Cognitive Behaviour Therapy for Eating Disorders: Treatment Attrition and Clinician Experiences of Delivery

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Abstract

Objective: This Thesis Portfolio[1] aims to explore cognitive behaviour therapy for eating disorders, particularly in relation to attrition rates and clinician experience.

Design: The Thesis Portfolio consists of the following: 1) an introduction to the key topics of relevance, 2) a systematic review and meta-analysis of attrition rate from cognitive behaviour therapy for eating disorders in routine clinical settings, 3) a bridging chapter, 4) an empirical research project presenting a qualitative investigation of clinicians' experiences of delivering Cognitive Behaviour Therapy Ten (CBT-T), 5) an additional methodology chapter providing further information about the methodology of the empirical research project, and 6) a discussion and critical evaluation of both papers.

Results: The systematic review and meta-analysis found attrition rates from cognitive behaviour therapy for eating disorders to be high. Attrition rate varied by diagnosis and cognitive behaviour therapy type, with patient age and eating disorder severity found to moderate attrition rates. The empirical research project presents three themes and 10 subthemes identified from thematic analysis of the data which describe clinicians' overall experiences of delivering CBT-T.

Conclusion: The Thesis Portfolio reports research which is the first to provide an estimate of attrition from cognitive behaviour therapy for eating disorders in routine clinical settings, and to investigate clinicians' experiences of delivering CBT-T. The systematic review and meta-analysis provides an insight into factors found to moderate attrition rates. The empirical research project highlights positive elements of delivering CBT-T, and areas of training and the treatment protocol that clinicians feel are underspecified. Practical and research implications are outlined and discussed, with consideration given to the impact of the implementation of these.

[1] I acknowledge that material from my ClinPsyD Thesis Proposal (submitted in July 2022) has been used throughout the Thesis Portfolio due to the inherent necessity to re-use material in this instance

Contents

List of Tables

List of Figures

Acknowledgements

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I would like to say a huge thank you to my husband, Ross, for your love and encouragement throughout my journey to becoming a Clinical Psychologist. These past 12 years of work and study have been so much more manageable with you by my side. Thank you also to my wonderful parents for always being there and encouraging me to follow my dreams. My nephews, Harry and Arthur, are still too young to understand why Auntie Coco is still at “school” but their love and happiness has helped me through this course more than they will ever know.

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Chapter One: Introduction to the Thesis Portfolio

This chapter will outline the key topics of relevance for the chapters that follow and comprise the Thesis Portfolio. It will begin by providing a general description and overview of eating disorders. This is followed by an outline of the National Institute for Health and Care Excellence (NICE) treatment guidelines for eating disorders, and an explanation of the development and use of cognitive behaviour therapy as a treatment for eating disorders. The chapter ends with an overview of the structure of the Thesis Portfolio.

Eating Disorders

Eating disorders are complex mental health problems and have the highest mortality rate of any mental illness (Jassogne & Zdanowicz, 2018; Meczekalski et al., 2013; Morris & Twaddle, 2007; Treasure et al., 2010). It is estimated that 1.25 million people in the United Kingdom are living with an eating disorder (Beat, n.d.), and that worldwide there are 3.3 million health life years lost annually as a consequence of eating disorders (van Hoeken & Hoek, 2020). In recent years, and particularly post the COVID-19 global pandemic, specialist eating disorder services in the United Kingdom have experienced substantial increases in referral rates (Ayton et al., 2022; Iacobucci, 2021), with reports suggesting that some individuals are waiting up to two years to access specialist treatment (Brown, 2021).

The Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (American Psychiatric Society, 2013) categorises eating disorders into types. The diagnostic criteria for each of these is as follows:

1. Anorexia nervosa is characterised by restriction of energy intake which leads to a significantly low body weight in the context of an individual's age, sex and developmental trajectory. A significantly low body weight is referred to as a body mass index (BMI) of 17.5kg/m^2 or less. This is accompanied by an intense fear of gaining weight or becoming fat, and body image disturbances, with a disproportionate influence of body weight and shape on self-evaluation. Anorexia nervosa is separated into two subtypes: restricting type and binge-eating/purging type. Anorexia nervosa restricting subtype refers to presentations in which an individual does not engage in recurrent episodes of binge-eating or purging (for example, self-induced vomiting, laxative misuse, diuretic misuse), with weight loss achieved though dieting, fasting, and/or excessive exercise. Anorexia nervosa binge-eating/purging

subtype refers to when an individual engages in recurrent episodes of binge-eating or purging behaviour in addition to restriction of their energy intake.

2. Bulimia nervosa is characterised by recurrent episodes of binge-eating, defined as eating an amount of food in a discrete period of time that is definitely larger than what most individuals would eat in a similar time period under similar circumstances, with a sense of lack of control over eating during the episode. The episodes of binge-eating are accompanied by recurrent inappropriate compensatory behaviours to prevent weight gain, such as self-induced vomiting, misuse of laxatives and diuretics, or fasting. The binge-eating and compensatory behaviours both occur at least once a week for three months, on average. As with anorexia nervosa, individuals with bulimia nervosa place a disproportionate influence of body weight and shape on self-evaluation. There is significant overlap of symptoms between bulimia nervosa and anorexia nervosa binge-eating/purging subtype, however the key difference between the diagnoses is BMI. A bulimia nervosa diagnosis is typically given when an individual's BMI is above 17.5kg/m^2.
3. Binge eating disorder is characterised by recurrent episodes of binge-eating, defined as eating an amount of food in a discrete period of time that is definitely larger than what most individuals would eat in a similar time period under similar circumstances, with a sense of lack of control over eating during the episode. These episodes of binge-eating occur, on average, at least once a week for three months. These episodes are associated with at least three of the following: eating until feeling uncomfortably full; eating large amounts of food when not physically hungry; eating alone because of feeling embarrassed by how much one is eating; or feeling disgusted with oneself, depressed, or very guilty afterwards. Marked distress regarding binge-eating is present, and binge-eating is not associated with the recurrent use of inappropriate compensatory behaviours.
4. Other specified feeding or eating disorder is diagnosed when an individual presents with eating disorder behaviours that cause significant distress and impairment, but these do not meet the diagnostic criteria for any of the other eating disorders. There are a number of presentations that can be described using this diagnosis, however the most common are:
    a. Atypical anorexia nervosa, whereby all of the criteria of anorexia nervosa are met, however, despite significant weight loss, an individual's weight is within or above a normal weight range.

b. Bulimia nervosa of low frequency and/or limited duration, whereby all of the criteria of bulimia nervosa are met except that the episodes of binge-eating and inappropriate compensatory behaviours occur, on average, less than once a week and/or have been occurring for less than three months.
c. Binge eating disorder of low frequency and/or limited duration, whereby all of the criteria of binge-eating disorder are met except that the episodes binge-eating occur, on average, less than once a week and/or have been occurring for less than three months.
d. Purging disorder, characterised by recurrent purging behaviour to influence weight or shape in the absence of episodes of binge-eating.

Anorexia nervosa is referred to as an underweight eating disorder, whereas bulimia nervosa, binge eating disorder and other specified feeding or eating disorder are known as non-underweight eating disorders.

There are three other presentations which also come under the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition categorisation of eating disorders: pica, rumination disorder, and avoidant restrictive food intake disorder (ARFID). These diagnoses were all new additions to the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders. Pica and rumination disorder are uncommon, with it rare that such cases present to services, and only in recent months have eating disorder services started to be commissioned to treat ARFID. Therefore, limited research exists regarding the treatment of these disorders. In addition, pica, rumination disorder and ARFID have very different underlying core psychopathologies compared to the eating disorders described above. For these reasons, pica, rumination and ARFID are not included in this thesis.

National Institute for Health and Care Excellence Treatment Guidelines for Eating Disorders

National Institute for Health and Care Excellence (NICE) provide clear guidelines (National Institute for Health and Care Excellence, 2017) for the treatment of eating disorders in adults. Whilst treatment aims, delivery and duration vary, cognitive behaviour therapy (CBT) is recommended by these guidelines for treatment of all eating disorder diagnoses.

For anorexia nervosa, cognitive behaviour therapy for eating disorders (CBT-ED) is recommended to be delivered on an individual basis, typically consisting of up to 40 sessions over a period of 40 weeks. For bulimia nervosa, it is recommended that individuals are offered a CBT-ED guided-self help programme

over a period of 16 weeks. If this is unacceptable, contraindicated, or ineffective after four weeks of treatment then individual CBT-ED should be considered, typically consisting of up to 20 sessions over 20 weeks. Guidelines for treatment of binge eating disorder are similar, however group CBT-ED is advised as the second-line treatment rather than individual therapy. These group sessions consist of 16 sessions over a 16 week period. If group CBT-ED is not available or is declined by an individual then individual CBT-ED should be considered, typically consisting of 16 to 20 sessions. For cases of other specified feeding and eating disorder, NICE recommend using the treatment for the eating disorder that the individual's difficulties most closely resemble.

Cognitive Behaviour Therapy for Eating Disorders

CBT was developed by Aaron Beck in the 1960s and is underpinned by the assumption that an individual's thoughts, feelings and behaviours are all connected. Although CBT was initially introduced as a treatment for depression (Beck, 1979), over the past 50 years CBT has been extensively researched and found to be an effective treatment for a wide range of mental health difficulties, including eating disorders.

Cognitive behaviour therapy for eating disorders (CBT-ED) has been in ongoing development since the early 1980s. Garner and Bemis (1982) were the first to apply CBT to anorexia nervosa, producing an outline of how to use CBT to treat anorexia nervosa (CBT-AN). Fairburn (1981) was the first to consider the application of CBT to bulimia nervosa and binge eating disorder, developing a comprehensive manual for treatment of binge-eating presentations using CBT (CBT-BN; Fairburn & Wilson, 1993). The theory underpinning these two CBT-ED approaches understood there to be different factors maintaining each of the eating disorder diagnoses, however, through ongoing evaluation and advances within CBT-ED, Fairburn et al., (2003) noted that all eating disorders have many of the same clinical features. This led them to propose that there may be common factors maintaining all eating disorders, rather than these being diagnosis dependent as was initially believed. On the basis of this, Fairburn et al., (2003) proposed a transdiagnostic form of CBT-ED: Enhanced Cognitive Behaviour Therapy (CBT-E). Over the past 20 years CBT-E has become the leading form of CBT-ED, with the underlying principles also being adapted for shorter guided self-help eating disorder treatments (for example, Fairburn, 2013).

CBT-E is a four stage treatment which can be adapted to meet an individual's specific needs. Treatment duration varies depending on diagnosis, with those who

are not significantly underweight usually being offered 20 treatment sessions over a period of 20 weeks, and those who are underweight being offered up to 40 sessions over a 40 week period. Stage one of treatment is focused on the individual and treating clinician developing a shared understanding of the individual's eating disorder, alongside helping them to make modifications to their eating pattern and providing relevant psychoeducation. Stage two is where initial progress is reviewed and the key factors to be addressed during stage three are identified based on the shared formulation that has been developed in stage one. Stage three is the longest phase of treatment and focuses on the factors and processes that are maintaining an individual's eating disorder. These can vary, however typically include addressing dietary restraint, body image, and developing coping strategies to deal with everyday events and emotions. Stage four of treatment is focused on the future, specifically focusing on maintaining the changes that have been achieved throughout treatment and planning for how any setbacks can be addressed.

Whilst there is ample research in support of CBT-E being an efficacious treatment (Atwood & Friedman, 2020; de Jong et al., 2020; Linardon et al., 2017; Tatham et al., 2020), some limitations have been identified. CBT-E is designed to be delivered by qualified therapists (such as Clinical Psychologists or CBT Therapists). This can make CBT-E a costly treatment to deliver, especially when considering CBT-E duration for individuals with anorexia nervosa. Furthermore, often underweight individuals are prioritised due to the risks associated with such presentations, making it difficult for those who are not underweight (i.e. individuals with bulimia nervosa, binge eating disorder, or other specified feeding or eating disorder) to access treatment. These limitations were recognised by Waller et al., (2019), who proposed an alternative form of CBT-ED specifically designed for treatment of non-underweight eating disorders which can be delivered by non-qualified clinicians under supervision: Cognitive Behaviour Therapy Ten (CBT-T).

CBT-T is a 10-session manualised treatment split into five phases. The first phase focuses on psychoeducation and exposure, with emphasis placed on implementing a regular eating pattern. The second phase uses cognitive restructuring and behavioural experiments to challenge beliefs about eating, food and weight. Phase three is optional depending on an individual's presenting difficulties, and focuses on addressing emotional triggers for eating disorder behaviours. Phase four focuses on body image work, and phase five is centred around relapse prevention and creation of a therapy blueprint to consolidate the work completed throughout the course of treatment.

There have been a number of studies published investigating the effectiveness of CBT-T, finding outcomes to be comparable to longer forms of CBT-ED (Keegan et al., 2022; Pellizzer et al., 2019a, 2019b; Rose et al., 2021; Tatham et al., 2020; Waller et al., 2018). Hoskins et al., (2019) investigated patients' experiences of CBT-T, finding that patients rated acceptability and effectiveness highly, and suggested that their research on patient experiences would benefit from comparison with investigation of clinician experiences of delivering CBT-T to aid with the ongoing development of this treatment. Waterman-Collins et al., (2014) have also identified that combining both clinician and patient perspectives provides a more in-depth understanding of treatment and can help inform future development of interventions and clinician training. This is also important given that it has been previously identified that it is important that clinicians' views of treatment are sought and considered when implementing new interventions (Greenhalgh et al., 2004), which has not yet been considered for CBT-T.

Despite there being variations in the types of CBT-ED used in eating disorder treatment, a consistent research finding across all types of CBT-ED is that non-completion rates are high. Some studies have found non-completion rates of CBT-ED to be over 50% (Allen et al., 2020; Frostad et al., 2021; Kessler et al., 2022; Ramklint et al., 2012). Linardon et al., (2018) were the first to specifically investigate non-completion rates of CBT-ED, using a meta-analysis to provide a drop-out estimate from CBT-ED randomised controlled trials. They found the overall non-completion rate of CBT-ED in such settings to be 24%. However, it is not possible to generalise this estimate to routine clinical practice because this analysis focused only on randomised controlled trials. This is important given that attrition rates in psychotherapy have been found to be higher in real-world settings than in efficacy studies (Swift & Greenberg, 2012), and therefore it may be expected that there is a higher rate of attrition from CBT-ED in routine clinical settings than that reported by Linardon et al., (2018). However, to date there have been no attempts made to systematically review non-completion rates of CBT-ED in routine clinical settings.

Outline of the Thesis Portfolio

This thesis portfolio aims to explore treatment attrition in CBT for eating disorders in routine clinical settings and investigate clinician experiences of delivering a specific form of CBT for eating disorders: CBT-T.

Chapter Two presents a systematic review and meta-analysis written for the International Journal of Eating Disorders, investigating attrition rates from CBT-ED

in routine clinical settings. This builds upon a previously published meta-analysis investigating attrition rates from CBT-ED in randomised controlled trials.

Chapter Three is a bridging chapter linking the systematic review and meta-analysis in Chapter Two and the empirical research project in Chapter Four.

Chapter Four presents a qualitative investigation into clinicians' experiences of CBT-T, written for European Eating Disorders Review. This empirical research project was carried out to compliment earlier research in the field and to address gaps in CBT-T research literature.

Chapter Five provides an extended methodology for the empirical research project, providing further explanation on the ontological and epistemological positioning, recruitment methods, ethical considerations, reflexivity, and the thematic analysis process.

Chapter Six is the final chapter of the Thesis Portfolio, providing an overall discussion of the systematic review and meta-analysis and empirical research project. This includes a critical evaluation of these papers, and discussion of the practice and research implications of the findings.

There are three reference lists presented within the Thesis Portfolio. The first is at the end of Chapter Two and contains the references within the systematic review and meta-analysis. The second is at the end of Chapter Four and contains the references within the empirical research paper. The third follows Chapter Six and includes the references from all other chapters.

Chapter Two: Systematic Review and Meta-Analysis

Attrition in cognitive behaviour therapy for eating disorders in routine clinical settings: A systematic review and meta-analysis

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This paper has been prepared for submission to the International Journal of Eating Disorders.
Author guidelines can be found in Appendix A.

Abstract

Objective: Cognitive behaviour therapy for eating disorders (CBT-ED) has been found to be an effective treatment for all eating disorder diagnoses, however attrition rates are high. This has important implications for recovery-related outcomes, yet despite consistent reporting of high attrition rates, little has been done to explore this further. This review aimed to provide an estimate of attrition rate from CBT-ED in routine clinical settings, also examining potential factors that may moderate this estimate including diagnosis, severity, age, and CBT-ED type.

Method: Five online databases were searched for relevant studies, with supplementary searches of grey literature also conducted. Full-text screening identified a total of 56 studies, providing 59 CBT-ED conditions, for inclusion in this review.

Results: The overall attrition rate across all studies was 31.22% (95% CI = 7.51-62.17%). Attrition rate varied per diagnosis. It was highest for anorexia nervosa samples and lowest for binge eating disorder samples. Differences were also found in attrition rate for CBT-ED type. Patient age and eating disorder severity were found to moderate attrition rate.

Conclusions: The attrition rate from CBT-ED is considerably higher than attrition rates from CBT for other mental health conditions. Further research is needed to examine why CBT-ED attrition rates are so high to aid with developing an understanding as to what may improve treatment retention in CBT-ED. This could help to identify how more patients can be supported to engage with CBT-ED, with the hope that this would help more patients to go on to recover from their eating disorder.

1 Introduction

Cognitive behaviour therapy (CBT) is a widely used evidence-based treatment for eating disorders. National Institute for Health and Care Excellence (NICE; National Institute for Health and Care Excellence, 2017) guidelines recommend the use of CBT with all eating disorder diagnoses, with numerous publications indicating the effectiveness of various forms of CBT for eating disorders (CBT-ED) including Enhanced Cognitive Behaviour Therapy (CBT-E), Cognitive Behaviour Therapy Ten (CBT-T), and CBT-based guided self-help (Atwood & Friedman, 2020; Carrard et al., 2011; M. de Jong et al., 2020; Linardon et al., 2017; Paphiti & Newman, 2023; Traviss-Turner et al., 2017).

Whilst CBT-ED is indicated to be an efficacious intervention, attrition rates are high. This has important implications for recovery-related outcomes. However, despite the high rates of attrition consistently reported across CBT-ED research, very little has been done to explore this further. If research can begin to understand more about CBT-ED attrition rates, this may help with the identification of those who are potentially more likely not to complete treatment, and the subsequent development of strategies to improve treatment retention. Consequently, an aim would be that more people could be supported to engage with and remain in treatment, and go on to make a full recovery from their eating disorder. This is especially important given the high levels of both physical and psychological risks associated with eating disorders and the impacts that these have on quality of life (Jenkins et al., 2011; van Hoeken & Hoek, 2020), alongside the social and economic costs associated with eating disorders globally (Erskine et al., 2016; Lee et al., 2021; Streatfeild et al., 2021; Tannous et al., 2022).

Linardon et al., (2018) identified that there are a number of knowledge gaps in understanding attrition for those undergoing CBT-ED, namely what the overall rate of attrition is for CBT-ED, what factors moderate the attrition rate, and whether the attrition rate is affected by the definition that is used. With these questions in mind, Linardon et al., (2018) conducted a meta-analysis of 99 randomised controlled trials to investigate the attrition rate in CBT-ED, providing an overall attrition estimate of 24%. Attrition was found to be lowest for CBT-E in comparison to other CBT-ED protocols, and highest for online delivery compared to other treatment modalities. Neither diagnosis or attrition definition were found to moderate estimates of attrition, and although baseline levels of eating disorder severity were positively related to non-completion of treatment, this association was not significant.

An identified limitation of the Linardon et al., (2018) review is that the results cannot be easily generalised to routine clinical practice as the review only included participants from randomised controlled trials. Randomised controlled trials often follow strict inclusion/exclusion criteria for participants (for example, age range, duration of disorder, and absence of co-morbidity), which can be unrepresentative of the heterogeneous nature of patients presenting for treatment in routine clinical settings. Furthermore, randomised controlled trials typically follow stringent protocols which do not necessarily reflect real-world treatment delivery and adherence. Similarly, the highly controlled environment of randomised controlled trials (for example, the frequency of the delivery of sessions) may not be representative of treatment delivery within routine clinical practice, posing issues around their external validity.

Swift & Greenberg (2012) have previously found that psychotherapy attrition rates are higher in routine clinical settings than in randomised controlled trials, and so it is estimated that the attrition rate for CBT-ED in routine clinical settings is likely to be higher than the estimate provided by Linardon et al., (2018). This meta-analysis, therefore, aimed to build upon the previous work of Linardon et al., (2018) to investigate the attrition rate from CBT-ED delivered in routine clinical settings.

The term ‘attrition’ is often used interchangeably with ‘drop-out’, although there are fundamental differences between the two terms. Whilst there is still no universal definition of ‘drop-out’, general definitions usually refer to an individual terminating treatment without the agreement of their therapist (Karekla et al., 2019; Kullgard et al., 2022; Swift & Greenberg, 2012). In comparison, ‘attrition’ is considered to reflect the number of people overall who do not complete treatment for any reason (Harris, 1998; Hellstern & Robinson, 2023). This may include drop-out, but also encompasses other factors such as moving out of area, a change in treatment modality, mutual termination of treatment with their therapist, or admission to hospital. For the purposes of this review, attrition is considered to reflect the number of people overall who do not complete treatment. The following a priori questions were identified:

1. What is the overall attrition rate from CBT-ED across all eating disorder diagnoses?
2. What is the overall attrition rate from CBT-ED for anorexia nervosa, bulimia nervosa, binge eating disorder, and other specified feeding or eating disorder?
3. Is attrition rate from CBT-ED moderated by eating disorder severity (as measured by pre-treatment Eating Disorder Examination Questionnaire

global score), age, CBT type, modality (i.e. face-to-face or online), diagnosis, or definition of attrition?

2 Method

This review was conducted in accordance with the Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) (Page et al., 2021). The review was registered with the International Prospective Register of Systematic Reviews (PROSPERO) on April 26, 2023 (Registration Number: CRD42023420828). A protocol (Appendix B) was produced prior to carrying out the review in line with the Preferred Reporting Items for Systematic Review and Meta-Analysis Protocol (PRISMA-P) guidelines (Moher et al., 2015). Any amendments to the protocol were detailed and justified within both the PROSPERO registration and the protocol.

2.1 Search Strategy

The search strategy was developed in collaboration with a specialist librarian at the University of East Anglia by referring to similar previously published literature. The search strategy was as follows: (attrition OR dropout OR drop-out OR "drop out" OR "dropped out" OR response OR outcome OR "terminat*" OR non-complete* OR "did not complete" OR withdr?w) AND (anorexi* OR bulimi* OR "binge eating disorder" OR "binge-eating disorder") AND ("cognitive behavio* therapy" or cbt) AND (audit OR “clinical setting” OR consecutive OR effectiveness OR efficacy OR evaluation OR implementation OR pragmatic OR real-world OR routine OR “service evaluation” OR uncontrolled).

Initial searches were run in May 2023 between inception and the date of the search. This search was updated on a monthly basis until December 2023 to identify any additional articles published within this timeframe that may meet the inclusion criteria. Five online databases were searched: Academic Search Ultimate, APA PsycInfo, CINAHL Ultimate, Complementary Index and MEDLINE Ultimate. Supplementary searches of grey literature were performed in Bielefeld Academic Search Engine (BASE), Data Archiving and Networked Services (DANS), Electronic Thesis Online Service (EThOS), Library Hub Discover and ProQuest Dissertations and Theses. The search term “CBT for eating disorders” was used to search for grey literature when the database did not have the capacity for systematic searching. The reference lists of all studies meeting criteria for inclusion in this review were manually screened to identify any additional relevant articles not identified by the search strategy.

2.2 Eligibility Criteria

Inclusion Criteria

To be included in this review, studies had to include primary data of treatment-seeking individuals aged 16 years old or above who had been diagnosed with either anorexia nervosa, bulimia nervosa, binge eating disorder, other specified feeding or eating disorder (OSFED) or eating disorder not otherwise specified (EDNOS) and had received CBT as treatment for their eating disorder in a routine clinical setting. Studies were required to be available in the English language to be eligible for inclusion.

Exclusion Criteria

Studies were excluded if treatment had taken place in an intensive setting, for example a day patient or inpatient setting. This was decided on the basis that those receiving treatment in such settings have less opportunity to discontinue treatment, and the difference in clinical presentation (and likely severity) between those being treated intensively and those being treated within routine specialist eating disorder outpatient services. Studies were also excluded if participants were not actively treatment-seeking and were recruited through advertisement for the purpose of the study, as these individuals could represent a different sample, affecting the generalisability of the findings. Randomised controlled trials or any form of controlled trial were excluded as these may not be representative of real-world clinical settings. Studies specifically stating ‘subthreshold diagnosis’ were excluded as this statement alone did not provide enough information as to whether such presentations met criteria for an atypical eating disorder diagnosis. Studies were also excluded if they did not report rates of treatment attrition, however the lead authors of all studies were first contacted to ask if they were able to provide this information prior to exclusion.

2.3 Study Selection

Following exportation of searches and removal of duplicate studies, author CH independently screened the titles and abstracts of the remaining studies for potential eligibility. Studies identified to be potentially eligible for inclusion in the review were screened by author CH based on the inclusion/exclusion criteria. Author SC independently reviewed a random sample of 20% of studies identified for inclusion in the final analysis to confirm that the inclusion criteria were met. Any disagreements were discussed and a consensus was reached.

2.4 Data Extraction and Quality Assessment

A data extraction tool (Appendix C) was created for this review to aid extraction of demographic information and other necessary data required to meet the review aims. This tool was piloted with five studies for refinement.

Author CH independently extracted the following data from included studies: author, year, country, design, age, gender, diagnosis, measure of eating disorder symptomology used, mean baseline Eating Disorder Examination Questionnaire (EDE-Q; Fairburn & Beglin, 2008) global score, the number of participants starting treatment, the number of participants who did not complete treatment, the number of participants who completed treatment, the mean number of sessions attended by those who did not complete treatment, attrition definition, CBT treatment type, and modality. To control extraction and ensure accuracy, GR independently extracted the data for a random sample of 20% of studies. Any discrepancies were discussed and a consensus was agreed, with consensus achieved in all cases.

The quality of included studies was assessed by CH using the Joanna Briggs Institute (JBI) tools for case series studies (Moola et al., 2017; Appendix D), quasi-experimental studies (Tufanaru et al., 2020; Appendix E) and cohort studies (Moola et al., 2017; Appendix F). As the JBI tools do not give an overall quality assessment score, a score of 1 was given to a ‘yes’ response and a score of 0 was given to a ‘no’ or an ‘unclear’ response to enable comparison of the quality of the included studies for the purpose of this review (McDonald & Mead, 2023; Siddiqui et al., 2021). As with previous reviews using the JBI quality assessment tools, a study was deemed high quality if it scored 70% or above, moderate quality if it scored between 50% and 69%, and low quality if scoring below 50% (for example, Dijkshoorn et al., 2021; George et al., 2014; Tesfay et al., 2023). MC independently quality assessed 20% of the included studies, with an inter-rater agreement of Cohen’s kappa = 0.64. Any discrepancies were discussed until a consensus was reached.

2.5 Data Analysis

Data analysis was conducted using the ‘metafor’ package (Viechtbauer, 2010) within R (Version 4.3.2). For the purposes of analysis, the diagnoses of EDNOS and OSFED were combined into a single diagnostic category and referred to as OSFED.

An overall estimate of attrition rate was calculated by aggregating the attrition proportion from each included study using a random effects meta-analysis. To ensure that the attrition proportions were accurately weighted to ascertain how much each study contributed to the overall estimate of attrition, attrition proportions were transformed using the Freeman-Turkey (double arcsine) transformation. This

analysis was also repeated for each diagnosis type from the included studies: anorexia nervosa, bulimia nervosa, binge eating disorder, OSFED, and transdiagnostic samples.

