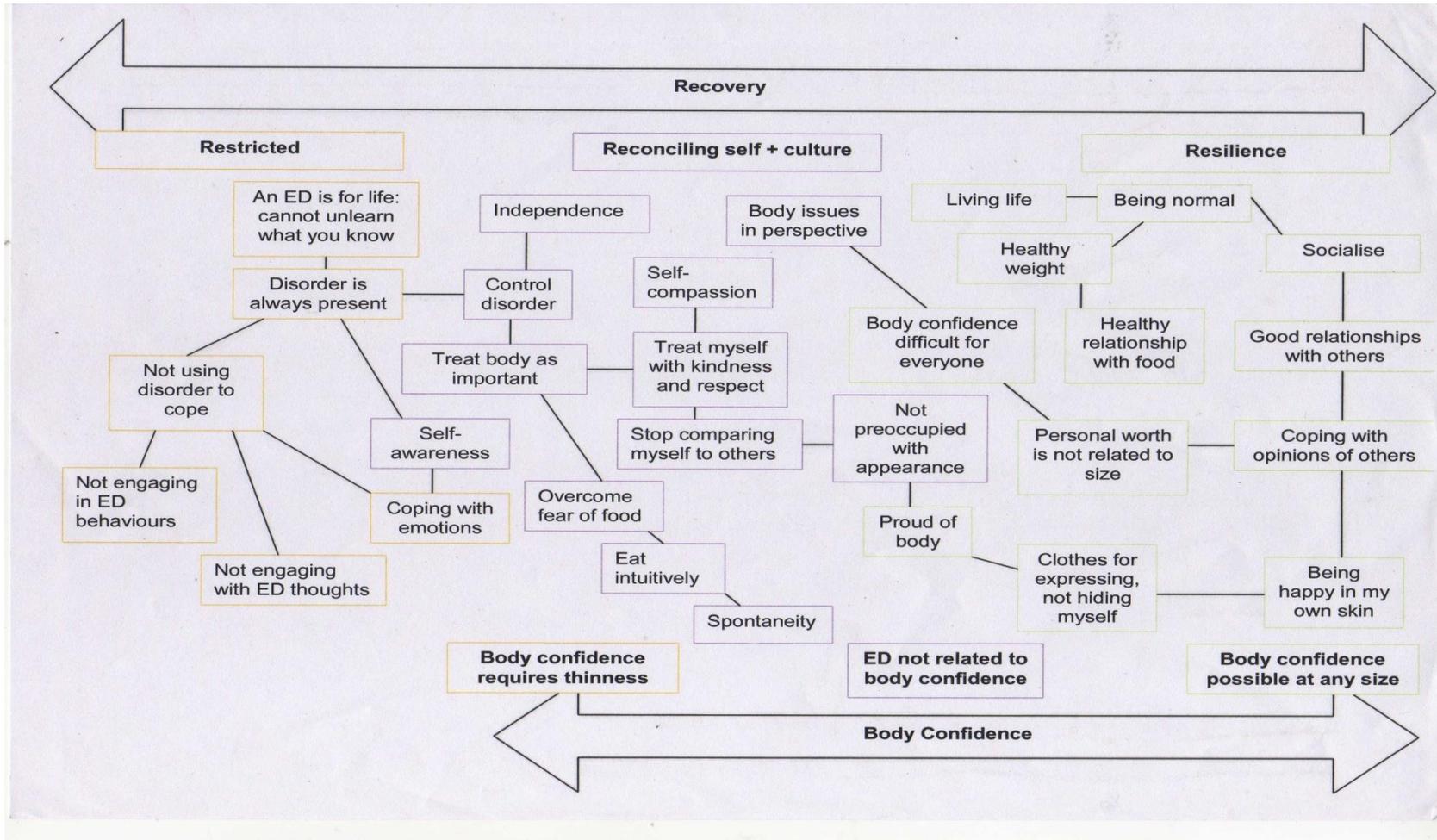
Appendix H.5.: Code occurrence in 'recovered' participants