Heterogeneity was assessed using the I^2 statistic, with Higgins & Thompson's (2002) guidelines used for interpretation. A forest-plot was also produced to summarise the attrition rate for each individual study included in the analysis and to allow for visual examination of the heterogeneity. Publication bias across studies was assessed using an Egger's regression and visual examination of funnel plot symmetry.

A series of meta-regression analyses were planned a priori and carried out to examine whether the mean age of participants or eating disorder severity (as measured by baseline EDE-Q global score) moderate attrition rate. It was decided post-hoc to also use a meta-regression to examine whether body mass index (BMI) moderated the attrition rate in the anorexia nervosa subgroup, as research was found which has previously identified BMI to be a predictor of attrition (Gregertsen et al., 2019; Huas et al., 2011; Watson et al., 2017), and to investigate whether year of publication moderated attrition rate to investigate potential changes in attrition rate over time.

A subgroup analysis was used to investigate whether attrition rate was moderated by eating disorder diagnosis. A series of subgroup analyses were also planned a priori to investigate whether attrition was moderated by the following categorical variables: CBT-ED type or attrition definition. There were an extremely wide variety of types of CBT-ED treatment used within the included studies, with only one study per CBT-ED type in some cases. Therefore, following discussion, it was decided to instead conduct random-effects meta-analyses on the three most common types of CBT-ED used (CBT-E, CBT-T and CBT-based guided self-help) to ascertain the attrition rates for each of these CBT-ED types for comparison. Furthermore, only three of the studies included in the review reported treatment modality, and there was a high level of variation with how attrition was defined between studies. Therefore, it was not possible to conduct these subgroup analyses.

A sensitivity analysis was planned a priori to be carried out using only high quality studies (as defined by the JBI quality assessment tools) to test the robustness of the results. Data extraction indicated that some studies had included participants who did not actually start treatment within their reports of attrition. It was, therefore, decided post-hoc to also carry out a sensitivity analysis on only

those studies that reported participants who actually commenced treatment within their reports of attrition.

3 Results

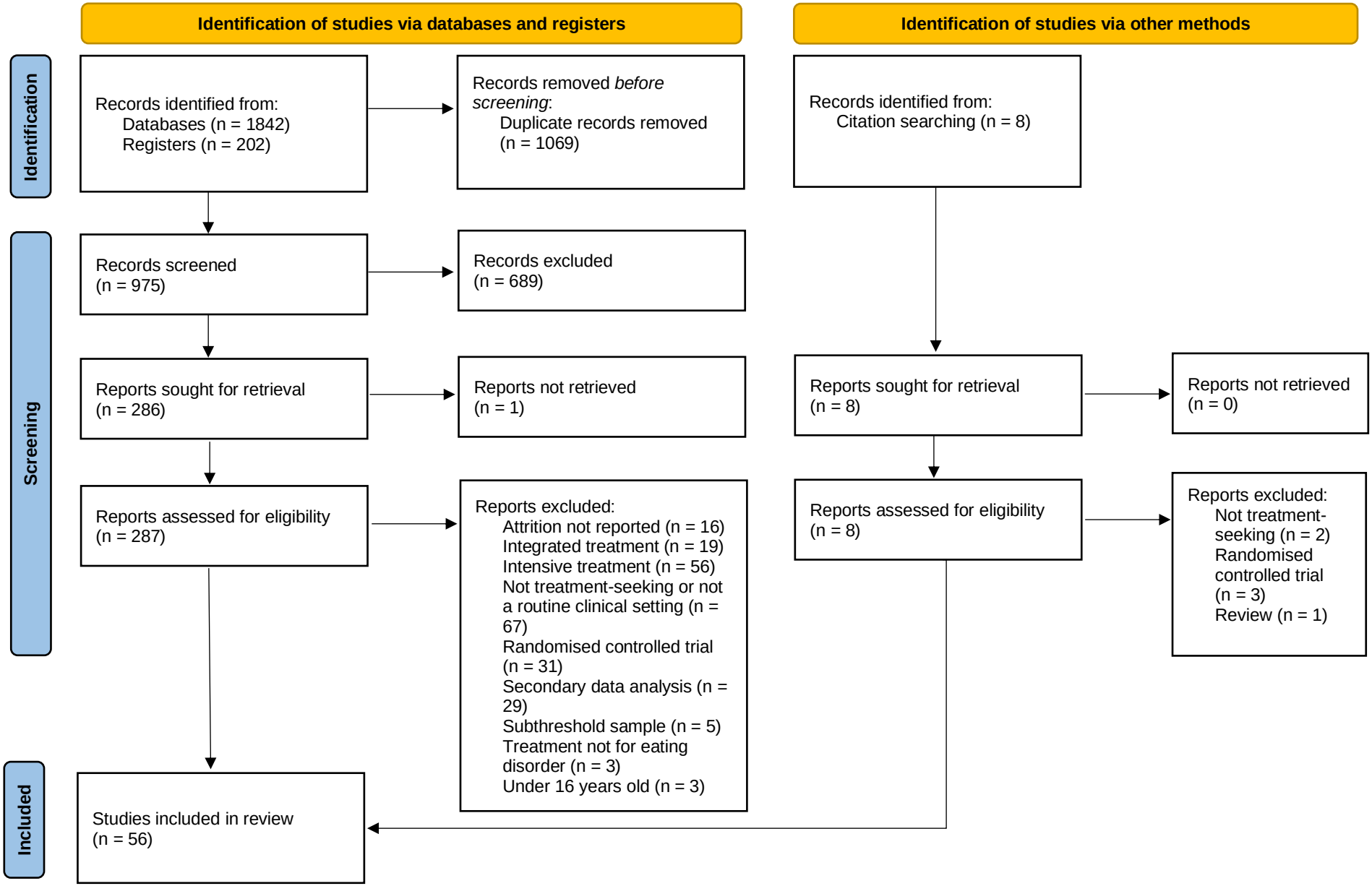
3.1 PRISMA Flowchart

The PRISMA flowchart (Figure 1) summarises each of the stages of this review. Database and register searching identified 2044 studies, of which 1069 were duplicates. The titles and abstracts were screened for 975 studies. There were 689 studies excluded at this point, including one which was not available in English, with 286 studies progressed for full-text review. One study was excluded at the point of retrieval as it was not accessible. Following full-text review of the remaining 285 studies, 67 were excluded because the study was not conducted in a routine clinical setting or participants were not treatment-seeking individuals, 56 were excluded because CBT was delivered in an intensive treatment setting (for example, day patient or inpatient care), 31 were excluded because the study was a randomised controlled trial or controlled trial, 29 were excluded because the study used secondary data or included participants already included in another study identified for inclusion, 19 were excluded because the study used an integrated treatment approach, 5 were excluded because the sample consisted of or included participants with a subthreshold diagnosis, 3 were excluded because the sample included participants under the age of 16, and 3 were excluded because the treatment participants received was not for their eating disorder. Citation searching identified a further eight studies potentially relevant to the review, of which three were excluded as they were randomised controlled trials, two were excluded as participants were not treatment-seeking, and one was excluded as it was a review paper.

Full-text screening identified a total of 56 studies, providing 59 CBT-ED conditions, for inclusion in this review.

Figure 1

PRISMA Flowchart



3.2 Study Characteristics

The characteristics of the 56 studies (59 CBT-ED conditions) included within this review are reported in Table 1. The total number of participants was 5414. The mean age was 26.73 years (SD = 3.81), which was calculated from the 49 studies that reported participant age. There were 45 studies which reported participant gender, and across these studies there were 4244 females, 296 males, and one person was transgender. The genders of the remaining 874 participants was unknown.

Of the studies included in the review, 19 were conducted within the United Kingdom, 12 in Australia, 9 in Italy, 3 in the Netherlands, 2 in Norway, 2 in the United States of America, 1 each from Brazil, Canada, Denmark, Iceland, Japan, Spain, Sweden, Switzerland, and 1 was a collaboration between the United Kingdom and Italy. Of the 59 CBT conditions, 36 studied multiple eating disorder diagnoses, 11 studied anorexia nervosa only, 9 studied bulimia nervosa only, and 3 studied binge eating disorder only. There were none which studied OSFED only.

The overall quality of each study was determined by the JBI tool, with ratings ranging from 37% to 86%. There were 41 studies rated as high quality, 13 as medium quality, and 2 as low quality. Quality ratings for each included study are reported in Appendix G.

Table 1

Study Characteristics

Author, publication year, and country of study	Mean age of participants (SD)	Participant gender (% female)	Diagnosis	Mean baseline EDE-Q score (SD)	Started treatment (n)	Completed treatment (n)	CBT type	Quality rating
Allen et al., (2011) Australia	26.44 (8.98)	NR	AN, BN, OSFED	NR	43	20	CBT-E	Medium
Bailer et al., (2004) Austria	24.2 (4.9)	NR	BN	NR	41	26	CBT – Jacobi et al., (1996)	Medium
Bandini et al., (2006) Italy	23.71 (1.72)	95.5	AN, BN, OSFED	NR	67	50	CBT based on transtheoretical model of change	Medium
Byrne et al., (2011) Australia	26.03 (9.41)	97.6	AN, BN, OSFED	NR	125	66	CBT-E	High
Calugi et al., (2021) Italy	22.4	96.66	AN	3.5 (1.5)	30	20	CBT-E	High

Table 1 (continued)

Author, publication year, and country of study	Mean age of participants (SD)	Participant gender (% female)	Diagnosis	Mean baseline EDE-Q score (SD)	Started treatment (n)	Completed treatment (n)	CBT type	Quality rating
Carrard et al., (2011) Spain	24.4 (3.7)	100	BN, OSFED	NR	31	19	Guided self-help	High
Carter et al., (2012) Australia	25.98 (8.54)	97.88	AN, BN, OSFED	NR	189	104	CBT-E	Medium
Cassioli et al., (2022) Italy	25.22 (9.55)	100	AN	3.28 (1.7)	120	105	CBT-E	High
Castellini et al., (2012a) Italy	38.3 (13.0)	NR	BN, BED	3.14	218	199	CBT-E	High

Table 1 (continued)

Author, publication year, and country of study	Mean age of participants (SD)	Participant gender (% female)	Diagnosis	Mean baseline EDE-Q score (SD)	Started treatment (n)	Completed treatment (n)	CBT type	Quality rating
Castellini et al., (2012b) – CBT based on Fairburn et al., (1993) condition Italy	28.37 (7.59)	98.86	BN	3.51 (1.32)	88	75	CBT based on Fairburn & Wilson, (1993)	High
Castellini et al., (2012b) – CBT based on Garner et al., (1997) condition Italy	26.54 (7.33)	95.58	AN	3.31 (1.51)	113	99	CBT based on Garner et al., (1997)	High
Chen et al., (2003) – Group condition Australia	NR	100	AN, BN	NR	30	22	CBT adapted from (Fairburn et al., 1993)	High

Table 1 (continued)

Author, publication year, and country of study	Mean age of participants (SD)	Participant gender (% female)	Diagnosis	Mean baseline EDE-Q score (SD)	Started treatment (n)	Completed treatment (n)	CBT type	Quality rating
Chen et al., (2003) – Individual condition Australia	NR	100	AN, BN	NR	30	22	CBT – Fairburn et al., (1993)	High
Cooper et al., 1996) – United Kingdom	23.8 (5.5)	NR	BN	NR	82	67	Guided self-help	High
Dawkins et al., (2013) Australia	25.5 (7.57)	100	BN, OSFED	NR	117	77	CBT-E	High
Duchesne et al., (2007) Brazil	37.2 (10.8)	85.71	BED	NR	21	18	CBT based on Fairburn et al., (1993)	Low
Fairburn et al., (2013) United Kingdom and Italy	24.0 (5.5)	96.96	AN	3.33	99	63	CBT-E	High

Table 1 (continued)

Author, publication year, and country of study	Mean age of participants (SD)	Participant gender (% female)	Diagnosis	Mean baseline EDE-Q score (SD)	Started treatment (n)	Completed treatment (n)	CBT type	Quality rating
Frostad et al., (2018) Norway	23.3 (6.9)	97.73	AN	NR	44	22	CBT-E	Medium
Frostad et al., (2021) Norway	25.5 (7.9)	NR	AN	4.0 (0.9)	21	10	CBT-E	Low
Graham & Walton, (2011) United Kingdom	33.0	90.91	BN, BED	NR	66	40	Guided self-help	High
Högdahl et al., (2013) Switzerland	27.9 (7.5)	95.45	BN, BED, OSFED	4.0 (1.0)	44	33	Guided self-help	High
Jenkins et al., (2018) United Kingdom	26.63	98.41	AN, OSFED	NR	63	34	CBT-E	High

Table 1 (continued)

Author, publication year, and country of study	Mean age of participants (SD)	Participant gender (% female)	Diagnosis	Mean baseline EDE-Q score (SD)	Started treatment (n)	Completed treatment (n)	CBT type	Quality rating
Jenkins et al., (2021) United Kingdom	34.7 (12.8)	93.05	BN, BED, OSFED	4.32 (0.9)	72	54	Guided self-help	High
Jones et al., (2013) Denmark	23.9 (4.3)	100	BN	NR	188	174	CBT based on the Toronto Manual (Davis et al., 1992)	High
Kessler et al., (2022) Norway	20.0	NR	AN	4.0	33	11	CBT-E	High
Knott et al., (2015) United Kingdom	28.74 (8.49)	97.05	BN, OSFED	NR	256	135	CBT-E	High
Laliberte & Lucibello, (2022) Canada	NR	NR	BED, OSFED	NR	101	77	CBT (Laliberte, 2018)	Medium

Table 1 (continued)

Author, publication year, and country of study	Mean age of participants (SD)	Participant gender (% female)	Diagnosis	Mean baseline EDE-Q score (SD)	Started treatment (n)	Completed treatment (n)	CBT type	Quality rating
Leung et al., (1999) United Kingdom	26.0 (7.66)	100	AN	NR	30	10	Based on existing CBT models for AN	High
Leung et al., (2000) United Kingdom	25.4 (5.2)	100	BN	NR	27	20	Based on existing CBT models for BN	High
Lo Sauro et al., (2013) Italy	NR	NR	AN	3.2 (1.36)	159	142	CBT – Garner et al., (1997)	High
Melisse et al., (2022) Netherlands	29.44 (4.71)	95.36	BN, BED, OSFED	3.99	625	391	CBT-E	Medium
Moore et al., (2021) United Kingdom	35.24 (12.27)	77.36	BED	3.28 (1.15)	53	41	CBT-T	High

Table 1 (continued)

Author, publication year, and country of study	Mean age of participants (SD)	Participant gender (% female)	Diagnosis	Mean baseline EDE-Q score (SD)	Started treatment (n)	Completed treatment (n)	CBT type	Quality rating
Moore & Waller, (2023) United Kingdom	26.3 (5.5)	100	BN, BED	3.5 (0.5)	8	8	CBT-T	High
Mountford et al., (2021) United Kingdom	NR	NR	AN, BN, BED, OSFED	NR	256	149	CBT-E	Medium
Pellizzer et al., (2019a) Australia	28.73 (9.57)	96.15	BN, OSFED	NR	26	13	CBT-T	High
Pellizzer et al., (2019b) Australia	26.42 (9.62)	90.38	AN, BN, BED, OSFED	3.81	52	32	CBT-T	Medium
Ramklint et al., (2012) Sweden	25 (7.2)	96.63	BN, BED, OSFED	4.4 (0.9)	89	40	Guided self-help	High
Raykos et al., (2014) Australia	NR	99.11	BN, OSFED	4.1 (1.0)	112	78	CBT-E	High

Table 1 (continued)

Author, publication year, and country of study	Mean age of participants (SD)	Participant gender (% female)	Diagnosis	Mean baseline EDE-Q score (SD)	Started treatment (n)	Completed treatment (n)	CBT type	Quality rating
Raykos et al., (2018) United Kingdom	22	97.01	AN	3.9 (1.4)	134	69	CBT-E	High
Ricca et al., (2010) Italy	27.48 (10.3)	100	AN	3.68	53	43	CBT – Garner et al., (1997)	Medium
Rose & Waller, (2017) United Kingdom	27.1 (6.64)	93.62	AN, BN, OSFED	3.89 (4.04)	47	35	CBT based on case formulation	High
Rose et al., (2021) United Kingdom	Median: 26	90	BN, OSFED	4.0 (1.5)	40	26	CBT-T	High
Rossi et al., (2022) Italy	27.1 (11.19)	100	AN, BN	3.4 (1.62)	185	123	CBT-E	High
Setsu et al., (2018) Japan	25.6 (5.52)	100	BN	4.1 (1.27)	25	23	Guided self-help	High

Table 1 (continued)

Author, publication year, and country of study	Mean age of participants (SD)	Participant gender (% female)	Diagnosis	Mean baseline EDE-Q score (SD)	Started treatment (n)	Completed treatment (n)	CBT type	Quality rating
Signorini et al., (2018) Australia	26.06 8.35	100	AN, BN, OSFED	4.03 (1.3)	114	57	CBT-E	High
Steel et al., (2000) Australia	23.0 (5.8)	96.88	BN	NR	32	18	CBT for ED – not specified	High
Stefánsson, (2022) Iceland	29.36 (9.06)	96.67	BN, OSFED	3.76 (1.1)	33	17	CBT-T	High
Tatham et al., (2020) – CBT-E condition United Kingdom	31.5 (12.4)	89.71	BN, BED, OSFED	4.36 (1.06)	138	52	CBT-E	High
Tatham et al., (2020) – CBT-T condition United Kingdom	29.3 (11.9)	94.55	BN, BED, OSFED	4.36 (1.11)	55	31	CBT-T	High

Table 1 (continued)

Author, publication year, and country of study	Mean age of participants (SD)	Participant gender (% female)	Diagnosis	Mean baseline EDE-Q score (SD)	Started treatment (n)	Completed treatment (n)	CBT type	Quality rating
Treasure et al., (1996) United Kingdom	25.9 (6.3)	NR	BN	NR	55	40	CBT for ED – not specified	High
Turner et al., (2015) United Kingdom	27.6 (9.2)	93.6	AN, BN, OSFED	4.17 (1.29)	203	100	CBT-E	High
van den Berg et al., (2022) Netherlands	NR	NR	AN, BN	NR	26	23	CBT-E	High
van Riel et al., (2023) Netherlands	NR	100	BED	NR	35	31	CBT-E	High
Waller, (1996) United Kingdom	21.5 (4.5)	100	NR	NR	43	28	CBT based on case formulation	Medium

Table 1 (continued)

Author, publication year, and country of study	Mean age of participants (SD)	Participant gender (% female)	Diagnosis	Mean baseline EDE-Q score (SD)	Started treatment (n)	Completed treatment (n)	CBT type	Quality rating
Waller et al., (2014) United Kingdom	27.8 (7.11)	100	BN, OSFED	NR	78	70	CBT – Waller et al., (2007)	High
Waller et al., (2018) United Kingdom	27.4 (8.66)	96.77	BN, BED, OSFED	4.0 (1.2)	93	64	CBT-T	Medium
Watson et al., (2012) Australia	26.05 (8.42)	98.98	AN, BN, OSFED	4.0 (1.19)	196	110	CBT-E	Medium
Williamson et al., (1989) United States of America	22.8	95.45	BN	NR	22	16	CBT for ED – not specified	High

Table 1 (continued)

Author, publication year, and country of study	Mean age of participants (SD)	Participant gender (% female)	Diagnosis	Mean baseline EDE-Q score (SD)	Started treatment (n)	Completed treatment (n)	CBT type	Quality rating
Zandberg & Wilson, (2013) United States of America	21.05 (3.0)	92.11	BN, BED, OSFED	NR	38	29	Guided self-help	High

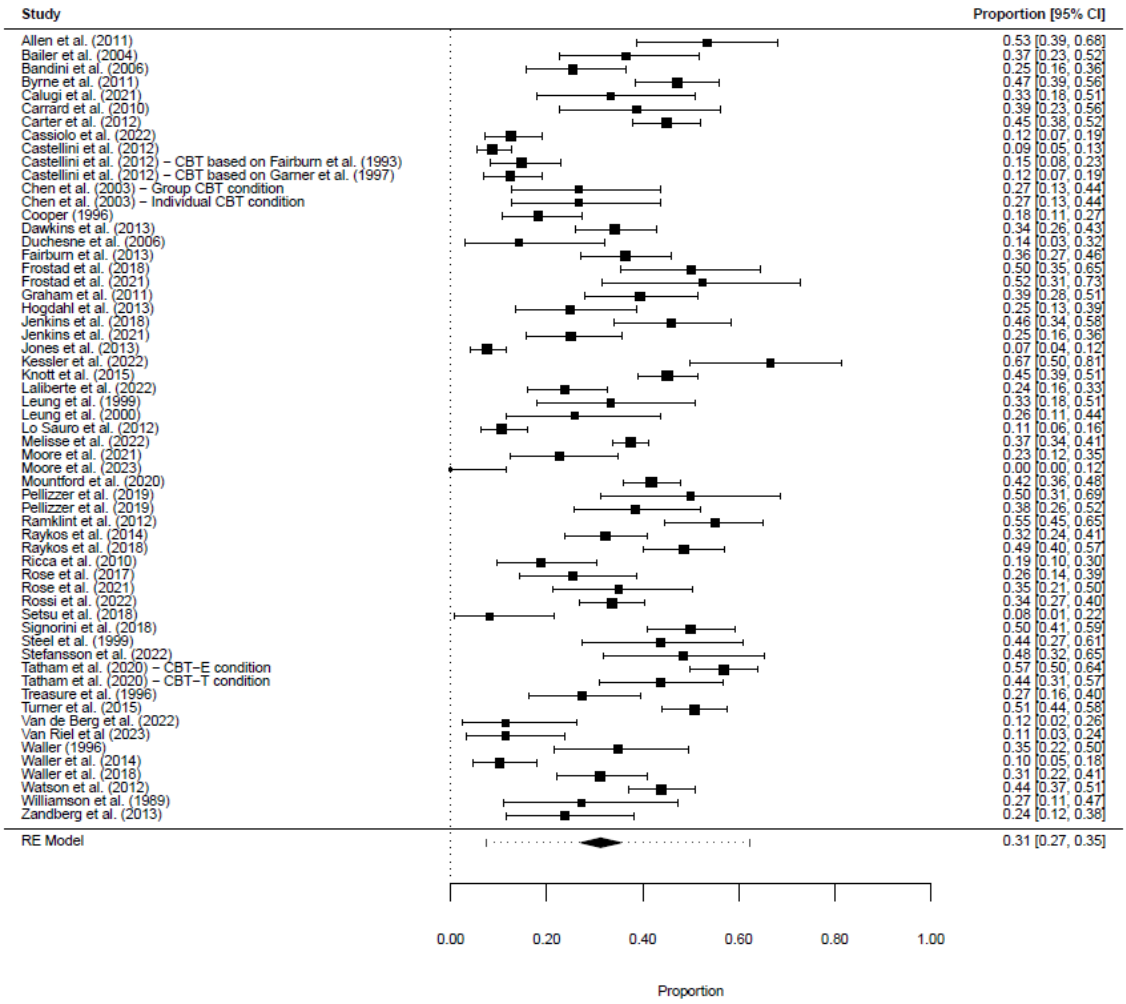
Abbreviations: AN, anorexia nervosa; BN, bulimia nervosa, BED, binge eating disorder, OSFED, other specified feeding or eating disorder; NR, not reported

3.3 Attrition Rates for All Eating Disorder Diagnoses

The overall attrition rate from CBT-ED across all eating disorder diagnoses and conditions was 31.22% (95% CI = 7.51–62.17%). There was considerable between study heterogeneity (I^2 = 90.22%) and so leave-one-out sensitivity analyses were conducted to repeat the analyses with the consecutive exclusion of each study (Higgins, 2008). Heterogeneity ranged from 89.55% to 90.62% and was not found to be significantly influenced by any individual study. A forest plot of studies included in the analysis can be seen in Figure 2. Publication bias across studies was assessed using an Egger's regression; this test was not significant, indicating no funnel plot asymmetry (p = .15). This was corroborated by the associated funnel plot (Appendix H).

Figure 2

Forest Plot of Arcsine Transformed Attrition Proportion of Each of the Included Studies



Pre-treatment EDE-Q global scores were available for 41 CBT-ED conditions. A meta-regression found eating disorder severity to be a significant moderator ($p < .05$) of attrition, whereby studies with a higher EDE-Q global score pre-treatment had higher rates of treatment attrition. Further meta-regressions did not find participant age ($p = .13$) or publication year ($p = .46$) to significantly moderate attrition rates. A subgroup analysis found diagnosis to be a significant moderator of attrition, with attrition highest in transdiagnostic and anorexia nervosa samples.

A sensitivity analysis was conducted using only the 53 studies (56 CBT-ED conditions) that included solely participants who actually commenced treatment within their reports of attrition. The overall rate of attrition from CBT-ED using only these studies was 30.91% (95% CI = 26.80–35.19%), remaining consistent with the results of the primary analysis. Similarly, a sensitivity analysis was conducted using only the 41 studies (44 CBT-ED conditions) rated as high quality, finding the overall attrition rate to be slightly lower at 29.52% (95% CI = 24.62–34.66%).

3.4 Attrition Rate for Anorexia Nervosa

Of the 56 studies included in the review, 27 included participants with a diagnosis of anorexia nervosa, and 16 of these studies reported the attrition rate specifically for this diagnosis. The overall attrition rate from CBT-ED across these studies was 38.29% (95% CI = 28.25–48.89%). Nine studies reported pre-treatment EDE-Q global score specifically for participants with anorexia nervosa. A moderator analysis found eating disorder severity to be a significant moderator ($p < .05$) of attrition, whereby higher pre-treatment EDE-Q global score was associated with a higher rate of attrition. However, BMI was not found to be a significant moderator of attrition ($p = .98$). Ten studies reported participant age specifically for those with anorexia, with a meta-regression finding age to significantly moderate attrition rate ($p < .05$). Lower age was associated with increased likelihood of attrition.

3.5 Attrition Rate for Bulimia Nervosa

Of the 56 studies included in the review, 43 included participants with a diagnosis of bulimia nervosa, and 16 of these reported the attrition rate for this subgroup. The overall attrition rate from CBT-ED across these studies was 27.18% (95% CI = 20.26–34.69%). Nine of these studies reported participant age, however a meta-regression did not find age to be a significant moderator of attrition ($p = .37$). Only three studies reported pre-treatment EDE-Q global score for participants with bulimia nervosa. Therefore, a meta-regression to investigate whether eating

disorder severity moderated attrition rate for this subgroup was not conducted due to the small number of studies.

3.5 Attrition Rate for Binge Eating Disorder

Of the 56 studies included in the review, 18 included participants with a diagnosis of binge eating disorder, and five of these reported the attrition rate for this subgroup. The overall attrition rate from CBT-ED across these five studies was 13.52% (95% CI = 20.26–34.69%). Only two studies reported pre-treatment EDE-Q global score and participant age specifically for those with binge eating disorder, so a moderator analyses could not be carried out using this data.

3.6 Attrition Rate for OSFED

Of the 56 studies included in the review, 29 included participants with a diagnosis of OSFED, and five of these studies reported the attrition rate for this subgroup. The overall attrition rate from CBT-ED across these studies was 45.14% (95% CI = 38.88–51.48%). None of these studies reported pre-treatment EDE-Q global score or age, so a moderator analysis to explore whether these variables moderate attrition rate for individuals with a diagnostic of OSFED was not possible.

3.7 Attrition Rate for Transdiagnostic Samples

Of the 56 studies included in the review, 36 used a transdiagnostic sample, giving 37 CBT-ED conditions. The attrition rate from CBT-ED across these studies was 34.98% (95% CI = 30.36–39.74%). Meta-regressions found both eating disorder severity and participant age to significantly moderate attrition ($p < .05$). Both higher pre-treatment EDE-Q global score and higher age were associated with increased treatment attrition.

3.8 Attrition Rate for CBT Type

Of the 56 studies included in the review, 24 included studies using CBT-E. The overall attrition rate from CBT-E was 38.68% (95% CI = 32.29–45.27%). A meta-regression found eating disorder severity to be a significant moderator of attrition in CBT-E, with higher pre-treatment EDE-Q global score associated with higher rates of attrition ($p < .05$). A meta-regression also found age to be a significant moderator of attrition, with lower age associated with increased attrition ($p < .05$).

Eight of the included studies used CBT-T, with an overall attrition rate of 33.53% (95% CI = 23.20–44.71%). Meta-regressions found both eating disorder severity

and participant age to significantly moderate attrition ($p < .05$), with higher pre-treatment EDE-Q global score and higher age associated with increased attrition.

Eight of the included studies used CBT-based guided self-help. The overall attrition rate from CBT-based guided self-help was 28.71% (95% CI = 18.96–39.58%). As with CBT-T, meta-regressions found eating disorder severity and higher participant age to be significant moderators of attrition ($p < .05$).

4 Discussion

This systematic review and meta-analysis aimed to investigate the attrition rate from CBT-ED in routine clinical settings, building upon the previous work and recommendations of Linardon et al., (2018). This present review estimated the attrition rate from CBT-ED in routine clinical settings to be 31.22%, with attrition ranging from 13.52% to 45.14% when considering attrition rate per eating disorder diagnosis. This finding is higher than the non-completion rates for CBT-ED reported in randomised controlled trials (Linardon et al., 2018). When considering the three most common types of CBT-ED used by studies included in the current review, attrition rate was highest for CBT-E at 38.68%, followed by CBT-T at 33.53% and 28.71% for CBT-based guided self-help. Eating disorder severity was found to be a consistent moderator of attrition, with higher pre-treatment EDE-Q global scores associated with increased attrition rate. Whilst age was not found to moderate the pooled attrition rate, age was found to significantly moderate attrition rates when attrition was considered per diagnosis and CBT-ED type. The only exception to this was in the bulimia nervosa subgroup, where age did not moderate attrition. Lower age was associated with increased attrition rate in anorexia nervosa and CBT-E samples, whereas higher rates of attrition were associated with older participants in transdiagnostic samples, CBT-T, and CBT-based guided self-help. The attrition rates for CBT-ED found within this review are considerably higher than treatment attrition rates for other mental health conditions including obsessive compulsive disorder (16.90%; Pozza & Dèttore, 2017), generalised anxiety disorder (17.14%; Gersh et al., 2017), and depression (23%; Schindler et al., 2013).

The findings of this review have important clinical implications. As younger age was found to be associated with increased attrition rate in those with anorexia nervosa, consideration needs to be given when formulating treatment plans for younger patients. It is widely accepted that the brain does not reach full development until the age of 25 (Anokhin et al., 1996; Arain et al., 2013), and that impaired cognition as a result of malnutrition is a common symptom for those with

anorexia nervosa (Cholet et al., 2021; Green et al., 1996; Zakzanis et al., 2010). Given that CBT has a relatively high cognitive demand, it could be argued that for younger patients with anorexia nervosa the combination of incomplete brain development and the impaired cognition as a result of their eating disorder may make it more difficult to engage with CBT, subsequently making it more likely for them not to complete treatment. Specialist Supportive Clinical Management (SSCM) and the Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA) are also first-line treatments for anorexia nervosa recommended in NICE guidelines (National Institute for Health and Care Excellence, 2017), and it may be that younger patients are better suited to these treatments and therefore should be offered these as a first-line treatment instead of CBT. To our knowledge, however, there is no published research investigating attrition in either SSCM or MANTRA, so further work is needed in these areas to consolidate this recommendation.

Similarly, greater levels of attrition were associated with lower age in CBT-E and with higher age in CBT-T and CBT-based guided self-help. When making decisions about treatment for individuals with non-underweight eating disorders, for which CBT is recommended as first-line treatment, consideration needs to be given as to which form of CBT-ED is the most appropriate. The results of this review suggest it is perhaps more appropriate to offer CBT-E to those who are older in age, and CBT-T or CBT-based guided self-help to those who are younger in age. However, there was a considerably larger number of CBT-E studies included in this review than those for CBT-T or CBT-based guided self-help (24 CBT-E compared with eight each for CBT-T and CBT-based guided self-help). Therefore, this finding needs to be interpreted with caution, with further investigation into attrition rates in CBT-T and CBT-based guided self-help required before this conclusion can be made with confidence.

The finding that eating disorder severity moderates attrition rate also has important clinical implications. Given that higher eating disorder severity (as measured by baseline EDE-Q global score) was found to be associated with increased levels of attrition in CBT-ED, and based upon the assumption that an individual's eating disorder will be less severe in its very early stages, this finding adds to the growing evidence-base arguing the importance of early intervention. Although research has highlighted the importance of early intervention in eating disorder treatment for many years (Rodgers & Paxton, 2014; Treasure & Russell, 2011), it is only in recent years that service models specifically focusing on early intervention, such as the first episode rapid early intervention for eating disorders model (FREED; Allen et al., 2020, 2023), have been introduced. If it is assumed that

an eating disorder may be at its least severe in its early stages, it can be suggested that this review demonstrates the importance of such services and the ongoing need for early intervention in eating disorder treatment. This could provide individuals with the best chance of remaining in and completing treatment, with consequent better treatment outcomes and chances of recovery.

It is important to note that this review focuses specifically on attrition from CBT-ED, not drop-out. Of the 56 studies included within this review, only 21 (37.5%) specified reasons for attrition, separating drop-out (defined as terminating treatment against advice of practitioners) from all other reasons for non-completion. The remaining 35 (62.5%) studies grouped all people who did not complete treatment more generally as non-completers, with considerable variation in the definitions of attrition applied across these studies. It must, therefore, be emphasised that the findings of this review report overall attrition from treatment, not drop-out, and should be referred to as such. In order to be able to consider drop-out rates, further research is needed that focuses on reports of the number of those who drop-out of or disengage from treatment as opposed to non-completion more generally. This would also enable further investigation of whether there are differences in rates of attrition depending on the reason for non-completion. This remains difficult whilst there remains no consensus definition of drop-out, however can be supported by future research clearly reporting reasons for non-completion rather than grouping all non-completers into a single category.

Whilst it is clear that the attrition rate from CBT-ED is high, what remains less clear is why this is the case. Although efforts have been made to try to understand this (Clinton, 1996; Fassino et al., 2009; Steel et al., 2000; Vinchenzo et al., 2022), to date no firm conclusions have been drawn. Research has previously identified the influence of patient experience of treatment on clinical outcomes, including treatment retention, in physical health settings (Navarro et al., 2021; Prakash, 2010; Prang et al., 2019). This emphasises the importance of understanding the patient experience of treatment. Despite CBT being a widely used treatment for eating disorders, there is very little research investigating how patients experience this (Cowdrey & Waller, 2015; de la Rie et al., 2008; Hoskins et al., 2019). Further research is needed to investigate whether there is an association between how patients experience treatment and attrition rate to improve understanding of the reasons for attrition within CBT-ED. It would be especially helpful to specifically explore the experiences of those who have commenced but not completed CBT-ED to provide a better understanding of non-completion, particularly those classed as ‘treatment drop-outs’. This would enable consideration of what might be helpful to

improve both engagement with treatment and rates of successful treatment completion, and reduce attrition.

It should be acknowledged that the review questions aiming to explore whether treatment modality or attrition definition moderated rates of attrition could not be investigated given the lack of reporting of treatment modality and high levels of variability in regards to attrition definitions. This was also the case for ascertaining whether treatment was delivered individually or as a group, with most of the included studies not reporting how treatment was delivered. Whilst prior to the COVID-19 pandemic most eating disorder treatment took place face-to-face, the past four years has seen a large increase in the use of online treatment delivery. Given that only three of the studies included within this review reported treatment modality, it was not feasible to investigate modality as a potential moderator of attrition. Future research in this field needs to make an explicit statement about treatment modality to enable investigation of any differences in outcomes depending on the way treatment is delivered. Clear information about treatment delivery (i.e. individual therapy or group therapy) is also needed to ascertain whether this may be a potential moderator of attrition. Similarly, the large degree of variation in definitions reported for attrition meant it was not possible to investigate whether these moderated attrition. This highlights the ongoing need for the development of standard definitions of attrition and drop-out, which has already been identified in previous research (Bağrıacık Yılmaz & Karataş, 2022; Fredum et al., 2021; Karekla et al., 2019; Kullgard et al., 2022; O'Keeffe et al., 2019). This would facilitate consistency in the reporting of this information to allow more reliable and consistent interpretation of findings.

There are limitations of this systematic review and meta-analysis which must be considered. Although the JBI quality assessment tools are widely used in the critical appraisal of research, these have some shortcomings. For example, the guidance for using the assessment tools is somewhat ambiguous and open to interpretation, which may impact on the reliability of the quality ratings given to the studies included within this review. Furthermore, although many of the included studies could be given points for meeting quality criteria, there was considerable variation in the extent to which the studies met this criterion, with this variation not accounted for within the overall quality ratings. This could result in an overestimation of the quality of some of the research included in this review. In addition, these tools do not acknowledge aspects such as sample size or power, which are likely to be important factors to consider when assessing the quality of research.

In addition to these limitations, it was also beyond the scope of this review to have two independent reviewers completing screening at title and abstract level or at full-text level. Although a second reviewer screened a proportion of the studies included in the review to confirm their eligibility, the remainder of the screening was completed by a single reviewer. Of the 56 studies included in this review, 38 took place in Europe, presenting the risk of a Eurocentric bias. The inclusion criteria of studies being available in the English language may also have contributed to biases, with previous research (Egger et al., 1997) finding that authors are more likely to publish research findings in an English-language journal if the results are statistically significant. This can, subsequently, lead to an overestimation of effects. However, there was only one study excluded from screening due to not being available in English.

In conclusion, this systematic review and meta-analysis aimed to investigate attrition rate from CBT-ED delivered in routine clinical practice settings, and is the first to provide an estimate of treatment attrition in these settings. This review has highlighted some key findings with respect to age, eating disorder diagnosis, and eating disorder severity. These have important implications for service planning and treatment delivery to facilitate better engagement with and retention in treatment. Further research is needed to examine why attrition rates in CBT-ED are so high in routine clinical practice settings to better understand the reasons for this, which could help ascertain what factors may improve retention in CBT-ED treatment.

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Chapter Three: Bridging Chapter

The systematic review and meta-analysis described in Chapter Two aimed to investigate attrition from CBT-ED delivered in routine clinical practice settings, and considered whether the attrition rate is moderated by factors such as diagnosis, eating disorder severity, age and CBT-ED type. There was considerable variation in attrition rates across CBT-ED type. The attrition rate was highest from CBT-E at 38.68% (95% CI = 12.16–69.54%) and lowest from CBT guided self-help at 28.71% (95% CI = 6.17–59.40%. Attrition rate for CBT-T sat midway between the two at 33.53% (95% CI = 9.66–63.19%).

As noted in Chapter One, CBT-T is a relatively new treatment developed by Waller et al., (2019) in an attempt to address the difficulties that patients with non-underweight eating disorders can face when attempting to access treatment. Previous research has indicated that CBT-T effective (Keegan et al., 2022; Pellizzer et al., 2019b, 2019a; Rose et al., 2021; Tatham et al., 2020; Waller et al., 2018) and that patients have a positive experience of the treatment (Hoskins et al., 2019). However, the remaining part of the 'CBT-T experience' that has not yet been investigated is how clinicians experience delivering CBT-T.

It is important to seek an understanding of clinicians' experiences and perspectives as ultimately they are the people responsible for delivering treatment (Foye et al., 2022). This is also important because clinician views on treatment has been found to affect treatment delivery (Waller & Turner, 2016). Furthermore, it has been suggested that the experiences of clinicians need to be considered alongside treatment outcome data to inform interpretation of this data (R. E. Byrne et al., 2020). Understanding clinicians' experience of delivering CBT-T would also enable insight into particular aspects of treatment which they may struggle to deliver or require further support with. In turn, this could potentially improve the quality of treatment that they provide (Najavits, 2002), which may lead to reduced rates of treatment attrition and improved treatment outcomes. Furthermore, CBT-T is a relatively newly established treatment for eating disorders and it is possible that further development and enhancement of some aspects of the treatment and protocol may prove beneficial. Understanding clinicians' experiences of delivering this form of CBT-ED intervention may therefore provide valuable insights into how this could be achieved.

With these considerations in mind, Chapter Four presents a qualitative investigation into clinicians' experiences of CBT-T. A sample of 13 practitioners currently delivering CBT-T with at least six months of experience delivering this

treatment were recruited and interviewed. Semi-structured interviews were conducted via Microsoft Teams, with Braun & Clarke's (2006) six-stage thematic analysis used to identify themes from the interview transcripts. Three themes and 10 subthemes were identified and are described and discussed in the next chapter of the Thesis Portfolio.

Chapter Four: Empirical Research Project

Clinicians' Experiences of Delivering Cognitive Behaviour Therapy Ten (CBT-T): A Qualitative Investigation

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Abstract

Objective: Cognitive Behaviour Therapy Ten (CBT-T) is a relatively new manualised treatment for non-underweight patients with eating disorders. It has been found to be an effective treatment and to be rated highly by patients. However, it is also important to consider clinicians' perspectives in the implementation and development of new interventions. This is because clinician perspectives can impact treatment delivery, leading to issues such as therapist drift. Using a qualitative approach, this research aimed to examine clinician experiences of delivering CBT-T.

Method: The sample comprised 13 clinicians currently delivering CBT-T with at least six months experience of delivering this treatment. Semi-structured interviews were conducted via Microsoft Teams, using Braun & Clarke's (2006) six-stage thematic analysis to identify themes from the interview transcripts.

Results: Three themes and 10 subthemes were identified. The main themes were: positive experiences of delivering CBT-T, changing experience over time, and challenges in delivery.

Discussion: Clinicians reported an overall largely positive experience of delivering CBT-T, with some challenges related to treatment delivery identified. Findings are discussed in relation to wider research literature, with recommendations given about how clinicians can be supported with their delivery of CBT-T, and for future research and CBT-T development.

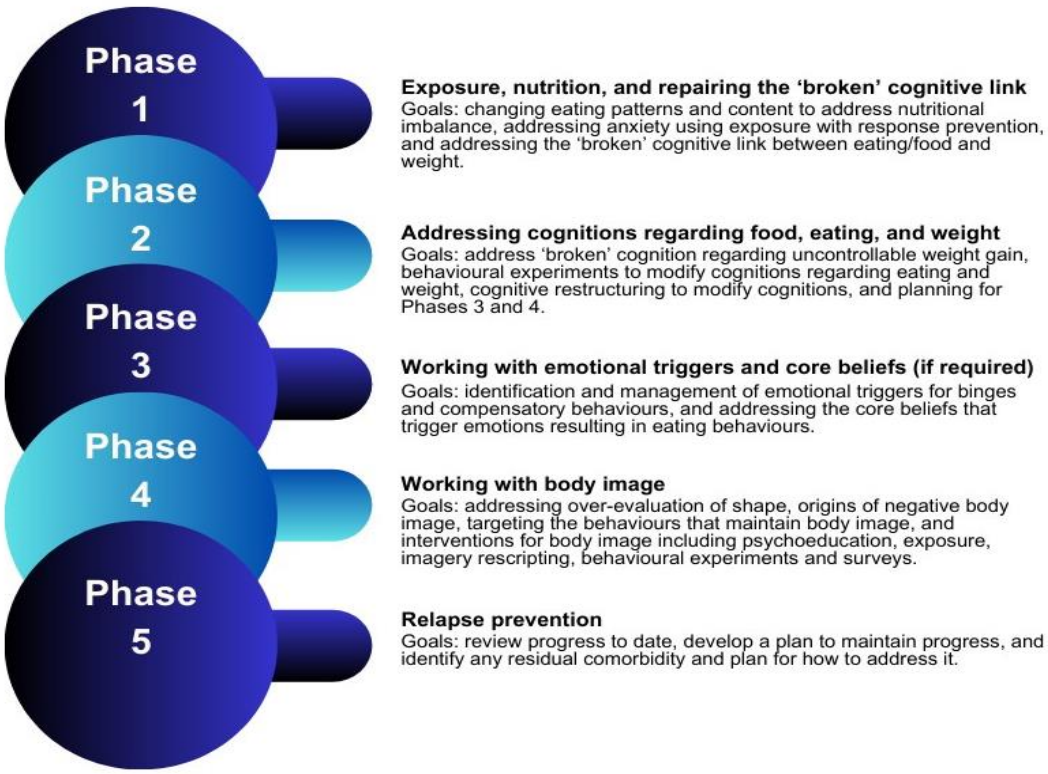
1 Introduction

Cognitive behaviour therapy (CBT) is a widely used, evidence-based treatment for eating disorders, recommended by National Institute for Health and Care Excellence ((National Institute for Health and Care Excellence, 2017)NICE; 2017) guidelines as a treatment for all eating disorder diagnoses. However, given the physical risks associated with anorexia nervosa (Puckett et al., 2021), individuals with this diagnosis often require prioritisation for treatment. This can mean that those with a non-underweight eating disorder, such as bulimia nervosa, binge eating disorder, or other specified feeding or eating disorders, often have to wait a long time to access treatment (Waller et al., 2019).

Cognitive Behaviour Therapy Ten (CBT-T) is a manualised 10-session therapy divided into five phases. It was developed by Waller et al., (2019) specifically for non-underweight eating disorders to address the difficulties that these individuals can have when attempting to access treatment. An outline of the structure of CBT-T and each phase of treatment is shown in Figure 3. Initial case series of CBT-T have shown it to be an effective treatment (Pellizzer et al., 2019a, 2019b; Waller et al., 2018).

Figure 3

The Structure of CBT-T



Hoskins et al., (2019) identified that in addition to investigating the effectiveness of new therapies, it is also necessary to consider how patients experience therapy. This has led researchers to investigate patients' experiences of receiving treatment, with Hoskins et al., (2019) investigating how patients experience CBT-T. They found the acceptability and effectiveness of CBT-T to be highly rated by patients. Key themes identified through a thematic analysis of patient responses were the therapeutic relationship, the nature of therapy, that CBT-T was challenging but beneficial, ending therapy, and the overall experience of CBT-T. Patients reported their experiences of this treatment as being mostly positive.

It has been identified that it is also important to consider clinicians' views of delivering treatment when implementing new interventions (Greenhalgh et al., 2004). It has been suggested that combining both clinician and patient perspectives provides a more in-depth understanding of treatment, informing both the future development of interventions and clinician training (Waterman-Collins et al., 2014). Consideration of clinicians' experiences also enables an understanding of how clinicians can be better supported in some of the challenges they may encounter when delivering interventions (Carayon et al., 2019). It is also important to understand how clinicians experience delivering the core components of treatment, as this is likely to influence treatment fidelity and delivery. For example, Shafran et al., (2009) found that clinicians' views of treatment can affect adherence to treatment delivery, which can lead to therapist drift. This is problematic, particularly if a clinician is delivering a manualised treatment such as CBT-T.

Understanding clinicians' views and experiences of treatment is important for a number of reasons as outlined above, but is yet to be considered for CBT-T. Understanding clinician experiences could inform ongoing development of CBT-T, and ascertain whether there is any additional support that clinicians may benefit from when delivering this therapy to ensure full adherence to the treatment manual. It would also allow direct comparison of patient and clinician experiences of CBT-T, providing a more in-depth understanding of this treatment. This would be helpful as well as pertinent to the current development of a shorter treatment for underweight eating disorders.

The aim of this research is to investigate clinicians' experiences of delivering CBT-T and to answer the following research questions:

1. What are clinicians' experiences of delivering CBT-T?
2. Are there any aspects of CBT-T where clinicians may benefit from additional support when delivering this intervention?

2 Method

2.1 Participants

To be eligible to take part in this research, participants had to be currently delivering CBT-T and have been delivering this therapy for at least six months. The criteria for currently delivering CBT-T was to ensure an accurate reflection of current experiences rather than retrospective accounts, which have previously been found to affect the accuracy of reporting of personal experiences (Coughlin, 1990; Solga, 2001). The criteria of at least six months experience delivering CBT-T was to ensure participants had a sufficient period of time to experience delivering this therapy.

Participants were a sample of 13 National Health Service (NHS) eating disorder clinicians. Of these, 84.62% were female (n = 11), with a mean age of 28.31 years at the time of interview (SD = 5.38). Participants had been delivering CBT-T for an average of 16.54 months (SD = 10.01) and had treated a mean number of 20.38 patients (SD = 18.46) with CBT-T. One participant had a core profession, with the remaining participants working under supervision as unqualified practitioners. Table 2 details the demographic information of all participants.

Table 2

Participant Demographics

Participant number	Age (years)	Gender identity	Ethnicity	Profession	Duration delivering CBT-T (months)	Number of people treated with CBT-T
P1	24	Female	White British	Clinical Associate Psychologist	30	20
P2	26	Female	White British	Assistant Psychologist	25	12
P3	24	Female	White British	Assistant Psychologist	7	9

Table 2 (continued)

Participant number	Age (years)	Gender identity	Ethnicity	Profession	Duration delivering CBT-T (months)	Number of people treated with CBT-T
P4	24	Female	White British	Community Practitioner	12	17
P5	27	Non-binary	White Greek	Assistant Psychologist	7	6
P6	29	Male	White British	Assistant Psychologist	22	50
P7	27	Female	White Canadian	Assistant Psychologist	12	4
P8	26	Female	White British	Assistant Psychologist	24	60
P9	28	Female	White British	Psychology Practitioner	18	42
P10	38	Female	White British	CBT Therapist	7	4
P11	30	Female	White British	Trainee Clinical Associate Psychologist	9	7
P12	24	Female	British Pakistani	Psychology Practitioner	6	14

Table 2 (continued)

Participant number	Age (years)	Gender identity	Ethnicity	Profession	Duration delivering CBT-T (months)	Number of people treated with CBT-T
P13	41	Female	White British	Eating Disorder Specialist	36	20

2.2 Ethical considerations

Ethical approval for this research was granted by the University of East Anglia's Faculty of Medicine and Health Sciences Research Ethics Committee in December 2022 (Ref: ETH2223-0245; Appendix J) and the Health Research Authority (Project ID: 321360; Appendix K) in April 2023. Participants were informed that their participation was voluntary, and that their interview transcript and personally identifying information would be anonymised. Participants were asked to create a unique patient identifier in the case of wanting to withdraw their data, and were advised that they could contact the researcher to withdraw their data should they wish to do so, up until the point that data analysis had commenced. No participants requested withdrawal of their data.

2.3 Procedure

Participants were recruited by emailing gatekeepers for four NHS eating disorder services known to deliver CBT-T a recruitment poster (Appendix L) and information about the research (Appendix M), asking them to disseminate this information to clinicians within the service. The recruitment poster was also shared on Twitter and Facebook. Individuals expressing an interest in taking part in this research were sent an information sheet (Appendix N) and consent form (Appendix O). There were 16 people who expressed an interest in participating, with 13 people returning a signed consent form. Upon receipt of a completed consent form, participants were contacted and a convenient time for interview was arranged. Interviews were semi-structured, using a topic guide (Appendix P). Using the topic guide, an initial interview schedule was developed by the authors, then shared with five qualified clinicians with experience of delivering CBT-T for feedback. Amendments were made to the schedule on the basis of this, with the finalised interview guide

comprising of 10 questions relating to various aspects of the experience of delivering CBT-T. Following initial pilot of the interview schedule, participants were also given time at the end of the interview to share any additional thoughts about their experience of delivering CBT-T that they felt they had not covered in the interview but wanted to share. All interviews took place via Microsoft Teams between July 2023 and October 2023, each lasting approximately one hour. Upon completion of the interview, participants were emailed a debrief form (Appendix Q) and were given a £10 gift card as a token of appreciation for their participation.

2.4 Data Analysis

Interview transcripts were analysed using Braun & Clarke's (2006) six-step process of thematic analysis. This analysis technique aligned with the critical realist positioning of this research and compliments the analysis in the research exploring patient experiences of receiving CBT-T.

Interviews were live transcribed using Otter, an artificial intelligence General Data Protection Regulation (GDPR) compliant transcription software offering live transcription at the time of interview. Transcripts were checked by author CH for accuracy, with any personally identifying information removed. Interview recordings were listened to at least twice in line with the guidance by Braun & Clarke (2022) to aid with familiarisation of transcripts. Transcripts were printed, with content relevant to the research questions coded by hand. These codes were then collated into potential themes and subthemes. Themes were reviewed both independently and through the use of supervision, with themes defined and named once these had been finalised. A reflective diary was kept throughout the research process to aid reflexivity and to record the rationale for key decision points throughout the research.

3 Results

From analysis of interview transcripts, three main themes and 10 subthemes were identified. These are shown in Table 3 and will be considered in turn.

Table 3

Themes and Subthemes

Main themes	Sub-themes
1. Positive experiences of CBT-T delivery	1a. Enjoyable to deliver 1b. Strong therapeutic alliance 1c. The treatment protocol 1d. Good experience for patients
2. Changing experience over time	2a. Reduced anxiety and increased confidence 2b. Belief in model
3. Challenges in delivery	3a. Better fit for some patients than others 3b. Areas requiring additional support 3c. Terminating treatment 3d. Treatment infidelity

Theme 1: Positive Experiences Of CBT-T Delivery

The first theme captures the largely positive experience that participants described of delivering CBT-T. There were four subthemes within this theme.

1a. Enjoyable To Deliver

Participants spoke about holding largely positive attitudes towards delivering CBT-T. Participants spoke highly of CBT-T, describing it as “a really nice therapy to deliver and work with patients on” (P13). It was described as feeling like a “safe therapy” (P1) to deliver, with one participant stating that they have “liked delivering CBT-T the most out of all therapies” (P2). It was reflected that part of the enjoyment of delivering CBT-T has been “because I have seen the changes that it can lead to in recovery” (P1). One participant in particular spoke very highly of their experiences of delivering CBT-T and discussed their enthusiasm for CBT-T that has developed from delivering the therapy: “I’m massively passionate about it. It’s a really lovely therapy” (P13).

1b. Strong Therapeutic Alliance

Participants identified that they have been able to build “generally good” (P13) therapeutic alliances with their CBT-T patients: “I feel like it’s [the therapeutic alliance] been really good. I think it tends to be strong” (P1). Some participants expressed their surprise that they had not had problems building a therapeutic

alliance with patients because “it’s something that maybe I thought would be more difficult with CBT-T just because of various elements that are quite different to the way I was working before” (P2), although reflected that they’ve “definitely still managed to build that relationship” (P7) without specific time being allocated to this.

An observation by participants was that they have been able to develop a better therapeutic alliance with patients who are finding CBT-T beneficial: “I think it’s better with people that are finding it helpful and are making changes” (P9). This was echoed by another participant who stated that “if they can do the changes then the therapeutic alliance is going to be stronger” (P1).

1c. The Treatment Protocol

Although some participants suggested that the CBT-T protocol can make treatment feel “limiting” (P8), participants generally felt that having a protocol to follow was very helpful as a clinician. It was discussed that the structure of CBT-T “is containing…having that guidance and knowing what to do” (P9), and that the protocol means that “you know you’re delivering the right thing that you’re meant to deliver each week” (P11). This appeared to be especially important when beginning to deliver CBT-T: “It was really helpful in those early days” (P6).

1d. Good Experience For Patients

When asked about perceptions of patient experiences of CBT-T, participants said their impressions are that patients have “largely positive” (P8) experiences of CBT-T. Participants spoke about feeling that patients see CBT-T as difficult initially: “They experience it as quite a confronting therapy and maybe a lot of work” (P3). Participants understood that this was “because in the first four sessions they are being really pushed to their most maximum tolerable anxiety that they can handle” (P12). However, it was reflected that the patient experience changes throughout the course of treatment and that “by the end [patients] feel really positive about things” (P1). One participant shared that “people always seem to say they feel more confident leaving the sessions, and I think that says a lot about how powerful CBT-T is”, referring to CBT-T as being “life-changing” for patients (P6).