Acceptance (of body)	17) Being completely at ease with your body, whether in clothes or naked...Not having hang ups and feeling a constant need to 'improve' oneself.
Liking body	110) being happy with your body 98) looking good
Happy in own skin	7) Being able to recognise your flaws but to love yourself regardless and be happy in your own skin. 67) Being happy / content/ satisfied with body shape and size 98) being happy in my own skin 110) feeling content in your own skin
Good body image	30) Feeling good about how I look 150) feeling good about the way you look
Feeling comfortable	14) Not loving your body but feeling comfortable with it and understanding that it is not realistic to maintain a low weight that is not natural for your own body. 30) Feeling comfortable in my own skin and shape. 98) feeling comfortable 136) To feel comfortable in your own body
Clothes looking/fitting nice	14) It is being able to wear clothes that you no longer feel are unflattering and don't feel self-conscious most of the time. 98) clothes fitting nice
Coping with others opinions (real/imagined)	110) not worry about what others think
Not related to size or appearance	142) you can be any size to be body-confident.
Treating body as important	148) It means treating your body like an important part of yourself (which it is!)
Not ashamed of body	17) Not feeling embarrassed/dislike towards your body. 136) not to feel ugly, fat, disgusting.
Self compassion	98) not feeling guilty and like a bad person and not wasting money on food that i purge.
Absence of ED cognitions and behaviours	17) Complete freedom from drastic bingeing/restricting on food (beyond 'normal' dieting) 30) Recovery would mean the ability to eat and not think about

	<p>calories, whether i should or shouldn't eat a certain food or whether i needed to work out to compensate for the food,</p> <p>67) Normal, regular eating habits. Absence of eating disordered behaviours (for me this means an end to bingeing and purging)</p> <p>81) Not having to exercise for 6 hours a day and go out walking for hours despite how bad the weather is. Not restricting food intake.</p> <p>98) being able to deal with meals, not purging</p> <p>110) no longer restricting/purging, no longer consumed by thoughts of food.</p> <p>136) not have to calorie count everything and not have to do exercise till your about to collapse, that is what recovery means to me consequence of after the event like to over excessive exercise or vomit.</p> <p>146) Being able to stop eating when I am full and not have the urge to eat abnormal amounts of food to the point where I feel sick</p>
Unrestricted	146) Being able to eat food without feeling guilty and trying to compensate for it. Being able to concentrate without thinking about food or my weight
Not being overwhelmed by feelings	<p>17) ability to eat and think about food without feeling direct emotions which affect behaviour e.g. guilt leading to compulsion to exercise or restrict to compensate.</p> <p>98) not feeling extreme guilt and anxiety around food/ and thought of food</p>
Living life	110) able to live a normal life not controlled by food.
Healthy weight	<p>67) Regaining weight into healthy weight range... Feeling more confident about being a healthy size for me</p> <p>96) But recovery to me means when your body is back to a healthy weight</p> <p>110) physically healthy</p>
Controlling disorder	7) to have enough control in your life to rationalise those thoughts and recognise that they are not healthy. It is being able to understand that these thoughts do not control you and that you are allowed to eat whatever you like and enjoy it.
Healthy lifestyle/diet	<p>7) Recovery is being able to live a healthy and happy life.</p> <p>146) To be able to eat and excercise healthily without counting calories. To be able to drink liquid calories.</p>
Good body image	<p>67) Improved body satisfaction</p> <p>98) good body image, no body dis-morphia</p>
Socialise	<p>67) Being able to sit down and eat with other people.</p> <p>98) able to cope in social situations around food.</p>

	146) To not be cold all the time and be able to want to hangout with friends and socialize again
Recovery=normal	146) Having a normal life again
Disorder always present	7) The thoughts of an eating disorder will always be there
Healthy relationship with food	30) the ability to eat because i want to enjoy food and not because i need it or allow myself to eat it.
Good relationships with others	14) having better, more stable relationships with the people close to me

Appendix H.6.: Initial draft of thematic map



Appendix I: Author Guidelines for submission to “European Eating Disorders Review”

<http://onlinelibrary.wiley.com/journal/10.1002/%28ISSN%291098-108X/homepage/ForAuthors.html>

**SUMMARY OF SERVICE RELATED RESEARCH AND ASSOCIATED
IMPACT**