Theme 2: Changing Experience Over Time

The second theme captures the way that participants’ experience of delivering CBT-T has changed over time.

2a. Reduced Anxiety and Increased Confidence

Participants spoke about high levels of anxiety when they first began to deliver CBT-T. One referred to CBT-T as “a baptism of fire to start with” (P6), with another describing their early experiences of delivering CBT-T as “a bit of a car crash” (P10).

Participants compared their initial experiences of delivering CBT-T with how they feel after having delivered this over a period of time, identifying that as they have become more familiar with delivering CBT-T, their confidence has improved: “I became more and more confident with delivering it” (P5) and “as time goes on I get more confident” (P4), with another saying that they have “got more confident with what I’m doing” (P11). One participant reflected that because they now have more experience “my anxiety has come down over time and my need to almost over-prepare for each session has been reduced” (P2).

2b. Belief In Treatment Model

Participants identified that their belief in CBT-T as a treatment has been enhanced through delivering it, specifically from seeing its effectiveness. Participants discussed how they had initial doubts about CBT-T being an effective treatment in the beginning: “In the beginning I just couldn’t understand how it was going to work” (P2). However, participants found that as they have experienced CBT-T being effective for patients, this has improved their belief in the treatment model. Participants spoke about how the experience of delivering CBT-T has now meant that they have “seen that it can work” (P1) and that they feel more comfortable offering people CBT-T as they “really know and appreciate what people can get from that” (P6). This contributes to participants having an overall positive experience of delivering CBT-T because “I’ve seen the positive outcome that it has” (P3).

Participants also spoke about how delivering CBT-T has enabled them to better understand the rationale behind different parts of the treatment: “Putting it into practice helps firm up my understanding” (P4). Another shared that the experience of delivering CBT-T has made them realise “the firm empathy is there for a reason. It helps you create the clear boundaries so you can have the outcomes you want” (P12).

Theme 3: Challenges In Delivery

Whilst participant narratives reflected a largely positive experience and increased confidence in the model and treatment delivery over time, there were, however, a range of challenges noted.

3a. Better Fit For Some Patients Than Others

A consistent challenge that participants identified from their experiences of delivering CBT-T is feeling that the treatment is better suited to some patients and presentations than others. Participants spoke about feeling that CBT-T “works really well when you get people who have certain presentations” (P9), citing examples of

bulimia nervosa and binge eating disorder as specific diagnoses where they have seen CBT-T to be the most effective: “When I see people who have binge eating disorder or bulimia, for me they’ve done really well” (P12).

Comorbidity and complexity were also raised as factors affecting the suitability of CBT-T. Participants spoke about feeling the CBT-T protocol is not suitable for people who are “more complex” (P10). In such cases, participants can find it difficult to keep to the 10-session structure of CBT-T: “Sometimes with people who would be described as complex, I find I really struggle to address everything in 10 sessions” (P5).

There were conflicting views regarding CBT-T and eating disorder longevity. Some participants commented that they have experienced CBT-T to be more effective with patients earlier on in the development of their eating disorder: “It’s working better for people who are FREED[2] patients” (P9). This was echoed by others who described feeling that CBT-T is less suited to patients whose eating disorder is more entrenched and long-standing. In comparison, others have experienced that it is more difficult for these patients to make progress with CBT-T: “If they’re very early within the eating disorder, say it’s only been two years, it can be difficult to get past that stage [phase 1]” (P12). Regardless of these conflicting views, patient motivation was identified as an important factor for patients to make progress within CBT-T, with discussion that patients need to have “high motivation” (P7) to make changes in order for CBT-T to be effective. For example, one participant spoke about the importance of patients being in the “right-mindset to be making changes” (P13), aligning with the views of another who discussed that “it’s the motivation that is important” (P4) for a patient to be able to make the necessary changes required for them to remain in therapy.

3b. Areas Requiring Additional Support

Participants talked about the parts of CBT-T they found most difficult to deliver. Both the phase three emotion work and imagery rescripting were raised by almost all participants interviewed. Imagery rescripting was found to be “really difficult” (P6), with there being a shared consensus that this is something that they would “like more training on” (P4). One participant said that “the imagery rescripting [in the manual] isn’t detailed enough to feel comfortable delivering it as a clinician” (P12), with another saying examples of “what good imagery rescripting looks like” are needed (P3). It was identified that additional support or training on imagery

[2] First Episode Rapid Early Intervention for Eating Disorders

rescripting would help those delivering the intervention to become both “a lot more comfortable” (P12) and “more confident” (P6) in delivering this aspect of treatment.

Similarly, in relation to emotion work, one participant spoke about feeling that this is “where the manual is a bit vague” (P9). Another participant explained that the manual “says you can use some DBT skills, but for somebody who has never really used DBT before it doesn’t really explain what that might look like in the context of CBT-T” (P2). They were, therefore, unsure “how do you address some of these emotions and different ways to cope with them” (P7) when a patient requires the third stage of treatment. Participants reflected that additional support around this element of CBT-T would give a “clearer understanding” (P12) of how to address the relationship between emotions and eating, and that it would enable them to be “more curious” (P13) about exploring this link with patients. One participant reflected that they have “moved into that emotional phase less because I have less training and less confidence with it” (P2). Participants also reported that due to feeling uncertain about how to manage this phase of treatment, they are more likely to deviate from the treatment protocol, with them feeling that they “stray and bring in other stuff” and are “freestyling” (P9).

3c. Terminating Treatment

It was noted by participants that they found it difficult to implement boundaries in terms of terminating treatment. One participant explained that “it feels really hard to be sat in front of another human, not as a patient and as a therapist, but as a human being saying, ‘you’ve not done enough to receive any more of our help’” (P3) with another explaining that “it feels difficult not to be able to offer them more time” (P6).

Terminating treatment was identified to be most difficult when the clinician and patient have differing views on the progress which has been made: “Sometimes the person thinks they’re on track to keep going and wants to keep going and we don’t feel the same, and that’s the difficult part” (P9). Other participants shared that “the hardest times have been when people are very keen, and they want help but have struggled to make the change” (P8) and that they find terminating treatment when the patient is not agreement with this to be uncomfortable and “anxiety provoking” (P2).

3d. Treatment Infidelity

Many examples were given by participants about times where they have not adhered to the treatment protocol or have “definitely had to make adaptations” (P7). These ranged from additional sessions to including material from outside CBT-T and addressing comorbid problems within treatment. Participants were consciously aware that they were deviating from the CBT-T protocol, and explained that this was

something that happens more generally within their service rather than this just being an individual experience: “If you’re going by the protocol you’re not supposed to slow it down or make adaptations, but with a real person we, in my service at least, often find that we have to” (P9).

Participants spoke about times where they have continued treatment beyond session four when a patient had not made the necessary changes, contrary to the CBT-T treatment manual: “Based on the manual they would qualify for it [treatment termination] and I didn’t do it” (P5). Similarly, participants gave examples of more general adaptations that they had made to the protocol, such as offering more sessions (“…with somebody with autism, for example, we ended up doing 15 sessions instead of 10 sessions”, P8) or changing the boundaries regarding therapy non-negotiables (“For people with ADHD, diary keeping and home practice can be really difficult. So sometimes we make the diary keeping a bit more lenient, like just writing a word, or just doing it consistently for a few days a week”, P9).

Some participants spoke about how they “don’t stop at the eating disorder” (P5) and bring in other material as “it’s hard not to veer out of it [the protocol] sometimes when other stuff comes up” (P11). Participants also gave examples of additions that they make to the protocol such as an extra session before commencing treatment: “We have a thing known as session zero, which is like a mini assessment to get to know the person that you’re going to work with” (P4).

4 Discussion

The aim of this study was to investigate clinicians’ experiences of delivering CBT-T using semi-structured interviews and thematic analysis. The study was designed to compliment the earlier research investigating patient experiences of receiving CBT-T (Hoskins et al., 2019). In the current research, the themes that were identified from the interviews were positive experiences of CBT-T delivery, the changing experience of delivering CBT-T over time, and the challenges that arise when delivering CBT-T. Clinicians were largely positive about their experience of delivering CBT-T, describing it as enjoyable and finding it useful to have a protocol to follow. They also talked about having been able to build strong therapeutic alliances with their patients within the short timeframe of CBT-T, and feeling that the treatment was a positive experience for patients. Clinicians identified that their experience of delivering CBT-T changed over time, specifically with regards to their confidence using CBT-T and their belief in the treatment model. Challenges identified by participants were that they felt that CBT-T was a better fit for some

patients than others, and that they found it difficult to terminate treatment when this is required. Participants also gave examples of when they have moved away from the treatment manual, with additional support needs identified for delivering the emotion work and imagery rescripting.

Participants becoming more confident with delivering CBT-T over time is unsurprising and is unlikely to be limited to the delivery of CBT-T. The same can be said for participants' belief in the CBT-T model being enhanced from seeing the effectiveness. However, what is more unexpected is the value that participants placed on the CBT-T treatment manual. Previous research largely indicates that clinicians often have unfavourable opinions towards manualised treatments (Addis & Krasnow, 2000; Muskat et al., 2010; Waller et al., 2013). In the current study, whilst there were indications that some participants found using a manualised treatment limiting, on the whole participants were positive about using a treatment manual. The results of a systematic review by Forbat et al., (2015) found that clinician views on manualised treatment can be affected by age, years of experience, gender, race, and educational background, with research by Addis & Krasnow (2000) also finding a relationship between less experienced clinicians and more positive attitudes towards manuals. Considering this finding, it is important to note that the majority of participants in this research were of a similar age and did not have a professional qualification. This also inhibited exploration of experiences of delivering CBT-T in comparison to other therapies, as most participants did not have the experience of delivering other interventions. Future research may helpfully address this limitation.

The previous research by Hoskins et al., (2019) showed patients' ratings of the therapeutic alliance in CBT-T to be high, with the current study demonstrating that clinicians' perspectives on this are complimentary. Within clinical practice there are two opposing views regarding the therapeutic alliance. The first is that building a therapeutic alliance is essential for change (Baier et al., 2020; Beck, 1979), whereas others suggest that the therapeutic alliance develops as a result of early change and patients seeing that treatment works (Tang et al., 2007; Waller et al., 2012); CBT-T aligns with the latter. One of the specific stipulations within the CBT-T manual is that there should not be a focus on developing a therapeutic alliance at the cost of progressing the tasks of therapy. Accordingly, time should not be specifically allocated to building a therapeutic alliance, and instead the focus should be on supporting patients to make changes from the start of treatment, with change emphasised from session one. Despite this, the findings of both this study and aforementioned research indicate that both patients and clinicians describe the therapeutic alliance in CBT-T to be strong. This aligns with the findings of a previous

meta-analysis by Graves et al., (2017) which found early symptom improvement to be related to the subsequent quality of the therapeutic alliance. This has implications theoretically in regards to the theory underlying the development and importance of the therapeutic alliance in regards to change. There are also key clinical implications in terms of how this is applied in clinical practice, as this finding indicates that it is still possible to build a good therapeutic alliance without allocating specific time to this.

It was clear from the identification of the subtheme 'treatment infidelity' that clinicians were not always delivering CBT-T in accordance with the protocol guidelines. Given that therapist drift is reported to be a common phenomenon across psychological treatments (Waller, 2009; Waller & Turner, 2016), this is perhaps unsurprising. Nevertheless, it is problematic as it results in patients receiving treatment that moves away from the evidence-base, potentially impacting treatment outcomes. Previous research has identified that there can be a range of reasons for therapist drift including therapist anxiety (Hernandez Hernandez & Waller, 2021; Moritz et al., 2019), clinical experience (Beidas et al., 2014; Sijercic et al., 2020), therapist knowledge (Becker-Haimes et al., 2019; Sars & van Minnen, 2015), therapist age (Mulkens et al., 2018; Wisniewski et al., 2018), and theoretical orientation (R. de Jong et al., 2020; Garcia et al., 2020). Although this research identified that clinicians were not consistently adhering to the treatment protocol, a limitation of the current research is that reasons for this were not explored. If it is possible to identify and understand why clinicians are not adhering to the protocol, this will enable any additional guidance or support to be developed, as appropriate, to improve treatment fidelity.

Emotion work and imagery rescripting were identified as the main areas that participants reported that they need additional support with implementing. Reasons for this appear to be related to participants feeling that this is not sufficiently covered within the CBT-T training and treatment manual. Accordingly, a recommendation of the current research is that CBT-T training should more explicitly cover these areas, and for the manual to provide clearer guidance on these areas. Participants in the current research indicated that if they had more understanding of these areas then they would be more likely to explore these with patients, which could enhance patients' experiences of treatment as a result. Given that role play is indicated to enhance learning and understanding (Flaherty, 2023; Issac Gibbs, 2019), training could include the opportunity to role play these interventions to aid with improving clinician understanding of and confidence with using these. The results of this research also indicate that future editions of the CBT-T manual should include

clearer guidance on how to address the areas of emotion work and imagery rescripting within the 10-session delivery. Research has indicated that clinicians' views on manualised treatment improve with protocol amendments made in accordance with their feedback (Stith et al., 2002; Taylor et al., 2011), so making these changes may also contribute to further enhancement of clinicians' overall experiences of delivering CBT-T. It would be of benefit to re-investigate clinicians' experiences of CBT-T after these changes have been made as a way of evaluating the impact with respect to both clinician experiences and the effects on their delivery of CBT-T.

A strength of the current research is that this is the first study to investigate clinicians' experiences of delivering CBT-T, complimenting the earlier research on patients' experiences of receiving this form of therapy. However, it is worthwhile noting some of the limitations of this research. The recruitment method could have introduced a source of bias in that those who were well disposed towards CBT-T were more likely to volunteer for this research, possibly influencing the positive experiences reported. Likewise, the age and relative inexperience of some of the participants, both with delivering therapeutic interventions and CBT-T specifically, may have also influenced the findings. Finally, although this research focused specifically on the delivery of CBT-T, it may be possible that some of the findings are more generally applicable to therapeutic interventions as a whole.

In conclusion, the current research found clinicians report largely positive experiences of delivering CBT-T, with a number of components identified to contribute to this. This mirrors previous findings on patient experiences of this treatment, indicating that CBT-T is seen as an acceptable treatment by both clinicians and patients. There are areas of CBT-T that clinicians report feeling less clear about and confident in delivering, namely imagery rescripting and emotion work, which may affect the quality of treatment delivery (Bartle-Haring et al., 2022; Seewald & Rief, 2023). The current research suggests that the ongoing development of CBT-T should incorporate additional information about and support for clinicians in these areas to allow them to maximally and confidently deliver all elements of this intervention, enhancing treatment delivery and allowing patients the best possible chance to recover from their eating disorder.

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Chapter Five: Additional Methodology

The aim of this chapter is to provide some additional context to the methodology and analysis of the empirical research project in Chapter Four. In the first instance, consideration is given to the ontological and epistemological position of the researcher, before providing further information about recruitment and ethical considerations. An explanation is then given as to how reflexivity was addressed, ending with a detailed outline of the analysis process.

Ontological and Epistemological Positioning

Qualitative research is underpinned by ontological and epistemological assumptions. Ontology refers to whether or not there is an objective truth or reality that exists separately from human understanding. This can be thought of as a continuum ranging from realism on one end to relativism on the other, with critical realism sitting between the two. Realism is an approach usually associated with quantitative research, assuming that there is an objective truth which we are able to discover through research and experience. Relativism, on the other hand, is the view that there are multiple constructed realities and that everyone has their own representation or account of what reality is. Critical realism distinguishes between two truths: the real and the observable. It shares similarities to realism in that it assumes an objective truth exists, however argues that this exists independent of human observation and cannot be observed. Rather, the way that reality is experienced and interpreted is shaped by our own perspectives and experiences.

Epistemology refers to how knowledge is acquired and evaluated. As with ontology, epistemology can also be thought of as a continuum from positivism to constructionism, with contextualism in between. Positivist epistemological positioning, generally associated with quantitative research, argues that there is a world that exists independently from our ways of knowing it, and that it is possible to discover truths about the world. On the contrary, constructionist positioning views knowledge as being subjective, and sees it as being constructed from human experience. It is believed, therefore, that there are multiple interpretations of any one situation. Sitting between positivism and constructionism is contextualism, which is comparable to critical realism. This approach posits that knowledge emerges from context and reflects the position of the researcher (Madill et al., 2000). Knowledge, therefore, is understood to be context-sensitive.

The current research is underpinned by a critical realist ontology and contextualist epistemology. In line with this, it is assumed that there are objective

realities about clinicians' experiences of delivering CBT-T, however that these realities are historically, socially and culturally situated. Furthermore, whilst there is believed to be an objective truth about these experiences, this truth is not observable and is experienced through a subjective perception.

Recruitment

It was planned that participants would be recruited from four National Health Service (NHS) eating disorder services which were known to have large numbers of clinicians delivering CBT-T. However, despite initial interest in this research from these services, only six people came forward to take part. Given the recruitment difficulties, it was decided that the study recruitment strategy would be extended to also include social media advertisement. This method was successful in recruiting a further seven participants.

Ethical Considerations

This study was designed in line with British Psychological Society's (BPS) Code of Ethics and Conduct (2021) and Code of Human Research Ethics (2021), and The Data Protection Act (2018) guidelines regarding General Data Protection Regulations (GDPR). Ethical considerations are detailed below.

Ethical Approval

Ethical approval was initially received from the University of East Anglia's (UEA) Faculty of Medicine and Health Sciences (FMH) Research Ethics Committee in December 2022 (Ref: ETH2223-0245; Appendix J) and the Health Research Authority (HRA; Project ID: 321360; Appendix K) in April 2023. Due to difficulties with recruitment, an amendment was submitted to the FMH Research Ethics Committee in August 2023 to extend study recruitment to social media advertising (Ref: ETH2324-0074). This request was approved (Appendix R).

The UEA Research and Innovation Services (RIN) acted as the UEA sponsor for this research. Upon receipt of ethical approval from both the FMH Research Ethics Committee and the HRA, the Research and Development (R&D) departments of the NHS teams who had given an agreement in principle to be a research site were emailed a Localised Information Pack, and were asked to confirm Capacity and Capability (C&C). The Localised Information Pack was comprised of the study information sheet, participant consent form, thesis protocol, a protocol diagram, Schedule of Events, and an Organisation Information Document (OID), with the OID forming the agreement between the sponsor and each NHS service. Confirmation of C&C and the signed OID from each of the R&D departments were forwarded to RIN,

who then gave the green light to proceed with recruitment. No research took place until the green light had been received.

Coercion

It was made clear to participants both in the participant information sheet and prior to the interview commencing that taking part in this research was entirely voluntary. Although it has been argued historically that offering participants financial recompense can be seen as a form of coercion (Macklin, 1989), Wertheimer & Miller (2008) have since analysed the concept of coercion, concluding that participant payment is not coercion as it is an offer and not a threat. It was felt that offering participants a gift voucher as a token of appreciation for participating in this research was justified as participation involved participants giving up their own time to attend an interview. It was, therefore, important and appropriate to show gratitude for them having done this.

Confidentiality

It was detailed in the participant information sheet and debrief form that participants could withdraw their data up until data analysis had commenced. Participants were asked to create an identifier based on the date of their birthday and the last three digits of their mobile number to allow identification of their transcript and demographic information should they wish to withdraw their data at a later date. Any personally identifying information was removed from transcripts to preserve participant anonymity. Participant contact details were deleted once data analysis commenced.

All study data was stored on OneDrive, with all documents password protected. Only the researcher and supervisory panel had access to this data. Data will be stored for at least 10 years as per UEA's Research Data Management Policy. In line with this policy, data will be uploaded to the UEA Research Data Repository upon study closure. Participants were informed of this information in the participant information sheet.

Consent

Individuals who responded to the study advertisement expressing an interest in participating in the research were emailed an information sheet and consent form. They were asked to read the information sheet and electronically sign and return the consent form if they had no further questions and agreed to participating. No data collection took place until a signed consent form had been received. As part of the introduction section of the topic guide, it was confirmed with each participant that they were happy to proceed with the interview.

Debriefing

Participants received a debrief form following their interview. This thanked them for their participation and echoed the information detailed in the information sheet about how their data would be kept confidential, the timescales for data withdrawal, and what would happen with their data. Participants were given the option of receiving a summary of the outcome of the research once data had been analysed and written up. The debrief form advised participants to make contact with the research team if they had any further questions. The debrief form contained signposting to relevant organisations should this be required, as the topic of the interview questions had the potential to cause some distress to participants given the nature of the therapy that they were describing.

Distress

Given the nature of the therapy that was being asked about, alongside the complexities and emotiveness of working with an eating disorder patient group, there was the possibility that participants may feel some distress during the interviews. It was planned that if a participant exhibited any signs of distress during the interview process then the interview would be paused, the distress acknowledged, and the participant would be asked if they wanted to take a break or stop, being reminded of their right to withdraw. The interview would be resumed accordingly, with the interviewer making frequent checks on participant wellbeing throughout the remainder of the interview. If a participant was to decline taking a break or terminating the interview, but was to continue to show significant signs of distress, then a decision would be made by the interviewer as to whether the interview should be terminated. This decision would be sensitively communicated to participants. During the research there were no participants who exhibited any signs of distress, and, therefore, no interviews required termination.

Reflexivity

It was important to acknowledge the researcher position throughout the research process and consider the influence of this on both the development of the research and on analysis. This was particularly important because I have previously been a clinician delivering CBT-T, and so I have my own experiences of what it is like to deliver this therapy. It was important that I ensured that I held a conscious awareness of this and continuously reflected on how this influenced how I approached all stages of the research to keep this “an acknowledged part of the research process” (Ortlipp, 2008, p. 695). To aid with this, I wrote a reflective piece about my own experiences of delivering CBT-T prior to conducting this research

(Appendix S). Use of a reflective journal (see Appendix T for examples of journal entries), regular attendance to a qualitative research forum, and research supervision also supported with this.

Thematic Analysis

Thematic analysis is a six-step process of data analysis for "developing, analysing and interpreting patterns across a qualitative dataset, which involves systematic processes of data coding to develop themes" (Braun & Clarke, 2022, p.4). Reflexive thematic analysis (Braun & Clarke, 2019) is one form of thematic analysis, emphasising the importance of critical reflection on being a researcher. This was felt to be especially important in this research given my own experiences of delivering CBT-T and the impact of this upon the research. This type of analysis also aligns with the ontological and epistemological underpinnings of the research. Each of the six stages of analysis will be considered in turn.

1. Familiarisation with the data:

Whilst a researcher transcribing their interviews is generally encouraged in qualitative research, thesis timescales meant that it was not possible for me to transcribe the interviews myself. Instead, a live transcription service was used to transcribe each interview as it took place. It could be argued that this could affect my ability to both immerse myself in and critically engage with the data, however I ensured that I really took the time to consider how I could limit the impact of not having completed the transcriptions myself. Following each interview, I listened back to the interview recording. I then listened back to the interview again alongside reading the transcript, amending any inaccuracies in the transcript whilst doing this. I then listened to the interviews and re-read transcripts again, including reading them aloud, before commencing coding. Familiarisation notes were made to critically engage with the transcripts to help begin to make sense of some of the initial ideas that were arising for me.

2. Coding:

Once I felt suitably familiar with my data, I printed copies of the interview transcripts and began coding these. Whilst I am aware that there is computer software available that aids with this, I personally find having things printed helps me to engage with them much more than reading from a screen. An inductive approach was taken to coding; this is where use of a reflective journal was

particularly useful because it enabled me to be mindful of the impact of my own CBT-T experiences. Some clear repetitions of codes arose, albeit phrased slightly differently. Examples of the interview transcript coding are presented in Appendix U.

3. Developing initial themes:

As I was coding the interview transcripts, some initial themes began to become clear from the data, which I continued to note within my reflective diary. There was a general sense that participants have had a positive experience of delivering CBT-T, however I also noticed that there are some clear aspects of CBT-T which were more difficult. To aid with the development of themes, I printed off each code. This enabled me to think more about the connections between codes and explore some possible clusters of meaning. This helped to form some initial ideas about possible themes and subthemes, for further refinement at stage four.

4. Reviewing themes:

I spent time reviewing the themes and subthemes that I had identified independently, before taking these to research supervision for discussion. These were also reviewed further through email correspondence with my research supervisor. At this point we began to consider potential theme names and think about the links between themes and subthemes.

5. Defining and naming themes:

During this fifth stage, I continued to revise the theme and subtheme names and drafted my theme definitions, which I continued to amend until I was happy that these definitions captured the essence of each theme. I then focused specifically on trying to finalise my theme names. This took some time as I was conscious of trying to ensure that the names accurately described the theme in a

clear but engaging way. I gave a lot of consideration to using quotes to create theme titles, however I struggled to find a quote for each that I felt really clearly reflected the scope of the theme. I found that I got quite caught up in trying to find the 'perfect' names for my themes, so in the end I decided to take a step back and began to write up the report using provisional theme names. I later came back to finalising these after a period of time away from being so immersed in the process, and having had further discussion with my research supervisor.

6. Writing the report:

The final stage of the analysis was writing up the results of my thematic analysis. Having had no experience of writing up the results section of a qualitative analysis previously, I found this difficult as it was something completely new to me. I was very aware that I had the same word limit for my chosen journal for this project as I would if I was writing up a quantitative research project, which at times felt constraining as it felt that there was a lot to say about my findings in a very limited number of words. I was mindful that I wanted to include as many quotes as possible to evidence my themes to aid with ensuring trustworthiness of my research. However, ultimately I had to reduce the number of quotes I included due to the word limit constraints. Reading through examples of published thematic analyses helped to reassure me that it was not necessary to give multiple quotes essentially saying the same thing, and that one or two quotes to illustrate a point would be adequate. I was conscious to ensure that quotes were used from all participants to ensure that all of their voices were included.

To aid with writing the discussion section of the report, I took each of the subthemes in turn and considered how these could be linked to existing literature, the implications of the findings, and limitations of the research. This enabled me to identify which points felt most important to cover within the discussion of the report and which may need further explanation in the discussion chapter of the thesis. Drafts of the report were read by members of my supervisory team, and the report was edited and amended on the basis of comments made and subsequent discussions in research supervision.

Chapter Six: Discussion and Critical Evaluation

This chapter aims to discuss and critically evaluate the systematic review and meta-analysis presented in Chapter Two and the empirical project presented in Chapter Four. The chapter opens with a summary of findings, and is followed by an evaluation of the strengths and limitations of the Thesis Portfolio. Practical and research implications are discussed, with recommendations for future directions outlined. The chapter ends with an overall conclusion of the Thesis Portfolio.

Summary of Findings

Systematic Review and Meta-Analysis

The systematic review and meta-analysis aimed to provide an estimate of attrition rate from cognitive behaviour therapy for eating disorders (CBT-ED) in routine clinical settings, finding the overall attrition rate from CBT-ED to be 31.22% (95% CI = 7.51-62.17%). Eating disorder severity, as measured by the Eating Disorder Examination Questionnaire (EDE-Q; Fairburn & Beglin, 2008) global score was found to significantly moderate attrition, with a higher pre-treatment EDE-Q global score associated with higher rates of attrition.

When considering attrition rate by eating disorder diagnosis, attrition was found to be highest for OSFED at 45.14% (95% CI = 38.87–51.48%) and lowest for binge eating disorder at 13.52% (95% CI = 3.57–28.47%). Attrition was also found to vary by CBT-ED type, finding the attrition rate for CBT-E to be the highest at 38.68% (95% CI = 12.16–69.54%) and lowest for CBT-based guided self-help at 28.71% (95% CI = 6.17–59.40%). Eating disorder severity was found to moderate attrition rates in anorexia nervosa and transdiagnostic samples, with higher pre-treatment EDE-Q global score associated with increased attrition. Eating disorder severity was also found to be associated with increased likelihood of attrition in all CBT-ED types. Similarly, age was found to be a significant moderator of attrition, with lower age associated with increased attrition in anorexia nervosa samples and higher age associated with increased attrition in transdiagnostic samples. Lower age was also associated with increased attrition in CBT-E, with higher age associated with increased attrition in CBT-T and CBT-based guided self-help.

Empirical Research Project

The empirical project aimed to investigate clinicians' experiences of delivering CBT-T, using thematic analysis to analyse interview transcripts. Three themes and

10 subthemes were identified. The first theme was positive experiences of CBT-T delivery, capturing the largely positive experience that participants described delivering CBT-T to be. The four subthemes within this theme were: enjoyable to deliver, strong therapeutic alliance, the treatment protocol, and a good experience for patients. The second theme was changing experience over time. The two subthemes within this theme were: reduced anxiety and increased confidence, and belief in model. The final theme was challenges in delivery. The four subthemes within this theme were: better fit for some patients than others, areas requiring additional support, terminating treatment, and treatment infidelity.

Strengths and Limitations of the Systematic Review and Meta-Analysis

A strength of the systematic review and meta-analysis is that it is the first to provide an estimate of attrition rates from CBT-ED in routine clinical settings, complimenting a previous systematic review and meta-analysis by Linardon et al., (2018) who investigated attrition rate from CBT-ED in randomised controlled trials.

In addition to the review being registered with the International Prospective Register of Systematic Reviews (PROSPERO), a review protocol was written before the review was carried out, with a clear rationale provided for any amendments that were made as the review progressed. This ensured full transparency of the review process. It is important to note that there was considerable between study heterogeneity ($I^2 = 90.22\%$), however attempts were made to address this through the use of a random-effects meta-analysis and leave-one-out sensitivity analyses.

It is typically recommended that there are at least two independent reviewers when carrying out a systematic review. However, due to the associated timescales of this review being conducted as part of the Thesis Portfolio, it was not possible to have two independent reviewers completing the screening at title and abstract level or full-text level. A second reviewer did screen a proportion of the studies included in the review to confirm their eligibility, however study exclusion was carried out by a single reviewer. Therefore, this means that there was an increased risk of imprecision, error, and bias in the screening.

It should be acknowledged that of the 56 studies included, just under 70% took place in Europe. This presents the risk of there being a Eurocentric bias within the review. The inclusion criteria of studies being available in the English language may also have contributed to biases, with research from Egger et al., (1997) finding that authors are more likely to publish research findings in an English-language journal if the results are statistically significant. This can then lead to an overestimate of

effects, biasing results. However, there was only one study excluded from screening due to not being available in English.

The Joanna Briggs Institute (JBI) quality assessment tools used for the quality assessment of the studies included within the review were chosen as these tools are very widely used in the critical appraisal of research. Nevertheless, these tools have some weaknesses. The guidance given for using these quality assessment tools is relatively ambiguous and open to the interpretation of each rater. This may, therefore, have impacted on the reliability of the quality ratings given. Furthermore, although it was possible to give many of the included studies points for meeting particular quality criteria, there was extensive variation in the extent to which each of these studies met criterion. This variation was not taken into account within the overall quality ratings, which may have led to an overestimation of study quality for some of the studies included in this review. These tools also do not acknowledge factors such as sample size or power, which can be important considerations when assessing research quality.

Strengths and Limitations of the Empirical Research Project

The empirical research project is the first study to investigate clinicians' experiences of delivering CBT-T, complimenting previous research into patients' experiences of this treatment (Hoskins et al., 2019).

Lincoln & Guba (1985) argue that the trustworthiness of qualitative research plays a crucial role in evaluation of its quality. Lincoln & Guba's (1985) evaluative criteria were used to aid the trustworthiness and methodological rigour of this research. This provides four criteria for assessment of trustworthiness: credibility, transferability, dependability, and confirmability. The credibility of research relates to the extent to which the findings and judgements made by the researcher can be trusted. To aid with the credibility of this research, regular research supervision throughout the course of the project enabled the opportunity for peer debriefing. The use of a reflective journal allowed for consideration of reflexivity, with a reflective piece written prior to carrying out the research regarding my own experiences of delivering CBT-T. In addition to this, multiple quotations were used from participants to evidence each of the themes identified. Participants were given the opportunity to review their interview transcripts prior to analysis, although none of the participants took-up this offer. Transferability refers to the extent to which research findings can be applied to other settings and contexts. Transferability was demonstrated in this research by giving detailed information about participant demographic information and the research process. Clear descriptive information was provided about the

research context, such as the method of sampling and inclusion/exclusion criteria, with supplementary information, such as the topic guide, provided in the appendices. This allows others reading the research to assess whether the findings are transferable to their own settings. Dependability is associated with research findings being consistent if the research was repeated with the same methods and participants. To aid with this, a clear and detailed description was provided of the entire research process, from recruitment to analysis, to enable replication. Confirmability relates to ensuring that research findings are derived from the data and not from the views of the researcher. Researcher understanding of participant responses was checked throughout each interview, as evidenced in interview transcripts. This was to ensure an accurate understanding of participant responses to reduce the risk of researcher views clouding the analysis. Reflective diary entries were made immediately after interviews, relating to any personal feelings and insights about the interview. The steps made to address credibility, transferability and dependability all contributed to the overall confirmability of the research.

The participant recruitment method is a potential limitation of the research as this could have led to a volunteer bias where those well disposed towards CBT-T were more likely to sign-up to participate. This may have, therefore, influenced the positive experiences reported, as those with a less favourable view of CBT-T may have been less inclined to take part. Furthermore, the age and relative inexperience of participants may have influenced findings. Forbat et al., (2015) have previously found that clinicians views on manualised treatment can be affected by their age and duration of clinical experience, with Addis & Krasnow (2000) finding a relationship between less experienced clinicians and more positive attitudes towards treatment manuals. Furthermore, one of the interview questions asked participants about their experiences of delivering CBT-T in comparison with their experiences of delivering other therapies. Many of the participants were unable to answer this question as CBT-T was their only experience of delivering therapy. This hindered the exploration of clinicians' experiences of delivering CBT-T in comparison to other therapies.

Although this research focused specifically on the delivery of CBT-T, it is possible that some of the findings, particularly theme two ('changing experience over time'), are applicable to other therapeutic interventions. This theme and the associated subthemes captured the way that clinicians described their experiences of delivering CBT-T as having changed over time. More specifically, this theme referred to their anxieties around delivering CBT-T having reduced, with improved confidence in delivering the treatment, and that their belief in the treatment model

has been enhanced from seeing its effectiveness. Neither of these findings are surprising and were perhaps to be expected, however it is important to consider that this may not be limited to the delivery of CBT-T and rather it could be argued that this would be the case for most clinicians when delivering any psychological intervention. This can also be said for some of the subthemes within the third theme ('challenges in delivery'), specifically with regards to participants feeling that treatment suits some patients better than others and there being parts of treatment that clinicians feel less confident with delivering.

Practice Implications

The findings of the systematic review and meta-analysis have important clinical implications in regard to patient age, specifically for those with anorexia nervosa. Younger age was associated with increased attrition rate in those with anorexia nervosa, suggesting that consideration should be given to age at presentation when allocating treatment plans to younger patients. It is widely accepted in research literature that the brain does not reach full development until around the age of 25 years old (Anokhin et al., 1996; Arain et al., 2013). Furthermore, impaired cognition is a commonly reported symptom in those with anorexia nervosa, resulting from malnutrition as a consequence of insufficient dietary intake (Cholet et al., 2021; Green et al., 1996; Zakzanis et al., 2010). CBT is a relatively cognitively-demanding treatment and it could be argued that for younger patients with anorexia nervosa, the combination of incomplete brain development and the impaired cognition as a result of their eating disorder might make it more difficult for them to engage with this. An assumption on the basis of the findings regarding age and attrition rate from CBT-ED for those with anorexia nervosa is that they will be less likely to go on to complete a full course of treatment. CBT is one of three first-line treatments for anorexia nervosa recommended by NICE guidelines, with the Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA) and Specialist Supportive Clinical Management (SSCM) also being identified as recommended evidence-based treatments for this eating disorder. It may be that younger patients are better suited to these treatments and perhaps should be offered these as a first-line treatment rather than CBT. However, currently there does not appear to be any published work specifically examining attrition rate from either MANTRA or SSCM. Therefore, further work is required to investigate this further to provide support for and strengthen this recommendation.

There were some a priori questions identified for the systematic review and meta-analysis which it was not possible to answer. The question aiming to explore

whether treatment modality (i.e. in-person or online treatment delivery) moderated attrition rates could not be answered due to a lack of reporting of treatment modality in the studies included in the systematic review and meta-analysis. Prior to the COVID-19 pandemic, most eating disorder treatment took place face-to-face, however over the past four years there has been an increase in the use of online treatment delivery. This means that it is not reliable to assume that treatment took place in-person without this being stated explicitly. Only three studies included within the review stated treatment modality, accounting for why this variable could not be explored as a potential moderator of attrition, and highlighting how infrequently treatment modality is reported in research. As we continue to move forward in a world where both in-person and online treatment have become the norm, future research needs to make a clear statement about treatment modality. This would enable investigation of any differences in outcomes in the way treatment was delivered. The same can also be said for treatment delivery, referring to whether treatment was delivered on a one-to-one basis or as a group. Post-hoc consideration of whether this could be a potential moderator of attrition could not be taken further, again due to this often not being reported. Therefore, future research also needs to be clear about the method of treatment delivery used to allow for investigation of whether this may affect attrition rates.

Furthermore, it was also not possible to answer the question aiming to explore whether definition of attrition moderated attrition rates due to the high levels of variability between definitions. The need for a development of a standard definition of attrition (and drop-out) has been argued in previous research (Bağrıacık Yılmaz & Karataş, 2022; Fredum et al., 2021; Hoskins et al., 2019; Karekla et al., 2019; Kullgard et al., 2022; O'Keeffe et al., 2019), with the current review highlighting that there is an ongoing need for these definitions. These standard definitions would facilitate consistency in the reporting of this information to allow more reliable and consistent interpretation of findings.

It is important to consider that eating disorder severity was found to significantly moderate attrition rate, with higher eating disorder severity associated with increased levels of attrition. Based upon the assumption that an individual's eating disorder may be least severe in its very early stages, this finding adds to the ever-expanding evidence-base arguing the importance of early intervention. Research has highlighted the importance of early intervention in eating disorder treatment for many years (Rodgers & Paxton, 2014; Treasure & Russell, 2011), however only in very recent years have service models specifically focused on providing this been introduced, such as the First Episode Rapid Early Intervention for Eating Disorders

model (FREED; Allen et al., 2020, 2023). Assuming that an eating disorder may be at its least severe when it is in its early stages, it could be argued that this review highlights the importance of these services and the ongoing need for early intervention for those with eating disorders. Ultimately, this may give individuals the best chance of remaining in and subsequently completing treatment, with better treatment outcomes and improved recovery rates.

Participants within the empirical research project clearly identified that they felt that they need additional training and support with regards to delivering the emotion work and imagery rescripting aspects of CBT-T. The CBT-T manual outlines two themes and five tasks for the emotion work phase of treatment. These two themes are identification and management of emotional triggers, and addressing the core beliefs that trigger emotions resulting in eating behaviours. The five tasks of this phase of treatment are identifying the need to address emotional and cognitive triggers, identifying emotional and cognitive triggers, use of exposure to the emotion and delaying the use of behaviours, use of DBT-based techniques for reducing emotional reactivity, and addressing core beliefs to reduce emotional triggering of behaviours. Imagery rescripting is outlined as an intervention that can be used within the emotion phase of treatment, but also within the body image stage of treatment for rescripting of unpleasant past experiences relating to body image. A bullet point list is provided in the manual outlining how to use imagery rescripting.

There was a consensus amongst participants that the emotion work and imagery rescripting components of CBT-T are insufficiently covered within training or the treatment manual, with participants suggesting that if they had a better understanding of these areas and how to address them then they would be more likely to explore these areas with patients. On the basis of this, one of the key practice implications of the current research is that consideration needs to be given as to how the CBT-T training and treatment manual can be adapted to support clinicians with the delivery of these parts of treatment. This would ensure that both areas are addressed fully and consistently. Future editions of the CBT-T manual should include clearer and more detailed guidance on how to address and deliver these parts of treatment, and CBT-T training should cover these areas more explicitly. This would also allow further examination of whether these are potent and effective elements of CBT-T. Previous research indicates that role play enhances learning and understanding (Flaherty, 2023; Issac Gibbs, 2019), suggesting that this may be a helpful addition to CBT-T training to aid with improving clinician understanding of how to introduce and use these interventions when delivering CBT-T. Previous research from Stith et al., (2002) and Taylor et al., (2011) has

found that clinicians' views on manualised treatment improve with protocol amendments made in accordance with their feedback. With this in mind, amendments made to the CBT-T training and treatment manual based on clinician comments may contribute to further enhancement of clinicians' overall experiences of delivering CBT-T.

There are two opposing viewpoints regarding the importance of the therapeutic alliance within clinical practice. One side of this argument views that it is essential for clinicians and patients to build a therapeutic alliance in order for change to occur (Baier et al., 2020; Beck, 1979). Conversely, others argue that the therapeutic alliance develops as a result of early change and patients seeing that treatment works (Tang et al., 2007; Waller et al., 2012). CBT-T aligns with the latter, with the treatment manual clearly stipulating that there should not be a focus on developing a therapeutic alliance at the cost of progressing with therapy tasks. Change is emphasised from session one, with there being no time specifically allocated to building a therapeutic alliance. Previous research into patients' experiences of CBT-T by Hoskins et al., (2019) found that patients rated the therapeutic alliance in CBT-T to be high, with the current study demonstrating that clinicians' perspectives on this are complimentary. This has implications with regards to the theory underlying the development and importance of the therapeutic alliance in facilitating change, and how this is applied in clinical practice. This finding indicates that it is still possible to build a good therapeutic alliance without allocating specific time to this, suggesting some support for the argument that it is not necessary to dedicate time to building a therapeutic alliance. Therefore, consideration needs to be made by clinicians when they are delivering psychological therapy and allocate time specifically to building a therapeutic alliance, as the overlap between patient and clinician experiences of the therapeutic alliance in CBT-T suggests that this may not be necessary.

Research Implications and Future Directions

The systematic review and meta-analysis highlighted that the attrition rate from CBT-ED is high, particularly in comparison to attrition rates from CBT for other mental health disorders. However, what continues to remain unclear is why this is the case. There have been some attempts made to try and understand the reasons behind the long-reported high rates of attrition in CBT-ED (Clinton, 1996; Fassino et al., 2009; Steel et al., 2000; Vinchenzo et al., 2022), however, despite this, no definitive conclusions have been drawn. Previous research has identified the influence of patient experiences on treatment retention in physical health settings

(Navarro et al., 2021; Prakash, 2010; Prang et al., 2019), emphasising the importance of understanding how patients experience treatment. However, although CBT has been used in eating disorder treatment for over 40 years, there is minimal research investigating how patients experience this treatment (Cowdrey & Waller, 2015; de la Rie et al., 2008; Hoskins et al., 2019). Given that previous research has identified a link between patient experiences and treatment retention, further research is needed to investigate the potential association between how patients experience treatment and attrition rate. It would be particularly helpful to specifically explore the experiences of those who have commenced but not completed CBT-ED to provide insight into their reasons for non-completion of treatment. This would enable the development of a better understanding of possible reasons for treatment attrition, aiding with subsequent consideration of what might be helpful to improve engagement with treatment and reduce attrition. This is particularly important when considering the ego-syntonic nature of eating disorder symptoms, which can hinder engagement with treatment and motivation for recovery (Gregertsen et al., 2019), and the psychological and physical impacts of eating disorders which may make it more difficult for patients to engage with and remain in treatment (Guarda, 2008; Keeler et al., 2022).

There are additional factors which have been identified in previous research to be potential moderators of attrition in eating disorder treatment that have not been considered within this review. Motivation for treatment (Gómez Del Barrio et al., 2019; Merrill et al., 1987; Ter Huurne et al., 2017; Vandereycken & Devidt, 2010), the presence of a comorbid mental health problem (Brachel et al., 2014; Pham-Scottez et al., 2012; Schnicker et al., 2013; Simpson et al., 2022), binge-purge subtype of anorexia nervosa (Abd Elbaky et al., 2014; Fassino et al., 2009; Kahn & Pike, 2001) and illness duration (Abd Elbaky et al., 2014; Jordan et al., 2014; Pham-Scottez et al., 2012) have all been previously identified to be significantly related to attrition. It was not within the scope of the review to consider all possible moderators of attrition, however a direction for future research would be for further reviews to be carried out which consider these other factors associated with treatment attrition in eating disorders, and provide an estimate of their effects on attrition. This would provide additional information about how these may affect attrition rates and help to aid with the ongoing identification of those who might be most at risk of not completing treatment.

As previously discussed, there is a possibility that the age and relative inexperience of the clinicians that took part in the empirical research project may have biased findings in a positive direction. Therefore, it may be helpful to extend

this research to focus more specifically on qualified clinicians' experiences of delivering CBT-T in comparison with other forms of intervention to address this limitation of the current research. This would enable comparison of the experiences of clinicians to see if the experience of delivering CBT-T varies depending on level of clinical experience and exposure to using a wider range of therapeutic interventions.

The identification of the subtheme of 'treatment infidelity' highlights that clinicians are not always delivering CBT-T in line with the treatment protocol. Therapist drift is reported to be extremely common in psychological treatments (Waller, 2009; Waller & Turner, 2016), so it was perhaps to be expected that this would also be found to be the case in the current research. However, the key implication of this is that patients subsequently receive treatment that is not aligned with the evidence-base, which ultimately can impact treatment outcomes and result in patients receiving sub-optimal treatment. This may be particularly pertinent to the two aspects of CBT-T (emotion work and imagery rescripting) where the participants in the current research felt the protocol was underspecified and additional training was required. It has been identified in previous research that there can be a number of different reasons for therapist drift including clinical experience (Aarons, 2004; Beidas et al., 2014; Sijercic et al., 2020), , therapist knowledge (Aarons et al., 2012; Becker-Haimes et al., 2019; Sars & van Minnen, 2015), therapist age (Mulkens et al., 2018; Wallace & von Ranson, 2012; Wisniewski et al., 2018), therapist anxiety (Daglish & Waller, 2019; Hernandez Hernandez & Waller, 2021; Moritz et al., 2019), and theoretical orientation (R. de Jong et al., 2020; Garcia et al., 2020; Nelson & Steele, 2008). Although the current research found that clinicians were not consistently adhering to the CBT-T treatment protocol, reasons why this is the case were not explored. Future research is needed to identify and understand why it is that clinicians do not adhere to the treatment protocol, which would enable the development of any additional guidance or support around CBT-T to improve clinician treatment fidelity.

If the recommended additions and amendments to the CBT-T training and treatment protocol are implemented, it will be of benefit to re-investigate clinicians' experiences of delivering CBT-T. This will allow the impact of these changes to be evaluated both in regards to the overall delivery of treatment and clinician experiences of delivering treatment. This would support ongoing refinement of the CBT-T training and treatment protocol to ensure that clinicians feel competent to deliver all aspects of CBT-T, which, in turn, may lead to improved treatment outcomes and manual fidelity. This will also facilitate research into whether the more

effective components of CBT-T are mainly the behavioural elements, or whether the cognitive elements, which are those clinicians identified feeling less confident with delivering at present, specifically add to the efficacy of CBT-T.

Overall Conclusion

This Thesis Portfolio aimed to explore CBT-ED, firstly in relation to attrition rates in routine clinical settings and secondly in relation to clinicians' experiences of delivering CBT-T, a 10-session manualised treatment for non-underweight eating disorders. A systematic review and meta-analysis was conducted to provide an estimate of attrition rates from CBT-ED, finding attrition rates to be high but to vary on factors such as diagnosis and CBT-ED type. In the empirical paper, semi-structured interviews, analysed using thematic analysis, were conducted to investigate clinicians' experiences of delivering CBT-T. This identified three themes and 10 subthemes describing clinicians' experiences of delivering CBT-T: positive experiences of CBT-T delivery, changing experience over time, and challenges in delivery.

This Thesis Portfolio provides a unique contribution to research and the field of Clinical Psychology as it is the first to provide an estimate of attrition from CBT-ED in routine clinical settings and to investigate clinicians' experiences of delivering a specific form of CBT-ED: CBT-T. The systematic review and meta-analysis also provides an insight into the factors which significantly moderate rates of attrition from CBT-ED. The empirical research project has highlighted elements of the CBT-T training and treatment protocol that are underspecified, leaving gaps in knowledge and of understanding of how these particular elements of treatment should be used and delivered. Ultimately this causes clinician uncertainty, impacting the overall experience of delivering CBT-T. This research also compliments the previous work that has been carried out into patient experiences of this treatment.

There are a number of practice implications identified from the findings of the Thesis Portfolio. These include, but are not limited to, patient age and consideration of appropriate treatment, the need for standardised definitions of attrition and drop-out, and changes to the CBT-T training and treatment manual. Research implications include working towards an understanding of why attrition rates from CBT-ED are so high, consideration of other potential moderators of treatment attrition, and developing a deeper understanding of clinician treatment manual infidelity in CBT-T. The consideration of both practical and research implications could enhance treatment delivery and overall experiences of CBT-ED, ensuring that patients receive evidence-based treatment and can be better supported to complete

treatment. This could help provide people with the best possible chance to go on to live a life free from their eating disorder.

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Appendices

List of Appendices

Appendix A

International Journal of Eating Disorders Author Guidelines

1. SUBMISSION AND PEER REVIEW PROCESS

Once the submission materials have been prepared in accordance with the Author Guidelines, manuscripts should be submitted online at: mc.manuscriptcentral.com/ijed.

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All scoping reviews must follow the PRISMA Guidelines for scoping reviews summarized in the Tricco et al. (2018) article entitled *"PRISMA extension for scoping reviews (PRISMA-ScR): checklist and explanation"* (Ann Intern Med.). Authors who choose this contribution type must include the 2020 PRISMA Flow Diagram in the manuscript and complete the PRISMA-ScR checklist upon submission of the manuscript. During the submission process, authors will be prompted to confirm they have followed the Scoping Review checklist in the submission form. The rationale for any unchecked items on the Scoping Review Checklist must be explicitly described in the accompanying Cover Letter.

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Spotlight – see checklist
This is a contribution type where authors propose an idea that may not yet have adequate empirical support or be ready for full empirical testing but holds great promise for advancing research of eating disorders. Authors are encouraged to write a piece that is bold, forward looking, and suggestive of new and exciting avenues for research and/or practice in the field. The manuscript should identify the specific knowledge gap and why filling the gap will advance research and practice in the field; it should delineate several concrete steps for addressing the gap.

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A Perspective expands upon the published research by offering additional context, interpretation, or suggestions regarding the potential application of the research for advancing science and practice in eating disorders. Perspective manuscripts may not merely summarize the published research, nor are they intended to primarily discuss the author's own work. Because the Original Research, Brief Report, or Systematic Review paper has already been peer reviewed, the Perspective manuscript should be viewed as an opportunity to develop the ideas and potential of the work reported, rather than a critique of the paper. Indeed, only submissions that add a new dimension to the published research will be considered suitable for publication.

Perspective articles should provide a personal viewpoint and, as such, authorship should be limited to one or two authors. We recognize various forms of expertise, including research expertise, clinical expertise, expertise by lived experience (e.g., individuals impacted by an eating disorder), policy expertise, or expertise in a scholarly field distinct from eating and weight disorders. When submitting a Perspective, authors are requested to specify in their Cover Letter their primary expertise as pertaining to the Perspective submission.

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If the study sample lacks diversity in demographic characteristics, particularly with populations typically underrepresented in eating disorders research (e.g., male participants, minoritized populations, etc.), this should be explained (unless self-evident, e.g., a study of obstetric complication in patients with eating disorders would not include male participants) and noted as a study limitation and an area for future research.

Authors should apply study relevant research reporting standards. A list of the most well-known guidelines is given here:

- Consolidated Standards of Reporting Trials (CONSORT)
- Standard Protocol Items: Recommendations for Interventional Trials (SPIRIT)
- Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA)
- PRISMA Protocols (PRISMA-P)
- STrengthening the Reporting of OBservational studies in Epidemiology (STROBE)
- Consolidated criteria for reporting qualitative research (COREQ)
- STARD 2015: An Updated List of Essential Items for Reporting Diagnostic Accuracy Studies
- TRIPOD: Transparent Reporting of a multivariable prediction model for Individual Prognosis Or Diagnosis
- Consolidated Health Economic Evaluation Reporting Standards (CHEERS)
- The EQUATOR Network: an author's one-stop-shop for writing and publishing high-impact health research
- FORCE11: Recommended reporting guidelines for life science resources
- ARRIVE (Animal Research: Reporting of In Vivo Experiments) guidelines
- Guidance for the Description of Animal Research in Scientific Publications
- The Gold Standard Publication Checklist
- Updated Guidance on the Reporting of Race and Ethnicity in Medical and Science Journals

Cross-Cultural Studies
If the work involves cross-cultural assessment or assessment in a new language or study population, authors should provide information about local literacy in the language of assessment, the validity of (or process for validating) a translation of an assessment. For inclusion of regional samples, a statement about the sample's representativeness of or distinction from the national sample is required.

Genetic Studies
For association studies, the IJED employs Methods guidelines published by the American Journal of Medical Genetics Part B: Neuropsychiatric Genetics. These guidelines recommend: minimum sample sizes; for positive findings, an adequately powered independent replication sample; adjustments for multiple comparisons; and reporting of effect size estimates. For more information, see Author Guidelines.

When referring to genetic material, the names of genes should be spelled out in full the first time they appear in the text, after which an italicized abbreviation can be substituted. Sequence variants should be described in the text and tables, using both DNA and designations whenever appropriate. Sequence variant nomenclature must follow the current Human Genome Variation Society (HGVS) guidelines (see varnomen.hgvs.org).

Intervention Studies
When submitting an intervention study manuscript, authors will be prompted to select whether the manuscript describes a) an Innovation or Implementation study; or b) a Comparative Treatment or Prevention Intervention trial.

In all cases, preregistration is encouraged but, unless otherwise noted, not required. Any presentation of post-hoc findings needs to be clearly justified and contextualized. The inclusion of qualitative feedback on the experience of patients and clients is encouraged.

Feasibility and Pilot Studies

Papers in this category demonstrate the potential of new interventions in the treatment for eating disorders. If randomization is not present, studies should meet the Template Intervention Description and Replication Checklist (TIDieR) standards. When randomization exists, studies should meet the CONSORT extension for randomization and feasibility studies.

Both feasibility and pilot studies describe studies undertaken in preparation for an RCT evaluating the effect of an intervention or therapy. Feasibility studies address whether the future trial can be done, should be done, and, if so, how, while pilot studies (that may or may not be randomized) can include feasibility and inform a future definitive RCT by analysing quantitative data. Feasibility and pilot studies can be combined into one submission, but both functions should be addressed adequately in that paper, with feasibility forming the primary aim. This requires a focus on information that addresses hypotheses about recruitment, acceptability, attrition, cost, accessibility, e.g., Can you recruit as many participants in the time allowed as your study proposes? Will the participants accept randomization? Will they comply with treatment protocols? Is the protocol for delivery of treatment well and clearly enough defined to promote fidelity? Will the participants accept the testing procedures? Can the testing procedures be completed in the time allowed? If these data are included in any subsequent study (e.g., an RCT), that fact should be explained transparently.

These can include single case experimental designs, where one or more cases are presented using visual or statistical methods to demonstrate the clinical impact of an intervention, based on at least an A-B design and session-by-session data. Such case reports should have heuristic value, and so need to be innovative and leading to stronger research. Such cases require a clear statement from the authors that the patient (or the patient's legal guardian) has given permission to publish the material anonymously. Case reports without such clinical outcome data and structured presentation of findings will not normally be considered.

It can also include innovative uncontrolled trials, using a case series to demonstrate the initial implementation of interventions, under uncontrolled conditions (e.g., a series of patients treated with a new therapy; a comparison of therapies for similar but not identical patients). Such case series should be placed in context (e.g., were the patients recruited as a true series, or were they selected from the available pool?) and supported with a CONSORT diagram or the appropriate procedural detail. Preregistration is encouraged but not required.

Finally, it can also include RCTs that are not designed to be adequately powered. Given the smaller numbers typically involved, we require that p values are not reported but rather an estimated between group effect size and its precision (such as 95% confidence interval). As outlined in "The role and interpretation of pilot studies in clinical research" by Leon, Davis and Kraemer (2011), generated effect sizes should not be used for power calculations for future RCTs as such estimates with small samples can be misleading.

Effectiveness Trials

This category requires evidence that an intervention has been compared to either a control or active condition and has been conducted and reported appropriately in conformity to the appropriate CONSORT checklist (http://www.consort-statement.org), particularly randomization of participants. This can include efficacy studies in highly controlled settings and effectiveness demonstrating the rolling out

of evidence from controlled trials to routine practice, other populations, etc. Differences relative to the original intervention should be outlined.

Pre-registration before enrollment of study participants is expected to ensure that the core aims and hypotheses are openly addressed. Exceptions may be made for cause upon request prior to manuscript submission. The preregistration number should be entered in the manuscript submission form and also be reported in the Method section. Examples of repositories include https://cos.io/prereg, https://www.clinicaltrials.gov, etc.

Studies attempting to replicate and extend prior findings are important and welcomed, whether or not they support the findings of prior studies.

Proof of concept and pilot studies are not required before an RCT can be published. However, such studies are accepted by IJED, as they form key steps in the development of ideas, grant proposals, etc. Proof of concept and pilot studies can be combined into one submission, but both functions should be addressed adequately in that paper, in such a case. The study description should conform to the CONSORT 2010 checklist of information that includes guidelines for reporting proof of concept or pilot study trials. See the CONSORT extensions for additional information (http://www.consort-statement.org/extensions).

Such trials require adequate sample size (demonstrated through the presentation of a power analysis) and state clear aims and hypotheses. Any anonymising (e.g., of researchers) and problems of de-anonymising should be clearly detailed. An appropriate follow-up period is required. Clear definitions of terms such as ‘attrition’, ‘remission’ and ‘recovery’ are required, and intervention protocols should be readily available to the reader. The study description should conform to the CONSORT 2010 checklist of information that must be included when reporting a randomized trial. Preregistration is required.

Reporting of intent-to-treat results is preferred unless a strong rationale for a different approach is provided, such as a large amount of missing data. Completer results can also be reported if this is considered to add important information. Results should include the mean and standard deviation of pre- and post-scores, within-group effect sizes with 95% confidence intervals, and pre- and post-score correlations (allowing within-subject effect sizes to be verified). Appropriate follow-up data are desirable.

Implementation Studies

Implementation focuses on the evaluation of an evidence-based intervention that can be widely adopted and maintained in real world settings. Implementation studies address outcomes described in the RE-AIM framework, notably reach or uptake of services, effectiveness, adoption, implementation and maintenance.

Implementation pays attention to the components of the implementation strategy, and contextual factors that support or hinder the achievement of impacts. Attention is paid to intervention transferability into different contexts, an important aspect of long-term implementation. Such reports typically include economic evaluations.

The Standards for Reporting Implementation Studies (StaRI) Statement should be used to guide the writing of such papers.

Qualitative Studies
Studies must delineate the approach (e.g., grounded theory, etc.) for the qualitative methodology used, and authors should identify the research paradigm (e.g., postpositivist, constructivist/interpretivist, etc.). Methodology, results, and the resulting discussion must be consistent with the chosen approach and paradigm. Studies using qualitative data must also include a statement about how sample size was determined (e.g., in relation to sampling saturation, etc.). Authors should refer to Table 1 in O'Brien et al. (2014) doi: 10.1097/ACM.0000000000000388.

3. AFTER ACCEPTANCE

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Table of contents entries should be submitted as 'Supplementary material for review' during the initial manuscript submission process.

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Nucleotide sequence data can be submitted in electronic form to any of the three major collaborative databases: DDBJ, EMBL, or GenBank. It is only necessary to submit to one database as data are exchanged between DDBJ, EMBL, and GenBank on a daily basis. The suggested wording for referring to accession-number information is: 'These sequence data have been submitted to the DDBJ/EMBL/GenBank databases under accession number U12345'. Addresses are as follows:

- DNA Data Bank of Japan (DDBJ): www.ddbj.nig.ac.jp
- EMBL Nucleotide Archive: ebi.ac.uk/ena
- GenBank: www.ncbi.nlm.nih.gov/genbank

Proteins sequence data should be submitted to either of the following repositories:

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Graphics that do not adhere to these guidelines will be recommended for revision or will not be accepted for publication.

Author Guidelines updated March 2022

Appendix B

PRISMA Protocol

Written in line with PRISMA-P 2015 statement.

Administrative information

Registration
In accordance with guidelines, this systematic review protocol will be registered with the International Prospective Register of Systematic Reviews (PROSPERO).

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Contributions
CH has produced this protocol and SC has provided comments and feedback. CH will be carrying out the title and abstract screening, full text screening, data extraction and quality ratings.

SC and AB will be providing supervision, support with data synthesis, and resolve any disagreements. GW will provide expert input.

All authors will read, provide feedback and approve the final manuscript.

Amendments
This protocol does not represent an amendment of a previously completed or published protocol.

Any important protocol amendments post-registration of this protocol will be recorded on PROSPERO. Amendments will be dated and accompanied by a description of the amendment made and the rationale for the amendment.

Support
There have been no sources of support, sponsorship or funding provided for this review. CH is a postgraduate research student (Doctorate in Clinical Psychology) at the University of East Anglia. SC and AB are academic staff at the University of East Anglia. GW is a member of the academic staff team at the University of Sheffield.

Introduction

Rationale

Linardon et al. (2018) conducted the first meta-analysis to provide an estimate of drop-out from CBT for eating disorders in randomised control trials. The overall drop-out rate from CBT for eating disorders was found to be 24%. A number of variables (diagnostic type, baseline symptom severity, study quality, drop-out definition and sample age) were investigated as potential moderators of drop-out estimate, however were not found to moderate the overall estimate of drop-out. Drop-out was found to be highest for studies delivering CBT through an online modality, and differences were found in drop-out between the types of CBT protocols that were delivered.

An identified limitation of the Linardon et al. (2018) meta-analysis is that drop-out estimates cannot be generalised to routine clinical practice because this analysis focused specifically on randomised control trials. Swift and Greenberg (2012) have previously found drop-out rates from psychotherapy to be higher in effectiveness studies than efficacy studies, and so therefore it may be expected that the drop-out rate from CBT for eating disorders in 'real world' settings is higher than the estimate provided by Linardon et al. Therefore, the present review aims to build upon this previous meta-analysis to specifically provide an estimate of drop-out rate in uncontrolled effectiveness study.

Objectives

The aim of this systematic review is to provide an estimate of the dropout rate from CBT for eating disorders in adults aged 16 and over under routine treatment conditions. To this end, the proposed systematic review will answer the following questions:

1. What is the attrition rate from CBT treatment for Anorexia Nervosa, Bulimia Nervosa, and Binge-Eating Disorder?
2. Is attrition rate moderated by the type of CBT that is delivered?
3. Is attrition rate moderated by CBT modality?
4. Is attrition rate from CBT moderated by eating disorder diagnosis?
5. Is attrition rate from CBT moderated by eating disorder severity?
6. Is the overall estimate of attrition rate moderated by the definition of attrition/drop-out/non-completion?

Amendments on 06/06/2023:
The lower age limit for inclusion has been reduced to 16 from 18. The initial lower age limit of 18 was set on the basis of the fact that UK adult eating disorder services treat individuals from the age of 18, with NICE guidelines recommending CBT as one of the main forms of adult eating disorders (with different treatments recommended for under 18s). However, abstract screening has indicated that in other countries adult services treat individuals from the age of 16. This may lead to papers potentially being excluded which would otherwise meet criteria for inclusion, which may risk biasing results. Therefore it was agreed that the lower age limit would be reduced to account for this.

Methods

Eligibility criteria

Studies will be selected according to the inclusion criteria outlined below:

1. Treatment seeking individuals aged 16 or above diagnosed with either Anorexia Nervosa, Bulimia Nervosa, Binge-Eating disorder, Other Specified

Feeding or Eating Disorder, or Eating Disorder Not Otherwise Specified who have received CBT as treatment for their eating disorder.
2. Identified literature must report the number of people (either as a figure or percentage) who dropped-out of treatment.
3. Only studies which are not randomised-controlled trials will be included in the review.
4. Only literature which is not a review article / secondary data analysis will be included in the review.
5. The literature search will be limited to the English language.
6. Treatment within a community setting.

There will be no restrictions by type of setting. Both published and unpublished literature will be included in the review.

Exclusion criteria:
1. Individuals aged below the age of 16.
2. Individuals who do not have a diagnosis of Anorexia Nervosa, Bulimia Nervosa, Binge-Eating Disorder, Other Specified Feeding or Eating Disorder, or who have a subthreshold diagnosis.
3. Individuals who have not received CBT as treatment for their eating disorder.
4. Number of people who dropped-out of treatment not reported.
5. Randomised controlled trials.
6. Article not written in English.
7. Review articles / secondary data analysis.
8. Inpatient treatment.
9. Individuals are not treatment-seeking.

Amendments on 06/06/2023:
1. The Lower age limit for inclusion has been reduced to 16 from 18. The initial lower age limit of 18 was set on the basis of the fact that UK adult eating disorder services treat individuals from the age of 18, with NICE guidelines recommending CBT as one of the main forms of adult eating disorders (with different treatments recommended for under 18s). However, abstract screening has indicated that in other countries adult services treat individuals from the age of 16. This may lead to papers potentially being excluded which would otherwise meet criteria for inclusion, which may risk biasing results. Therefore it was agreed that the lower age limit would be reduced to account for this.

2. Other Specified Feeding and Eating Disorders and Eating Disorder Not Otherwise Specified have been added to the inclusion criteria as these are eating disorder diagnoses within their own right and have significant overlap with the three diagnoses that had previously been identified for inclusion. Papers specifically stating 'subthreshold diagnosis' will be excluded as this statement alone is unclear in whether presentations would have met criteria for an atypical eating disorder (such as Other Specified Feeding or Eating Disorder / Eating Disorder Not Otherwise Specified).

3. Inpatient treatment has been added as an exclusion criteria as the number of papers reporting CBT for treatment of an eating disorder was underestimated initially. Those receiving CBT as an inpatient have less opportunity to drop out of treatment and there are differences between those being treated as an inpatient and those being treated within the community, creating additional heterogeneity.
Amendment on 01/08/2023 – Inclusion criteria amended to only include treatment-seeking individuals. Full-text screening has indicated that a number of papers which

specifically recruited participants for the purpose of the research. This could be a different sample to those actively seeking treatment for their eating disorder and therefore may affect the usefulness of overall findings if these papers are included within the review.

Information sources

Literature search strategies have been developed using medical subject headings (MeSH) and text words relating to the review topic. The search terms of previous reviews into treatment drop-out have been used to aid with this (Bevens et al., 2021; Gucciardi, 2008; Karekla et al., 2019), alongside support with clarifying search terms from a Librarian with expertise in systematic review searching. Searches will be performed from inception until the date that the search is performed. The literature search will be limited to the English language.

The following databases will be used to search for published literature:
Academic Search Ultimate
APA PsycInfo
CINAHL Ultimate
Complementary Index
MEDLINE Ultimate

Amendment on 26/04/2023 - CINAHL Complete changed to CINAHL Ultimate due to CINAHL Ultimate offering access to more literature.

The following databases will be used to search for grey literature:
Bielefeld Academic Search Engine (BASE)
Data Archiving and Networked Services (DANS)
EThOS
Library Hub Discover
ProQuest (Dissertations and Theses)

To ensure literature saturation, the reference lists of studies to be included in the review will also be checked.

Search strategy

(attrition OR dropout OR drop-out OR "drop out" OR "dropped out" OR response OR outcome OR "terminat*" OR non-complete* OR "did not complete" OR withdr?w)

AND (anorexi* OR bulimi* OR "binge eating disorder" OR "binge-eating disorder")

AND ("cognitive behavio* therapy" or cbt)

AND (audit OR “clinical setting” OR consecutive OR effectiveness OR efficacy OR evaluation OR implementation OR pragmatic OR real-world OR routine OR “service evaluation” OR uncontrolled)

Amendment on 26/04/2023 – efficacy added to search strategy after further piloting of the study selection process

Study records

Data obtained from the literature search will be exported to Microsoft Excel. Separate sheets will be created within the Microsoft Excel file for each stage of the systematic review to allow for the tracking of literature excluded from the review. Reasons for exclusion will be recorded.

Duplicate records will be removed. CH will screen the titles and abstracts obtained from the literature search against the identified inclusion criteria. Full text reports will be obtained for all titles that appear to meet the inclusion criteria or where there is uncertainty. Full texts will be screened to decide whether these meet inclusion criteria. A second reviewer will also be used to screen a randomised selection of 20% of the full text reports. Any disagreement will be resolved through discussion or consultation with SC or AB.

CH will extract the data from all included literature using a form created for the purpose of the systematic review. This will be piloted prior to use.

Each stage of the review will be detailed in a PRISMA diagram, mapping out the number of records identified, number of records included and excluded, and the reasons for any exclusions.

Data items

Data extraction will include the following variables:

1. Author information
2. Year of publication
3. Country where study took place
4. Study design
5. Number of participants
6. Age range and mean age of participants
7. Gender of participants (and number of each)
8. Eating disorder diagnosis
9. Comorbidities
10. Measure of eating disorder symptomatology used
11. If reported, mean baseline Eating Disorder Examination Questionnaire (EDE-Q) global score
12. If reported, mean baseline episodes of objective binge-eating episodes over the past 28 days
13. Number of participants who started treatment
14. Number of participants who completed treatment
15. Number of participants who dropped out of treatment
16. Number of participants who completed treatment
17. Mean number of treatment sessions attended by those who dropped out of treatment
18. Definition of drop-out
19. CBT treatment type (e.g. CBT-E, CBT-T, CBT-BN)
20. Modality (in person or online treatment)

Amendment on 26/09/2023 – Removed typo (number of participants who completed treatment had been listed twice).

Outcomes

The primary outcome for this review is to establish an effect size by calculating a drop-out proportion for each study. The drop-out proportion will be calculated by dividing the number of participants who dropped out of treatment by the number of participants who started treatment.

The secondary outcomes for this review are to investigate whether the following variables moderate drop-out proportion: diagnosis, CBT type, CBT modality, drop-

out definition, mean age of participants, mean baseline measure of eating disorder symptomatology, and comorbidity.

Risk of bias in individual studies

The risk of bias for each included study will be independently reviewed by CH and a second reviewer who will most likely be another student undertaking the Doctorate in Clinical Psychology at the University of East Anglia. The second reviewed will review a randomised selection of 20% of the included studies. Any situations of disagreement will be mediated by SC or AB. Cohen's Kappa coefficient will be used as an assessment of reviewer agreement.

The risk of bias in individual studies will be assessed using the Joanna Briggs Institute quality assessment tool.

Amendment on 26/09/2023 - The quality assessment tool has been changed to the Joanna Briggs Institute from National Heart, Lung, and Blood Institute (NHLBI). This is because there is not a clear criteria provided by the NHLBI for assessing case series, which is what most papers to be included within the review have been identified as. Therefore, this quality assessment tool is therefore open to subjective interpretation which may affect overall quality ratings. Contact was made with the NHLBI for guidance regarding use of the case series quality assessment tool, however no solution was identified.

Data synthesis

A meta-analysis will be undertaken using a random effects model; R and/or SPSS will be used to carry out this analysis.

An overall estimate drop-out rate will be calculated by aggregating the drop-out proportion from each included study using a random effects proportional meta-analysis. To ensure that the drop-out proportions are accurately weighted to ascertain how much each study contributes to the overall estimate of drop-out rate, drop-out proportions will be transformed using the Freeman-Turkey (double arcsine) transformation.

A chi-squared test will be used to ascertain whether heterogeneity is present, and any heterogeneity will be assessed using the I^2 statistic. Percentages detailed in the most recent Cochrane guidelines (Higgins & Green, 2022) will be used as a rough guide to interpret the degree of heterogeneity. A forest-plot will also be produced to allow for visual examination of the heterogeneity of included studies.

Subgroup analyses will be conducted to investigate whether the following categorical variables moderate CBT drop-out: diagnosis, CBT type, CBT modality, drop-out definition, and comorbidity. A series of meta-regression analyses will be used to test whether the following continuous variables moderate CBT drop-out: mean age of participants, mean baseline EDE-Q global score, and mean baseline episodes of objective binge-eating episodes over the past 28 days. These subgroup analyses and meta-regression analyses will also allow for investigation of any substantial heterogeneity.

A sensitivity analysis will be carried out using only high quality studies to test the robustness of the results.

Meta-bias(es)
Included studies will be assessed for publication bias across studies. An Egger's regression and visual examination of funnel plot symmetry will be used for this assessment.

Confidence in cumulative evidence
Risk of bias – Risk of bias will be assessed using the Joanna Briggs Institute quality assessment tool.

Inconsistency – Consistency of findings will be assessed using assessments of heterogeneity as detailed under 'data synthesis'.

Imprecision – Precision will be assessed using confidence intervals.

Publication bias – An Egger's regression and visual examination of funnel plot symmetry will be used to assess for publication bias.

Amendment on 26/09/2023 - The quality assessment tool has been changed to the Joanna Briggs Institute from National Heart, Lung, and Blood Institute (NHLBI). The rationale for this has been detailed elsewhere within this protocol.

Appendix C

Data Extraction Table

Author Information	Year of Publication	Country where study took place	Study design	Number of participants	Mean age and age range of participants	Gender of participants and number of each	Eating disorder diagnoses	Comorbidities	Measure of ED symptomology used

			Mean baseline EDE-Q global score
			Mean baseline episodes of objective binge-eating episodes of the past 28 days
			Number of participants who started treatment
			Number of participants who did not complete treatment
			Number of participants who completed treatment
			Mean number of sessions attended by non-completers
			Definition of attrition/drop-out/non-completion
			CBT treatment type
			Modality

Appendix D

JBI Quality Assessment Tool and Guidance for Case Series Studies

Author:				
Year:				
	Yes	**No**	**Unclear**	**N/A**
Was there clear criteria for inclusion in the case series?				
Was the condition measured in a standard, reliable way for all participants included in the case series?				
Were valid methods used for the identification of the condition for all participants included in the case series?				
Did the case series have consecutive inclusion of participants?				
Did the case series have complete inclusion of participants?				
Was there clear reporting of the demographics of the participants in the study?				
Was there clear reporting of clinical information of the participants?				
Were the outcomes or follow up results of cases clearly reported?				
Was there clear reporting of the presenting site(s)/clinic(s) demographic information?				
Was statistical analysis appropriate?				

Guidance

Were there clear criteria for inclusion in the case series?
The authors should provide clear inclusion (and exclusion criteria where appropriate) for the study participants. The inclusion/exclusion criteria should be specified (e.g., risk, stage of disease progression) with sufficient detail and all the necessary information critical to the study.

Was the condition measured in a standard, reliable way for all participants included in the case series?
The study should clearly describe the method of measurement of the condition. This should be done in a standard (i.e. same way for all patients) and reliable (i.e. repeatable and reproducible results) way.

Were valid methods used for identification of the condition for all participants included in the case series?
Many health problems are not easily diagnosed or defined and some measures may not be capable of including or excluding appropriate levels or stages of the health problem. If the outcomes were assessed based on existing definitions or diagnostic criteria, then the answer to this question is likely to be yes. If the outcomes were assessed using observer reported, or self-reported scales, the risk of over- or under-reporting is increased, and objectivity is compromised. Importantly, determine if the measurement tools used were validated instruments as this has a significant impact on outcome assessment validity.

Did the case series have consecutive inclusion of participants?
Studies that indicate a consecutive inclusion are more reliable than those that do not. For example, a case series that states 'we included all patients (24) with osteosarcoma who presented to our clinic between March 2005 and June 2006' is more reliable than a study that simply states 'we report a case series of 24 people with osteosarcoma.'

Did the case series have complete inclusion of participants?
The completeness of a case series contributes to its reliability. Studies that indicate a complete inclusion are more reliable than those that do not. A stated above, a case series that states 'we included all patients (24) with osteosarcoma who presented to our clinic between March 2005 and June 2006' is more reliable than a study that simply states 'we report a case series of 24 people with osteosarcoma.'

Was there clear reporting of the demographics of the participants in the study?
The case series should clearly describe relevant participant's demographics such as the following information where relevant: participant's age, sex, education, geographic region, ethnicity, time period, education.

Was there clear reporting of clinical information of the participants?
There should be clear reporting of clinical information of the participants such as the following information where relevant: disease status, comorbidities, stage of disease, previous interventions/treatment, results of diagnostic tests, etc.

Were the outcomes or follow-up results of cases clearly reported?
The results of any intervention or treatment should be clearly reported in the case series. A good case study should clearly describe the clinical condition post-intervention in terms of the presence or lack of symptoms. The outcomes of management/treatment when presented as images or figures can help in conveying the information to the reader/clinician. It is important that adverse events are clearly documented and described, particularly a new or unique condition is being treated or when a new drug or treatment is used. In addition, unanticipated events, if any that may yield new or useful information should be identified and clearly described.

Was there clear reporting of the presenting site(s)/clinic(s) demographic information?
Certain diseases or conditions vary in prevalence across different geographic regions and populations (e.g. women vs. men, sociodemographic variables between countries). The study sample should be described in sufficient detail so that other researchers can determine if it is comparable to the population of interest to them.

Was statistical analysis appropriate?
As with any consideration of statistical analysis, consideration should be given to whether there was a more appropriate alternate statistical method that could have been used. The methods section of studies should be detailed enough for reviewers to identify which analytical techniques were used and whether these were suitable.

Appendix E

JBI Quality Assessment Tool and Guidance for Quasi-Experimental Studies

Author:				
Year:				
	Yes	**No**	**Unclear**	**N/A**
Is it clear in the study what is the 'cause' and what is the 'effect' (i.e. there is no confusion about which variable comes first?				
Were the participants included in any comparisons similar?				
Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest?				
Was there a control group?				
Were there multiple measures of the outcome both pre and post the intervention/exposure?				
Was follow up complete and if not, were the difference between groups in terms of their follow up adequately described and analysed?				
Were the outcomes of participants included in any comparisons measured in the same way?				
Were outcomes measured in a reliable way?				
Was appropriate statistical analysis used?				

Guidance

Is it clear in the study what is the 'cause' and what is the 'effect' (i.e. there is no confusion about which variable comes first?
Ambiguity with regards to the temporal relationship of variables constitutes a threat to the internal validity of a study exploring causal relationships. The 'cause' (the independent variable, that is, the treatment or intervention of interest) should occur in time before the explored 'effect' (the dependent variable, which is the effect or outcome of interest). Check if it is clear which variable is manipulated as a potential cause. Check if it is clear which variable is measured as the effect of the potential cause. Is it clear that the 'cause' was manipulated before the occurrence of the 'effect'?

Were the participants included in any comparisons similar?
The differences between participants included in compared groups constitute a threat to the internal validity of a study exploring causal relationships. If there are differences between participants included in compared groups there is a risk of selection bias. If there are differences between participants included in the compared groups maybe the 'effect' cannot be attributed to the potential 'cause', as maybe it is plausible that the 'effect' may be explained by the differences between participants, that is, by selection bias. Check the characteristics reported for participants. Are the participants from the compared groups similar with regards to the characteristics that may explain the effect even in the absence of the 'cause', for example, age, severity of the disease, stage of the disease, co-existing

conditions and so on? *[NOTE: In one single group pre-test/post-test studies where the patients are the same (the same one group) in any pre-post comparisons, the answer to this question should be 'yes.']*

Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest?
In order to attribute the 'effect' to the 'cause' (the exposure or intervention of interest), assuming that there is no selection bias, there should be no other difference between the groups in terms of treatments or care received, other than the manipulated 'cause' (the intervention of interest). If there are other exposures or treatments occurring in the same time with the 'cause', other than the intervention of interest, then potentially the 'effect' cannot be attributed to the intervention of interest, as it is plausible that the 'effect' may be explained by other exposures or treatments, other than the intervention of interest, occurring in the same time with the intervention of interest. Check the reported exposures or interventions received by the compared groups. Are there other exposures or treatments occurring in the same time with the intervention of interest? Is it plausible that the 'effect' may be explained by other exposures or treatments occurring in the same time with the intervention of interest?

Was there a control group?
Control groups offer the conditions to explore what would have happened with groups exposed to other different treatments, other than to the potential 'cause' (the intervention of interest). The comparison of the treated group (the group exposed to the examined 'cause', that is, the group receiving the intervention of interest) with such other groups strengthens the examination of the causal plausibility. The validity of causal inferences is strengthened in studies with at least one independent control group compared to studies without an independent control group. Check if there are independent, separate groups, used as control groups in the study. *[Note: The control group should be an independent, separate control group, not the pre-test group in a single group pre-test post-test design.]*

Were there multiple measurements of the outcome both pre and post the intervention/exposure?
In order to show that there is a change in the outcome (the 'effect') as a result of the intervention/treatment (the 'cause') it is necessary to compare the results of measurement before and after the intervention/treatment. If there is no measurement before the treatment and only measurement after the treatment is available it is not known if there is a change after the treatment compared to before the treatment. If multiple measurements are collected before the intervention/treatment is implemented then it is possible to explore the plausibility of alternative explanations other than the proposed 'cause' (the intervention of interest) for the observed 'effect', such as the naturally occurring changes in the absence of the 'cause', and changes of high (or low) scores towards less extreme values even in the absence of the 'cause' (sometimes called regression to the mean). If multiple measurements are collected after the intervention/treatment is implemented it is possible to explore the changes of the 'effect' in time in each group and to compare these changes across the groups. Check if measurements were collected before the intervention of interest was implemented. Were there multiple pre-test measurements? Check if measurements were collected after the intervention of interest was implemented. Were there multiple post-test measurements?

Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analysed?
If there are differences with regards to the loss to follow up between the compared groups these differences represent a threat to the internal validity of a study exploring causal effects as these differences may provide a plausible alternative explanation for the observed 'effect' even in the absence of the 'cause' (the treatment or exposure of interest). Check if there were differences with regards to the loss to follow up between the compared groups. If follow up was incomplete (that is, there is incomplete information on all participants), examine the reported details about the strategies used in order to address incomplete follow up, such as descriptions of loss to follow up (absolute numbers; proportions; reasons for loss to follow up; patterns of loss to follow up) and impact analyses (the analyses of the impact of loss to

follow up on results). Was there a description of the incomplete follow up (number of participants and the specific reasons for loss to follow up)? If there are differences between groups with regards to the loss to follow up, was there an analysis of patterns of loss to follow up? If there are differences between the groups with regards to the loss to follow up, was there an analysis of the impact of the loss to follow up on the results?

Were the outcomes of participants included in any comparisons measured in the same way?
If the outcome (the 'effect') is not measured in the same way in the compared groups there is a threat to the internal validity of a study exploring a causal relationship as the differences in outcome measurements may be confused with an effect of the treatment or intervention of interest (the 'cause'). Check if the outcomes were measured in the same way. Same instrument or scale used? Same measurement timing? Same measurement procedures and instructions?

Were outcomes measured in a reliable way?
Unreliability of outcome measurements is one threat that weakens the validity of inferences about the statistical relationship between the 'cause' and the 'effect' estimated in a study exploring causal effects. Unreliability of outcome measurements is one of different plausible explanations for errors of statistical inference with regards to the existence and the magnitude of the effect determined by the treatment ('cause'). Check the details about the reliability of measurement such as the number of raters, training of raters, the intra-rater reliability, and the inter-raters reliability within the study (not to external sources). This question is about the reliability of the measurement performed in the study, it is not about the validity of the measurement instruments/scales used in the study. *[Note: Two other important threats that weaken the validity of inferences about the statistical relationship between the 'cause' and the 'effect' are low statistical power and the violation of the assumptions of statistical tests. These other threats are not explored within Question 8, these are explored within Question 9.]*

Was appropriate statistical analysis used?
Inappropriate statistical analysis may cause errors of statistical inference with regards to the existence and the magnitude of the effect determined by the treatment ('cause'). Low statistical power and the violation of the assumptions of statistical tests are two important threats that weakens the validity of inferences about the statistical relationship between the 'cause' and the 'effect'. Check the following aspects: if the assumptions of statistical tests were respected; if appropriate statistical power analysis was performed; if appropriate effect sizes were used; if appropriate statistical procedures or methods were used given the number and type of dependent and independent variables, the number of study groups, the nature of the relationship between the groups (independent or dependent groups), and the objectives of statistical analysis (association between variables; prediction; survival analysis etc.).

Appendix F

JBI Quality Assessment Tool and Guidance for Cohort Studies

Author:				
Year:				
	Yes	**No**	**Unclear**	**N/A**
Were the two groups similar and recruited from the same population?				
Were the exposures measured similarly to assign people to both exposed and unexposed groups?				
Was the exposure measured in a valid and reliable way?				
Were confounding factors identified?				
Were strategies to deal with confounding factors stated?				
Were the groups/participants free of the outcome at the start of the study (or at the moment of exposure)?				
Were the outcomes measured in a valid and reliable way?				
Was the follow-up time reported and sufficient to be long enough for outcomes to occur?				
Was follow-up complete, and if not, were the reasons to loss to follow-up described and explored?				
Were strategies to address incomplete follow-up utilized?				
Were appropriate statistical analysis used?				

Guidance

Were the two groups similar and recruited from the same population?
Check the paper carefully for descriptions of participants to determine if patients within and across groups have similar characteristics in relation to exposure (e.g. risk factor under investigation). The two groups selected for comparison should be as similar as possible in all characteristics except for their exposure status, relevant to the study in question. The authors should provide clear inclusion and exclusion criteria that they developed prior to recruitment of the study participants.

Were the exposures measured similarly to assign people to both exposed and unexposed groups?
A high quality study at the level of cohort design should mention or describe how the exposures were measured. The exposure measures should be clearly defined and described in detail. This will enable reviewers to assess whether or not the participants received the exposure of interest.

Was the exposure measured in a valid and reliable way?
The study should clearly describe the method of measurement of exposure. Assessing validity requires that a 'gold standard' is available to which the measure can be compared. The validity of exposure measurement usually relates to whether a current measure is appropriate or whether a measure of past exposure is needed. Reliability refers to the processes included in an epidemiological study to check repeatability of measurements of the exposures. These usually include intra-observer reliability and interobserver reliability.

Were confounding factors identified?
Confounding has occurred where the estimated intervention exposure effect is biased by the presence of some difference between the comparison groups (apart from the exposure investigated/of interest). Typical confounders include baseline characteristics, prognostic factors, or concomitant exposures (e.g. smoking). A confounder is a difference between the comparison groups and it influences the direction of the study results. A high quality study at the level of cohort design will identify the potential confounders and measure them (where possible). This is difficult for studies where behavioral, attitudinal or lifestyle factors may impact on the results.

Were strategies to deal with confounding factors stated?
Strategies to deal with effects of confounding factors may be dealt within the study design or in data analysis. By matching or stratifying sampling of participants, effects of confounding factors can be adjusted for. When dealing with adjustment in data analysis, assess the statistics used in the study. Most will be some form of multivariate regression analysis to account for the confounding factors measured. Look out for a description of statistical methods as regression methods such as logistic regression are usually employed to deal with confounding factors/variables of interest.

Were the groups/participants free of the outcome at the start of the study (or at the moment of exposure)?
The participants should be free of the outcomes of interest at the start of the study. Refer to the ‘methods’ section in the paper for this information, which is usually found in descriptions of participant/sample recruitment, definitions of variables, and/or inclusion/exclusion criteria.

Were the outcomes measured in a valid and reliable way?
Read the methods section of the paper. If for e.g. lung cancer is assessed based on existing definitions or diagnostic criteria, then the answer to this question is likely to be yes. If lung cancer is assessed using observer reported, or self-reported scales, the risk of over- or underreporting is increased, and objectivity is compromised. Importantly, determine if the measurement tools used were validated instruments as this has a significant impact on outcome assessment validity. Having established the objectivity of the outcome measurement (e.g. lung cancer) instrument, it’s important to establish how the measurement was conducted. Were those involved in collecting data trained or educated in the use of the instrument/s? (e.g. radiographers). If there was more than one data collector, were they similar in terms of level of education, clinical or research experience, or level of responsibility in the piece of research being appraised?

Was the follow up time reported and sufficient to be long enough for outcomes to occur?
The appropriate length of time for follow up will vary with the nature and characteristics of the population of interest and/or the intervention, disease or exposure. To estimate an appropriate duration of follow up, read across multiple papers and take note of the range for duration of follow up. The opinions of experts in clinical practice or clinical research may also assist in determining an appropriate duration of follow up. For example, a longer timeframe may be needed to examine the association between occupational exposure to asbestos and the risk of lung cancer. It is important, particularly in cohort studies that follow up is long enough to enable the outcomes. However, it should be remembered that the research question and outcomes being examined would probably dictate the follow up time.

Was follow up complete, and if not, were the reasons to loss to follow up described and explored?
It is important in a cohort study that a greater percentage of people are followed up. As a general guideline, at least 80% of patients should be followed up. Generally a dropout rate of 5% or less is considered insignificant. A rate of 20% or greater is considered to significantly impact on the validity of the study. However, in observational studies conducted over a lengthy period of time a higher dropout rate is to be expected. A decision on whether to include or exclude a study because of a high dropout rate is a matter of judgement based on the reasons why people dropped out, and whether dropout rates were comparable in the exposed and unexposed groups. Reporting of efforts to follow up participants that dropped out may be regarded as an indicator of a well conducted study. Look for clear and justifiable description of why people were left out, excluded, dropped out etc. If there is no clear description or a statement in this regards, this will be a 'No'.

Were strategies to address incomplete follow up utilized?
Some people may withdraw due to change in employment or some may die; however, it is important that their outcomes are assessed. Selection bias may occur as a result of incomplete follow up. Therefore, participants with unequal follow up periods must be taken into account in the analysis, which should be adjusted to allow for differences in length of follow up periods. This is usually done by calculating rates which use person-years at risk, i.e. considering time in the denominator.

Was appropriate statistical analysis used?
As with any consideration of statistical analysis, consideration should be given to whether there was a more appropriate alternate statistical method that could have been used. The methods section of cohort studies should be detailed enough for reviewers to identify which analytical techniques were used (in particular, regression or stratification) and how specific confounders were measured. For studies utilizing regression analysis, it is useful to identify if the study identified which variables were included and how they related to the outcome. If stratification was the analytical approach used, were the strata of analysis defined by the specified variables? Additionally, it is also important to assess the appropriateness of the analytical strategy in terms of the assumptions associated with the approach as differing methods of analysis are based on differing assumptions about the data and how it will respond.

Appendix G

Quality Assessment Scores

Case Series Studies

	Question Number											
Study	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Score**	**Quality Rating**
Calugi et al., (2021)	Y	Y	Y	Y	N	Y	Y	Y	N	U	7/10	High
Moore et al., (2021)	N	Y	Y	Y	Y	Y	Y	Y	Y	U	8/10	High
Pellizzer et al., (2019a)	N	Y	Y	U	U	N	Y	Y	Y	U	5/10	Medium
Rose et al., (2021)	Y	Y	Y	U	Y	Y	Y	Y	Y	Y	9/10	High
Waller et al., (2018)	Y	Y	Y	U	Y	N	Y	Y	N	U	6/10	Medium

Quasi-Experimental Studies

	Question Number										
Study	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**Score**	**Quality Rating**
Allen et al., (2012)	Y	U	Y	Y	N	Y	N	Y	U	5/9	Medium
Bailer et al., (2004)	Y	N	Y	N	Y	Y	Y	Y	U	6/9	Medium
Bandini et al., (2006)	Y	Y	N/A	N	N	Y	N/A	Y	U	4/7	Medium
Byrne et al., (2011)	Y	Y	Y	N	Y	Y	Y	Y	Y	6/7	High
Carrard et al., (2011)	Y	Y	N/A	N	Y	Y	N/A	Y	U	5/7	High
Carter et al., (2012)	Y	Y	N/A	N	N	Y	N/A	Y	U	4/7	Medium
Cassioli et al., (2021)	Y	Y	N/A	N	Y	Y	N/A	Y	U	5/7	High
Castellini et al. (2012a)	Y	Y	N/A	N	Y	Y	N/A	Y	Y	6/7	High

Castellini et al. (2012b)	Y	Y	N/A	N	Y	Y	N/A	Y	U	5/7	High
Chen et al., (2003)	Y	Y	Y	N	Y	Y	Y	Y	U	7/9	High
Cooper et al., (1996)	Y	Y	N/A	N	Y	Y	Y	Y	N	5/7	High
Dawkins et al., (2013)	Y	Y	N/A	N	Y	Y	N/A	Y	U	5/7	High
Duchesne et al., (2006)	Y	Y	N/A	N	N	Y	N/A	U	U	3/7	Low
Fairburn et al., (2013)	Y	Y	N/A	N	N	Y	N/A	Y	Y	5/7	High
Frostad et al., (2018)	Y	Y	N/A	N	N	U	N/A	Y	U	4/7	Medium
Frostad et al., (2021)	Y	Y	N/A	N	N	Y	N/A	U	U	3/7	Low
Graham and Walton (2011)	Y	Y	N/A	N	Y	Y	N/A	Y	U	5/7	High
Hogdahl et al., (2013)	Y	Y	N	Y	Y	Y	Y	Y	U	7/9	High
Jenkins et al., (2018)	Y	Y	N/A	N	Y	Y	N/A	Y	U	5/7	High
Jenkins et al., (2021)	Y	Y	N/A	N	Y	Y	N/A	Y	Y	6/7	High
Jones and Clausen (2013)	Y	Y	N/A	N	N	Y	N/A	Y	Y	5/7	High
Kessler et al., (2022)	Y	Y	N/A	N	Y	Y	N/A	Y	U	5/7	High
Knott et al., (2015)	Y	Y	N/A	N	Y	Y	N/A	Y	Y	6/7	High
Laliberte et al., (2022)	Y	Y	N/A	N	N	N	N/A	Y	Y	4/7	Medium
Leung et al., (1999)	Y	Y	N/A	N	Y	Y	N/A	Y	U	5/7	High
Leung et al., (2000)	Y	Y	N/A	N	Y	Y	N/A	Y	Y	6/7	High
Lo Sauro et al., (2012)	Y	Y	N/A	N	Y	Y	N/A	Y	U	5/7	High
Moore & Waller (2023)	Y	Y	N/A	N	Y	Y	N/A	Y	U	5/7	High
Mountford et al., (2021)	Y	U	Y	N	Y	Y	Y	Y	U	6/9	Medium
Pellizzer et al., (2019b)	Y	Y	N/A	N	Y	Y	N/A	Y	U	5/7	High
Ramklint et al., (2012)	Y	Y	N/A	N	Y	Y	N/A	Y	U	5/7	High

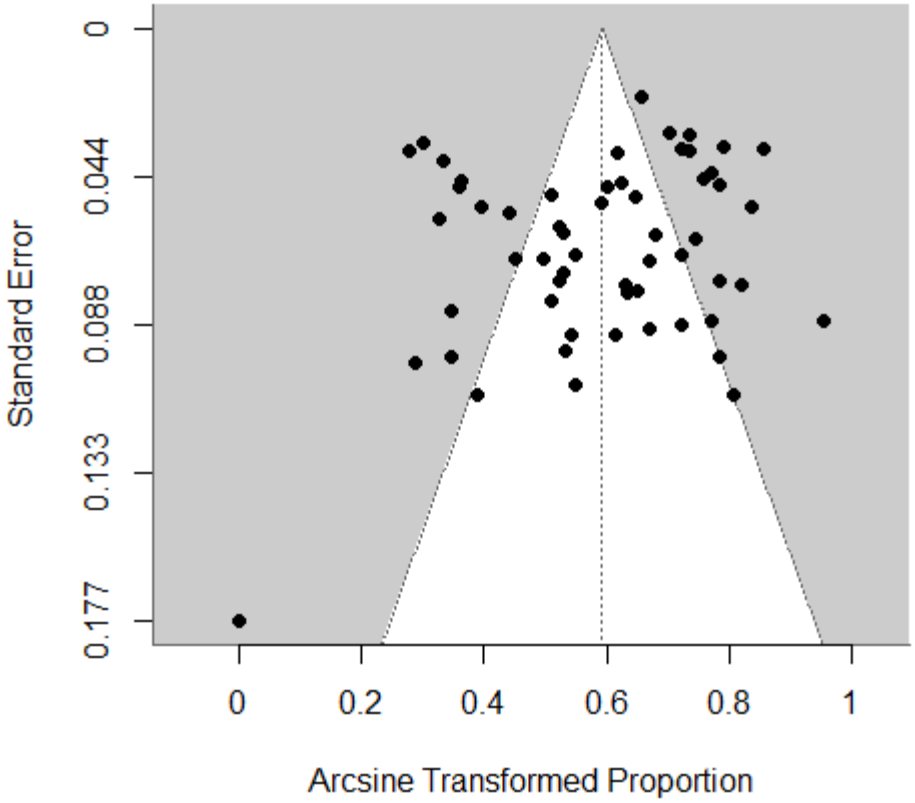
Raykos et al., (2014)	Y	Y	N/A	N	Y	Y	N/A	Y	U	5/7	High
Raykos et al., (2018)	Y	Y	N/A	N	Y	Y	N/A	Y	U	5/7	High
Ricca et al., (2010)	Y	N	Y	N	Y	Y	Y	Y	U	6/9	Medium
Rose and Waller (2017)	Y	Y	N/A	N	Y	Y	N/A	Y	U	5/7	High
Rossi et al., (2022)	Y	Y	N/A	N	Y	Y	N/A	Y	N	5/7	High
Setsu et al., (2018)	Y	Y	N/A	N	Y	Y	N/A	Y	U	5/7	High
Signorini et al., (2018)	Y	Y	N/A	N	Y	Y	N/A	Y	U	5/7	High
Steel et al., (1999)	Y	Y	N/A	N	Y	Y	N/A	Y	U	5/7	High
Stefansson et al., (2022)	Y	Y	N/A	N	Y	Y	N/A	Y	U	5/7	High
Tatham et al., (2020)	Y	Y	Y	N	Y	Y	Y	Y	U	7/9	High
Treasure et al., (1996)	Y	Y	Y	Y	Y	Y	Y	Y	U	8/9	High
Turner et al., (2015)	Y	Y	N/A	N	Y	Y	N/A	Y	Y	6/7	High
van de Berg et al., (2022)	Y	Y	Y	Y	N	Y	Y	Y	U	7/9	High
van Riel et al., (2023)	Y	Y	N/A	N	Y	Y	N/A	Y	U	5/7	High
Waller (1996)	Y	N	N/A	N	N	Y	N/A	Y	U	4/7	Medium
Waller et al., (2014)	Y	Y	N/A	N	Y	Y	N/A	Y	Y	6/7	High
Watson et al., (2012)	Y	Y	N/A	N	Y	Y	N/A	Y	U	5/7	High
Williamson et al., (1989)	Y	Y	N/A	N	Y	Y	N/A	Y	U	5/7	High
Zandberg and Wilson (2013)	Y	Y	N/A	N	Y	Y	N/A	Y	U	5/7	Medium

Cohort Studies

	Question Number												
Study	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Score**	**Quality Rating**
Melisse et al., (2022)	N/A	N/A	Y	N	N	Y	Y	Y	Y	Y	U	6/9	High

Appendix H

Funnel Plot



Appendix I

European Eating Disorders Review Author Guidelines

1. SUBMISSION

New submissions should be made via the Research Exchange submission portal https://wiley.atyponrex.com/journal/ERV. Should your manuscript proceed to the revision stage, you will be directed to make your revisions via the same submission portal. You may check the status of your submission at anytime by logging on to submission.wiley.com and clicking the “My Submissions” button. For technical help with the submission system, please review our FAQs or contact submissionhelp@wiley.com.

Data Protection

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed.

Preprint Policy

European Eating Disorders Review will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

2. AIMS AND SCOPE

European Eating Disorders Review provides an international forum for disseminating cutting-edge theoretical and empirical research that significantly advances understanding of the relationship between Eating Disorders and Abnormal Eating/Weight conditions and well-being in humans.

European Eating Disorders Review publishes authoritative and accessible articles, from all over the world, which review or report original research that has implications for the treatment and care of people with eating disorders and obesity, and articles which report innovations and experience in the clinical management of eating disorders. The journal focuses on implications for best practice in diagnosis and treatment. The journal also provides a forum for discussion of the causes and prevention of eating disorders, and related health policy.

Authors may submit original theoretical systematic reviews, methodological, or empirical research articles (5000 words or less) brief reports (2,500 words or less) and commentaries (2,000 words or less). The journal also publishes invited conceptual reviews from leading worldwide researchers in the field of Eating Disorders and/or Obesity. The aims of the journal are to offer a channel of communication between researchers, practitioners, administrators and policymakers who need to report and understand developments in the field of eating disorders.

The journal

- Reports on useful research and experience related to the treatment and prevention of eating disorders in primary care and hospital settings, with

special attention to therapy oriented translational research, high quality reviews, clinical trials and pilot innovative therapy approaches.
- Provides information about 'good practice' and systematic reviews.
- Offers a forum for new thinking about the nature, incidence, diagnosis and clinical management of eating disorders (namely anorexia nervosa, bulimia nervosa, binge eating disorders, OSFED and other abnormal eating or feeding behaviors associated with childhood and obesity.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Research articles reporting new research of relevance as set out in the aims and scope should not normally exceed 5000 words (excluding abstract, references, tables or figures), with no more than five tables or illustrations. They should conform to the conventional layout: title page, Abstract, Introduction and Aims, Method, Results, Discussion, Acknowledgements and References. Each of these elements should start on a new page.
Word Limit: 5,000 (excluding abstract, references, tables or figures).
Abstract: 200 words, structured
References: up to 60.

Review articles: Systematic and meta-analytic review papers are welcomed if they critically review the available literature in a topic than will enhance clinical practice. Articles should have clear focus and enough number of studies should be available for a substantive review paper. Studies that only describe or list previous studies without a critical overview of the literature will not be considered.
Word Limit: 5,000 (excluding abstract, references, tables or figures).
Abstract: 200 words.
References: up to 100.
Figures/Tables: 5 maximum, but should be appropriate to the material covered. Additional tables might be included as supplementary information, if needed.
Review articles must follow the PRISMA Guidelines. Authors may want to have a look at the review check lists that reviewers when assessing review articles.

Brief reports should concisely present the essential findings of the author's work and be compromised of the following sections: Abstract, Introduction and Aims, Method, Results, Discussion, and References. Tables and/or figures should be kept to a minimum, in number and size, and only deal with key findings. In some cases authors may be asked to prepare a version of the manuscript with extra material to be included in the online version of the review (as supplementary files).
Submissions in this category should not normally exceed 2500 words in length. Brief reports bring with them a whole host of benefits including: quick and easy submission, administration centralised and reduced and significant decrease in peer review times, first publication priority (this type of manuscript will be published in the next available issue of the journal).

Commentary articles are short, evidence-based opinion articles from one or more people (who may agree or disagree) on a published work, current understanding/status of an area, or how practice should be undertaken. Commentaries are invited by the Editors or open submission. They should not normally exceed 2,000 words (excluding abstract and references), with no tables or illustrations.
Word Limit: 2,000 (excluding abstract, references).
Abstract: 200 words, unstructured

References: up to 5
Figures/Tables: none

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- *Clinical Case Reports* which aims to directly improve health outcomes by identifying and disseminating examples of best clinical practice
- *Mental Health Science* which brings various fields together to address the common, pressing, and growing crisis of mental health

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Before you submit, you will need:

- Your manuscript: this should be an editable file including text, figures, and tables, or separate files – whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, conclusions and highlights. Figures and tables should have legends. Figures should be uploaded in the highest resolution possible. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. Supporting information should be submitted in separate files. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers, and the editorial office will send it back to you for revision. Your manuscript may also be sent back to you for revision if the quality of English language is poor.
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    - Statements relating to our ethics and integrity policies, which may include any of the following:
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        - funding statement
        - conflict of interest disclosure
        - ethics approval statement
        - patient consent statement
        - permission to reproduce material from other sources
        - clinical trial registration

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Cover Letters
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Abstract
All manuscripts should contain an abstract of up to 200 words. An **abstract** is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work. It must be structured, under the sub-headings: Objective; Method; Results; Conclusions.

Graphical TOC/Abstract
The journal's table of contents/abstract will be presented in graphical form with a brief abstract. The table of contents entry must include the article title, the authors' names (with the corresponding author indicated by an asterisk), no more than 80 words or 3 sentences of text summarizing the key findings presented in the paper and a figure that best represents the scope of the paper. Table of contents entries should be submitted as 'Supplementary material for review' during the initial manuscript submission process. The image supplied should fit within the dimensions of 50mm x 60mm and be fully legible at this size.

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Graphics that do not adhere to these guidelines will be recommended for revision or will not be accepted for publication.

Highlights
Highlights are mandatory for European Eating Disorders Review. These should appear as three bullet points that convey the core findings of the article.

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Include up to five **keywords** that describe your paper for indexing purposes.

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Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

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Any appeal against a decision on a manuscript should be filed by the corresponding author within 28 days of notification of the decision. The appeal should be in the form of a letter addressed to the Editor-in-Chief and submitted by email to the editorial office (EEDRedoffice@wiley.com). The letter should include clear and concise grounds for the appeal, including specific points of disagreement with the decision. The appeal will then be assessed by the editorial team, led by the Editor-in-Chief, and informed by the reviewer assessments and recommendation of the Associate Editors, where appropriate. Authors lodging an appeal will be informed of its outcome within 28 days. The decision will be final.

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Accurate and complete reporting enables readers to fully appraise research, replicate it, and use it.

Authors are expected to adhere to the following research reporting standards:

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2. Been involved in drafting the manuscript or revising it critically for important intellectual content; and
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Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section (for example, to recognize contributions from people who provided technical help, collation of data, writing assistance, acquisition of funding, or a department chairperson who provided general support). Prior to submitting the article all authors should agree on the order in which their names will be listed in the manuscript.

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9. EDITORIAL OFFICE CONTACT DETAILS

EEDRedoffice@wiley.com

Appendix J

Faculty of Medicine and Health Sciences Ethics Approval Letter

Study title: Clinicians' experiences of delivering brief cognitive behavioural therapy (CBT-T) for patients with non- underweight eating disorders: A qualitative investigation.

Application ID: ETH2223-0245

Dear Chloe,

Your application was considered on 9th December 2022 by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

The decision is: **approved**.

You are therefore able to start your project subject to any other necessary approvals being given.

If your study involves NHS staff and facilities, you will require Health Research Authority (HRA) governance approval before you can start this project (even though you did not require NHS-REC ethics approval). Please consult the HRA webpage about the application required, which is submitted through the IRAS system.

This approval will expire on **20th September 2024**.

Please note that your project is granted ethics approval only for the length of time identified above. Any extension to a project must obtain ethics approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) before continuing.

It is a requirement of this ethics approval that you should report any adverse events which occur during your project to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) as soon as possible. An adverse event is one which was not anticipated in the research design, and which could potentially cause risk or harm to the participants or the researcher, or which reveals potential risks in the treatment under evaluation. For research involving animals, it may be the unintended death of an animal after trapping or carrying out a procedure.

Any amendments to your submitted project in terms of design, sample, data collection, focus etc. should be notified to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) in advance to ensure ethical compliance. If the amendments are substantial a new application may be required.

Approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) should not be taken as evidence that your study is compliant with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. If you need guidance on how to make your study UK GDPR compliant, please contact the UEA Data Protection Officer (dataprotection@uea.ac.uk).

Please can you send your report once your project is completed to the FMH S-REC (fmh.ethics@uea.ac.uk).

I would like to wish you every success with your project.

On behalf of the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee)

Yours sincerely,

Paul Linsley

Appendix K

Health Research Authority Ethics Approval Letter

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Mrs Chloe Hewitt
University of East Anglia
Norwich
Norfolk
NR4 7TJN/A

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

18 April 2023

Dear Mrs Hewitt

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Clinicians' experiences of delivering brief cognitive behavioural therapy (CBT-T) for patients with non-underweight eating disorders: A qualitative investigation.**
IRAS project ID:	**321360**
Protocol number:	**N/A**
REC reference:	**23/HRA/0847**
Sponsor	**University of East Anglia**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Appendix L

Recruitment Poster

Recruitment Poster
(Version 3, November 2022)

University of East Anglia

Do you work in a NHS eating disorder service?

Do you currently deliver CBT-T?

Have you had at least 6 months of experience delivering this intervention?

If you meet this criteria, we would like to invite you to take part in our research project investigating clinicians' experiences of delivering CBT-T.

This will involve attending a one-off interview via Microsoft Teams at a time convenient to you.
The interview will last up to 60 minutes and you will be given a £10 Amazon eGift Voucher as a token of appreciation for your time.

If you are willing to take part in this research, please email Chloe.Hewitt@uea.ac.uk to register your interest.

This research is being conducted by Chloe Hewitt, Trainee Clinical Psychologist on the Doctorate in Clinical Psychology at the University of East Anglia.
This is research is being carried out under the supervision of Professor Sian Coker, Dr. Aaron Burgess, and in collaboration with Professor Glenn Waller.

Full ethical approval has been granted for this project by both the University of East Anglia's Faculty of Medicine and Health Sciences Research Ethics Committee and the Health Research Authority.

IRAS Project ID: 321360

UEA Application ID: ETH2223-0245

Appendix M

Email to Gatekeepers

Dear (name of service),

I am a Trainee Clinical Psychologist undertaking my Doctorate in Clinical Psychology at the University of East Anglia in Norwich.

For my Doctorate thesis I am examining clinician experiences of delivering Cognitive Behaviour Therapy (CBT-T), supervised by Professor Sian Coker and Dr. Aaron Burgess (University of East Anglia), and in collaboration with Professor Glenn Waller (University of Sheffield). Full ethical approval has been granted for this project by both the University of East Anglia's Faculty of Medicine and Health Sciences Research Ethics Committee (Application ID: ETH2223-0245) and the Health Research Authority (IRAS Project ID: 321360).

I am now at the stage of recruiting clinicians to take part in my research and I am hoping to recruit staff from your service. This will involve attending one interview via Microsoft Teams which will last up to 60 minutes, and participants will be given a £10 Amazon eGift Voucher as a token of appreciation for taking part. We hope that this research will help us to develop an insight into clinicians' experiences of delivering CBT-T, which will aid with future development of CBT-T, clinician training, and understanding of how clinicians can be supported with delivery of this treatment.

I would be most grateful if you could please forward this email and the attached information sheet on to the relevant staff working in your service to aid with my recruitment. We are looking to recruit staff that are currently delivering CBT-T and have been doing so for a minimum of 6 months.

Best wishes,
Chloe Hewitt

Trainee Clinical Psychologist
University of East Anglia

Appendix N

Information Sheet

University of East Anglia

Study Title: Clinician's Experiences of Delivering Cognitive Behaviour Therapy Ten (CBT-T)

Information Sheet (Version 6, March 2023)

1. Introduction

You are being invited to take part in a research study. Before you make your decision, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. You may want to talk to others about the study before taking part.

2. What is this purpose of this research?

CBT-T is a relatively new intervention in the field of eating disorders. The evidence base for CBT-T continues to grow and to date research has been published about the effectiveness of this intervention and patients' experiences of this treatment. Previous research has identified that it is also important to understand clinicians' views about treatment when implementing new interventions.

It is necessary to learn about clinicians' experiences because clinicians' views of treatment have been found to affect the overall treatment delivery. Understanding clinicians' experiences will not only allow a deeper understanding of what it is like to deliver this therapy, but may also highlight any aspects of CBT-T for which clinicians would benefit from additional support when delivering this intervention, acting as a tool for supervision and training. It will also allow direct comparison with previously published research on patients' experiences of this treatment to examine similarities and differences between clinician and patient experiences of CBT-T, which will be helpful to inform ongoing development of CBT-T.

3. Do I have to take part?

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part then you will be asked to sign a consent form. No data will be collected from you until you have signed and returned this form. Agreeing to take part in this research does not mean that you have to complete it. You are free to withdraw at any stage without giving a reason.

4. What will taking part involve?

We will arrange a convenient date and time to meet for a virtual (online) interview via Microsoft Teams. The interview will be recorded and transcribed to produce a written version of the interview.

You will be asked a series of questions regarding general information about you, for example your age and profession. You will then be asked a series of questions

relating to your experience of delivering CBT-T. It is estimated that the interview will take up to 60 minutes to complete. On completion of the interview, you will be sent a £10 Amazon eGift Voucher as a token of appreciation for your participation.

5. Are there any restrictions that may prevent me from taking part?

You must be currently delivering CBT-T and have at least 6 months experience delivering this intervention.

6. Will I be recorded and how will the recorded media be used?

As noted above your interview will be recorded and transcribed.
Otter transcription, a UK GDPR artificial intelligence transcription software, will be used to live transcribe your interview, with recording being used as a back-up and to aid with the analysis process. Your interview recording will be used only for transcription and analysis.

No other use will be made of the recording without your written consent, and no-one outside of the project team will be allowed to access the original recordings. Recordings will be deleted following publication of this research.

7. How will we use information about you?

We will need to use information from you for this research project. This information will include your name and email address. People will use this information to do the research or to check your records to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.
Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

8. How will my information be kept confidential?

Your interview data will be stored using your unique ID code in password protected documents which will be stored on UEA secure servers. Only the researcher and supervisory panel will have access to this.
Your contact information will be deleted once analysis has commenced, unless you wish to receive a summary of the research (see point 14). In this case your details will be stored in a secure database and will be deleted once this summary has been shared with you.

All the information collected about you during the course of the research will be kept strictly confidential. Direct quotations from interviews will be used in the write of the research and in other outlets (for example, publications. These will be completely anonymised and will not include any information that could identify you as a research participant.

If during the course of the interview there is any disclosure of unlawful activity or any indication of circumstances that would put you or others at risk, I may be required to refer the matter to the appropriate authority.

9. What are the possible disadvantages and risks of taking part?

Some people may find CBT-T a challenging and emotive intervention to deliver, so the questions you will be asked during your interview about delivering this form of treatment may have the potential to cause some distress. If you do become distressed in the interview we will pause, take a break and you can make a decision about whether you wish to continue with the interview or not. Signposting to relevant organisations will be included in the research debrief form should any further support be required.

10. What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people who take part in this research, it is hoped that this work will provide an in-depth understanding of how clinicians experience delivering CBT-T. It will provide you with the opportunity to voice your own experience of delivering CBT-T. We hope this will help to inform future developments in CBT-T and clinician training, and highlight whether there is any additional support that clinicians may benefit from when delivering this treatment.

11. What are your choices about how your information is used?

You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.

12. Will I be able to withdraw my data from the research?

You can withdraw your data from the research up until data analysis has commenced as outlined below.

At the start of your interview you will be asked to create an ID code based on the date of your birthday and the last three digits of your mobile number. Please keep a note of this and, if you decide to withdraw from the study at a later date, you can email Chloe Hewitt, quote this ID code to have your data identified for removal from the research.

13. Will it be possible for me to review my interview transcript?

You will have the opportunity to review your interview transcript up until data analysis has commenced. If you request to review your interview transcript, you will have 10 days from the date that your interview transcript is sent to you to advise of any amendments you wish to make. If you do not request any amendments during this time frame, then it will be assumed that you do not wish to make any modifications to your transcript.

14. What will happen to the results of this research?

The results of this research will be written up and submitted as part of Chloe Hewitt's Thesis Portfolio for the Doctorate in Clinical Psychology in 2024. It is also planned for this research to be submitted for publication in an academic journal and the findings presented at academic conferences.
At the end of your interview you will be asked if you would like to receive a summary of the research via email when this has been completed.

15. What will happen to the data collected within this study?

Data (your general information and interview transcript) will be stored for at least 10 years as per UEA's Research Data Management Policy. In line with this policy, data (your general information and interview transcript with any personally identifiable information removed) will be uploaded to the UEA Research Data Repository upon completion of the research.

16. Where can you find out more about how your information is used?

You can find out more about how we used your information:

- At www.hra.nhs.uk/information-about-patients/
- Our leaflet available from: www.hra.nhs.uk/patientdataandresearch
- By asking one of the research team
- By sending an email to researchsponsor@uea.ac.uk
- By ringing us on 01603 591574

17. Who is running this study?

This research is being conducted by Chloe Hewitt, Postgraduate Researcher on the Doctorate in Clinical Psychology at the University of East Anglia. The research is being carried out under the supervision of Professor Sian Coker, Dr. Aaron Burgess, and in collaboration with Professor Glenn Waller. The research is funded by the University of East Anglia.

Full ethical approval has been granted for this project by both the University of East Anglia's Faculty of Medicine and Health Sciences Research Ethics Committee and the Health Research Authority.

18. Who do I contact if I have any further questions or have a complaint or concerns about this study?

If you have any further questions, please contact Chloe Hewitt via email at Chloe.Hewitt@uea.ac.uk.

If you are concerned about the way that this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the UEA Faculty of Medicine Health Sciences administration team at Med.Reception@uea.ac.uk. They will direct your concerns to a senior faculty member.

19. What happens next?

If you would still like to take part in this research and have no further questions, please read and complete the consent form. Thank you for your consideration.

Appendix O

Participant Consent Form

University of East Anglia

Study Title: Clinician's Experiences of Delivering CBT-T

Consent Form (Version 5, March 2023)

	Please initial:
I confirm I have read and understand the information sheet dated March 2023.	
I have been given the opportunity to ask questions about the research.	
I understand that taking part in this project will involve me attending an online interview via Microsoft Teams which will be recorded and live transcribed.	
I understand that my taking part is voluntary and that I can withdraw from the study at any time without giving any reasons and without any consequences.	
I understand that I have up until data analysis has commenced to contact the research team to exercise my right to withdraw and have my contact information and interview data removed and destroyed.	
I understand that the interview data will remain confidential.	
I understand that only the research team will have access to my data and that this data will be anonymised.	
I understand that my anonymised words may be used in subsequent reports and publications.	
I understand that my anonymised interview transcript and demographic information will be stored on secure severs at the University of East Anglia (UEA) and that on completion of the research these will be stored in the UEA Research Data Repository for at least 10 years as per UEA's Research Data Management Policy.	
I understand that if there is any disclosure of unlawful activity or any indication of circumstances that would put you or others at risk, I may be required to refer the matter to the appropriate authority.	
I consent to being a participant in this project.	

Name:	
Date:	
Signature:	

Once completed, please return this consent form to Chloe.Hewitt@uea.ac.uk

Appendix P

Topic Guide

Topic Guide

Theme	Prompt
Introduction.	Introductions. Explain purpose of research project. Explain interview will be recorded. Confirm expected duration of interview (60 minutes). Ask if participant has any questions. Check participant is happy with proceed with interview.
Collation of demographic information.	Age. Gender. Ethnicity. Profession. Duration of experience delivering CBT-T. Number of patients treated with CBT-T (approximately). Length of working with eating disorder patient group. Number of people delivering CBT-T in service.
Core interview schedule.	What is your general experience of delivering CBT-T? Which are the most difficult elements of CBT-T to deliver? Why? Session 4 is the point where a patient's current progress is reviewed and the decision is made as to whether to continue therapy past this point. What is your experience of this session. Why?

	Has your experience of delivering CBT-T changed over time and if so, why do you think that was the case? In your experience, which elements of treatment are the most helpful to patients? Why? How do you think patients experience CBT-T? Why? What is your experience of the therapeutic relationship (or alliance) in CBT-T? Are there any particular elements of the treatment protocol that you feel you would benefit from receiving more support or training in implementing? If so, what different might this support or training make for you? How does your personal experience of delivering CBT-T compare with any previous experience you have of delivering psychological therapy? Has delivering CBT-T impacted on any other therapy you have delivered since?
Debrief.	Ask participant how they found the interview. Ask participant if they have any questions. Confirm email address for eGift Voucher to be sent to. Explain debrief form will be sent via email and advise participant to make contact if they have any further questions.

Appendix Q

Participant Debrief Form

Study Title: Clinician's Experiences of Delivering Cognitive Behaviour Therapy Ten (CBT-T)

Debrief Form (Version 3, October 2022)

Thank you for taking the time to participate in this research.

1. Purpose of this study

The aim of this research is to investigate clinicians' experiences of delivering CBT-T and to answer the following research questions:

3. What are clinicians' experiences of delivering CBT-T.
4. Are there any aspects of CBT-T identified for which clinicians may benefit from additional support when delivering this intervention?
5. What are the commonalities and differences between clinician and patient experiences of CBT-T?

2. How will my information be kept confidential?

Your data will be processed in accordance with UK GDPR guidelines.
Your interview data will be stored using your unique ID code in password protected documents which will be stored on UEA secure servers. Only the researcher and supervisory panel will have access to this.

Your contact information will be deleted once analysis has commenced, unless you wish to receive a summary of the research (see point 4). In this case your details will be stored in a secure database and will be deleted once this summary has been shared with you.

All the information collected about you during the course of the research will be kept strictly confidential. We may use some of your words from the interview in the write-up of the research and in other outputs (for example, publications), but no names or identifying details will ever be included.

If there is any disclosure of unlawful activity or any indication of circumstances that would put you or others at risk, I may be required to refer the matter to the appropriate authority.

3. What will happen if I want to withdraw my data?

You can withdraw your data from the research up until data analysis has commenced without giving any reason. You can do this by emailing Chloe.Hewitt@uea.ac.uk and stating that you wish to withdraw your data, quoting your ID code (the date of your birthday and last three digits of your mobile number) so that your data can be identified for deletion.

4. Is it possible for me to review my interview transcript?

You can review your interview transcript up until data analysis has commenced. You can do this by emailing Chloe.Hewitt@uea.ac.uk and stated that you wish to review your interview transcript, quoting your ID code (the date of your birthday and last three digits of your mobile number) so that your interview transcript can be identified. You will have 10 days from the date that your interview transcript is sent to you to advise of any amendments you wish to make. If you do not request any amendments during this time frame, then it will be assumed that you do not wish to make any modifications to your transcript.

5. What will happen to the results of this research?

The results of this research will be written up and submitted as part of my Thesis Portfolio for the Doctorate in Clinical Psychology in 2024. It is also planned for this research to be submitted for publication in an academic journal and the results presented at academic conferences.

If you would like to receive a summary of the findings, please email Chloe.Hewitt@uea.ac.uk and this will be sent to you upon completion of the research.

6. What will happen to the data collected within this study?

Data (your general information and interview transcript) will be stored for at least 10 years as per UEA's Research Data Management Policy. In line with this policy, data (your general information and interview transcript with any personally identifiable information removed) will be uploaded to the UEA Research Data Repository upon completion of the research.

7. What should I do if I have been affected by taking part in this study?

If you feel upset after having taken part in this study or found that some questions or aspects of the study were distressing, there are a number of sources of available support:

- Speak to your GP.
- Contact your local Staff Mental Health and Wellbeing Hub (www.england.nhs.uk/supporting-our-nhs-people/support-now/staff-mental-health-and-wellbeing-hubs)
- Contact your NHS Trust Staff Support Service.
- Text FRONTLINE to 85248 – this is a confidential text support staff set up by the NHS for NHS staff who have had a tough day, who are feeling worried or overwhelmed, or who have a lot on their mind and need to talk it through.
- Project5 (www.project5.org) – a service set up to help NHS staff to manage personal stress and burnout, offering three free confidential psychological support sessions.
- Duty to Care (www.dutytocare.info/s) – an online resource for NHS workers to go to for instant help and support when they need it most. You are able to

book one-to-one online sessions and find advice on how to manage your mental health independently on a day-to-day level.

8. Who do I contact if I have any further questions or have a complaint or concerns about this study?

If you have any further questions, please contact me via email at Chloe.Hewitt@uea.ac.uk.
If you are concerned about the way that this study has been conducted or you wish to make a complaint to someone independent from the study, please contact the UEA Faculty of Medicine Health Sciences administration team at Med.Reception@uea.ac.uk. They will direct your concerns to a senior faculty member.
Thank you again for your participation in this study. You may wish to keep a copy of this debrief form for your records.

Appendix R

Faculty of Medicine and Health Sciences Ethics Amendment Approval Letter

Study title: Clinicians' experiences of delivering brief cognitive behavioural therapy (CBT-T) for patients with non- underweight eating disorders: A qualitative investigation.

Application ID: ETH2324-0074 (significant amendments)

Dear Chloe,

Your application was considered on 17th August 2023 by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

The decision is: **approved**.

You are therefore able to start your project subject to any other necessary approvals being given.

If your study involves NHS staff and facilities, you will require Health Research Authority (HRA) governance approval before you can start this project (even though you did not require NHS-REC ethics approval). Please consult the HRA webpage about the application required, which is submitted through the IRAS system.

This approval will expire on **20th September 2024**.

Please note that your project is granted ethics approval only for the length of time identified above. Any extension to a project must obtain ethics approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) before continuing.

It is a requirement of this ethics approval that you should report any adverse events which occur during your project to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) as soon as possible. An adverse event is one which was not anticipated in the research design, and which could potentially cause risk or harm to the participants or the researcher, or which reveals potential risks in the treatment under evaluation. For research involving animals, it may be the unintended death of an animal after trapping or carrying out a procedure.

Any amendments to your submitted project in terms of design, sample, data collection, focus etc. should be notified to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) in advance to ensure ethical compliance. If the amendments are substantial a new application may be required.

Approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) should not be taken as evidence that your study is compliant with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. If you need guidance on how to make your study UK GDPR compliant, please contact the UEA Data Protection Officer (dataprotection@uea.ac.uk).

Please can you send your report once your project is completed to the FMH S-REC (fmh.ethics@uea.ac.uk).

I would like to wish you every success with your project.

On behalf of the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee)

Yours sincerely,

Dr Paul Linsley

Appendix S

Reflections on Experiences of Delivering CBT-T

I was introduced to CBT-T when I joined the adult eating disorder service in January 2019. I hadn't heard of this treatment before, however when joining the team I was advised that a key part of my Assistant Psychologist role was going to be having a caseload of CBT-T patients. I still vividly remember going to meet Glenn Waller in a café at the Royal College of GPs in London to have some training on how to deliver CBT-T, before going on to begin to deliver CBT-T from March 2019. I then delivered CBT-T up until I left the team in September 2021 to start my clinical training. In total, I was delivering CBT-T for about 18 months, treating just over 20 patients using CBT-T over this time. Around 15 of these went on to successfully complete treatment.

I remember my first ever CBT-T session and how nervous I was. I remember spending lots of time before the appointment going over everything that I needed to cover in the session, almost writing a script of what I was going to say and how I was going to say it. I am sure I came across as very robotic in those early sessions as I was so worried about deviating from the protocol and doing something "wrong". This was also before the CBT-T book had been published, so the only guidance that I had was from the time that I had spent with Glenn, who had very much emphasised the importance of sticking to the protocol and the firm empathy stance.

I definitely had some reservations about how much could be achieved in the space of 10-sessions, which I think, on reflection, comes from having previously worked in a child eating disorder service where patients remained open to the service for much longer than this. My experiences had, therefore, been of seeing people for long periods, and usually them being relatively unmotivated for recovery, mostly coming to appointments as their parents told them that they had to, rather than them being there through personal choice. I think that's one of the first lessons I learnt about CBT-T: that patients have to be motivated for treatment to be effective. There is none of the motivational enhancement work involved in CBT-T that I had become so used to using in the child service. CBT-T is very much about making changes from session one, with a patient needing to be motivated to engage in treatment to be able to do this. I found that you could get a sense from session one of how well people were going to engage with CBT-T purely based on their motivation to make changes; it became very clear very quickly that CBT-T was only going to work for those people who wanted it to work and would buy into the treatment tasks. The people who did not go on to complete treatment were mostly those who were very ambivalent about making changes, with those who excelled in treatment being the ones who threw themselves into making changes to their eating immediately.

I found one of the most powerful parts of CBT-T to be when a patient regulated their eating pattern, a very behavioural intervention but with truly remarkable effects. With almost all of the patients that I treated with CBT-T, once they had regulated their eating pattern and were eating enough, their binges completely stopped. When I would outline the structure of CBT-T at session one, and explain that phase 3 focuses on emotional reasons for bingeing/purging but that this might not be something that we needed to do, almost everyone commented that their episodes of bingeing/purging were "definitely" emotional. I think overall I only ever had to explore the emotional triggers for eating disorder behaviours with three patients. The first was related to bingeing, and the other two were related to self-induced vomiting as they had more of a purging disorder presentation. I really liked using the

Newton's cradle analogy to explain the process of emotional triggers, and patients seemed to be able to understand this. I remember I even bought my own Newton's cradle to use in session with people to help illustrate the idea. Within this, however, I never needed to address core beliefs or imagery rescripting with patients in regards to their emotions, which I was thankful for as I never really understood how this is done, and was quite scared of the idea of imagery rescripting having never had any previous experience of treating trauma. We didn't really cover phase three within the training I attended due to limited time, and I do think that this is something that I really needed some additional support with when I was delivering CBT-T as I feel like I did purposely avoid using those two interventions due to just not having a clue how to deliver them.

I used to really enjoy making surveys with patients, and this is something that I also found to be a really powerful part of treatment as it really enabled us to challenge the beliefs that patients held. It was always quite anxiety provoking, however, reviewing the survey responses during sessions in case someone had responded with something that actually supported the patient's belief, as I was never sure how I would respond to this in the moment. Thankfully that never happened. Behavioural experiments were also a very powerful intervention that I used with patients. I remember the first few times being really worried that the experiment would "go wrong" and the patient's prediction would end up being true, which probably did make me more cautious when setting up these experiments initially as I was worried about doing them unless I could almost guarantee that the outcome would go against the patient's prediction. However, as I gained more experience of delivering CBT-T, I think I definitely became more confident with setting these up and encouraging patients to challenge themselves to do more difficult behavioural experiments to really push themselves, rather than settling for an easier option.

One of my biggest worries going into CBT-T was the session four review, particularly what it was going to be like if I had to terminate someone's treatment. I had never been in that position before, and I imagined it was going to be a really difficult conversation to have to have with someone. It was also the same with the 'five minute session', as I really worried what effect that would have on the therapeutic relationship if someone turned up to a session and I turned them away for not having done their food diaries, although completely understood the rationale for this. The day finally came where I had to do a five minute session, and, as with most things in life, it was nowhere near as bad as I had expected it to be. That person never forgot their food diaries again and it seemed to have a really powerful impact. The session four reviews where treatment had to be terminated also weren't as bad as I had expected. I only really had to do this around three times, and all of those times thankfully the patient was in agreement with the termination of treatment. I never had to face terminating treatment when they were not in agreement, which I think might have been a very difficult experience as I would have felt really mean withdrawing treatment from someone who still felt that they should be allowed to continue.

About one year into my delivery of CBT-T, the COVID-19 pandemic hit. This meant an overnight change from in-person to virtual sessions. Like most people, I had no experience of delivering CBT-T virtually, and I was incredibly dubious about how this would work. I had been so used to patients completing paper food diaries, however because they were no longer coming in for face-to-face sessions I began to get my patients to use an app (Rise Up) to record their food diaries. They would then export these to me prior to the session. This worked incredibly well, and I found that people were much more likely to complete their diaries in real-time when using the app. My main concern about delivering CBT-T online was the body image work,

specifically the mirror exposure; I just couldn't see how it would work without me being in the room with the patient to make sure that they were not avoiding looking in the mirror. I must admit, I was pleasantly surprised by how well CBT-T worked online and how easy it was to adapt the interventions. I had been worried about there being a loss of effectiveness if treatment was delivered virtually, but I really didn't find this to be the case at all.

My experiences of delivering CBT-T were incredibly positive. I was fortunate to work with some really lovely patients who engaged well, and it was a real honour to be a part of their recovery journey and see them go on to make a full recovery from their eating disorder. I think the follow-up sessions were also really valuable, both for me as a clinician and seeing the prolonged effects of treatment for patients, and for patients to have that ongoing accountability for those additional three months. There was one patient I worked with who did just enough to get by, but was not completely asymptomatic even by the end of follow-up. I don't think they ever completely bought into the treatment, and I think they did have some comorbid mental health problems which did make change more difficult for them. Nevertheless, all of my other patients who went on to complete treatment made a full recovery from their eating disorder. Some of them were much earlier on in their presentation, whereas others had struggled with an eating disorder for many years. There was one patient in particular who was coming up to her 60th birthday and had had an eating disorder since she was 18. CBT-T enabled her to make a complete recovery. That particular case has stayed with me as I feel that it really shows how effective CBT-T can be. When I first started to deliver CBT-T I don't think I would have really believed someone with such a long-standing eating disorder would be able to progress that far in only 10 weeks, but they proved it really is possible to make significant change during such a time-limited therapy.

Appendix T

Examples of Reflective Journal Entries

"I found this interview really enjoyable as the participant was really engaged with the interview process and gave some really thoughtful responses to the questions that I asked them. It seems that they have had a good experience of delivering CBT-T and have worked with a huge number of patients to be able to comment meaningfully on their experience. I found myself being particularly drawn to this person given their engagement with the interview and the clear enthusiasm for CBT-T, which I tried to be mindful of throughout the interview in order to ensure that I obtained a balance of opinion rather than just pursuing the positive comments that they made about the therapy. I noticed similarities with this person's experiences of CBT-T and my own experiences, which I feel is what also drew me into their interview more as there were many of the points that they made which I could relate to. Initial ideas that have come from the interview are being aware and acknowledging when you are drifting from the protocol, a reduction in anxiety as experience with CBT-T increases, usefulness of supervision, and the idea that seeing CBT-T working with patients has built up a belief in this therapy and subsequently impacting on how therapy is then delivered."

"This interview was very long and I felt myself becoming very frustrated at times because it felt like the interviewee was not really answering the questions that I was asking them, so I am not sure how much of the interview is useful in terms of answering my research questions. It felt like every question I asked they ended up going on a tangent about something else, and it was really difficult to bring them back on track. I don't know if that's because of my inexperience of doing interviews or whether this was on more related characteristics of the participant. Something that was very clear is that they do not stick to the CBT-T protocol which feels uncomfortable in so much as their patients believe that they are receiving a therapy which they are not actually receiving as it should be delivered. It will be interesting when I start coding this interview to see what I am able to draw from the responses that the participant gave."

"This interview really felt like hard work. Even despite my prompts and additional questions, I really could not get much response from the participant and as much as I tried to drag the interview out, it really did not last as long as I had hoped and I'm not expecting to have much to take forward from it at the point of analysis. Quite frustrating given how hard recruitment has been, but with the final two interviews I have planned plus the other interviews I have completed already I hoping that one less in-depth interview won't have too much impact on the overall data that I have collected. There was nothing new that came up in this interview which hasn't come up before, so I feel I am definitely reaching the point now where I am unlikely to find any new ideas that have not yet come up, but we will see."

"I am behind where I had hoped and planned to be by this time for a variety of reasons, however today I'm going to start coding my interviews. Although I am excited to see what I have been able to find from my transcripts, I am really apprehensive about the analysis process as I have never done thematic analysis before and I'm really worried about getting it "wrong". I'm also aware that the thesis deadline is looming but that I don't want to rush the analysis. I also still don't

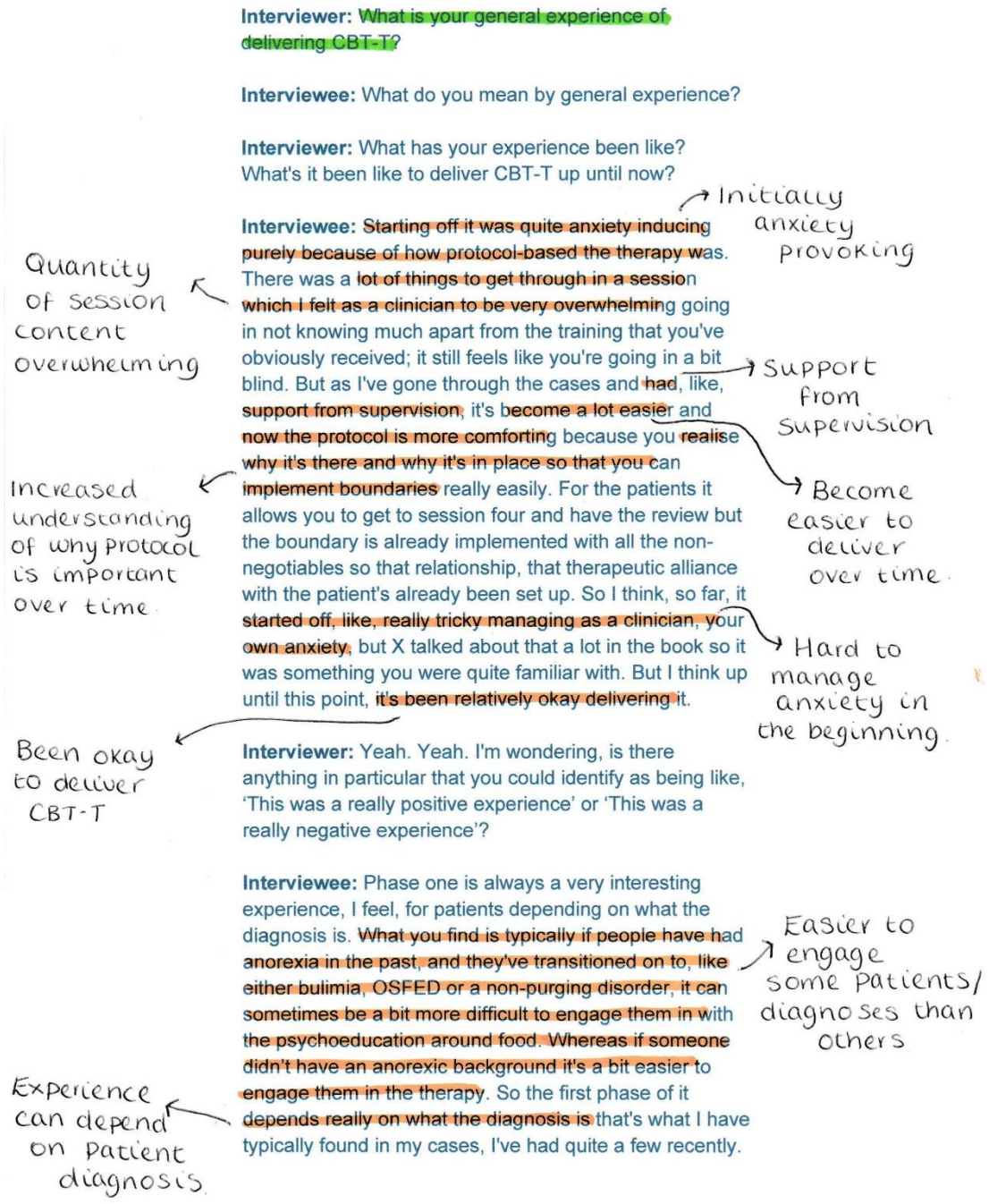
understand epistemology and ontology and this is continuing to cause me a lot of stress because I know I need to write about this within my paper and extended methods section. I'm hoping by doing my coding this is something that might start to become clearer for me. I have no idea how long this coding will taking me and I know that there are a couple of transcripts I am slightly dreading analysing as I don't have especially positive memories of the interviews. I just need to make sure that I keep an open mind and as soon as I notice that I am feeling less focused that I give myself permission to take a bit of a break before resuming the coding. Here goes…"

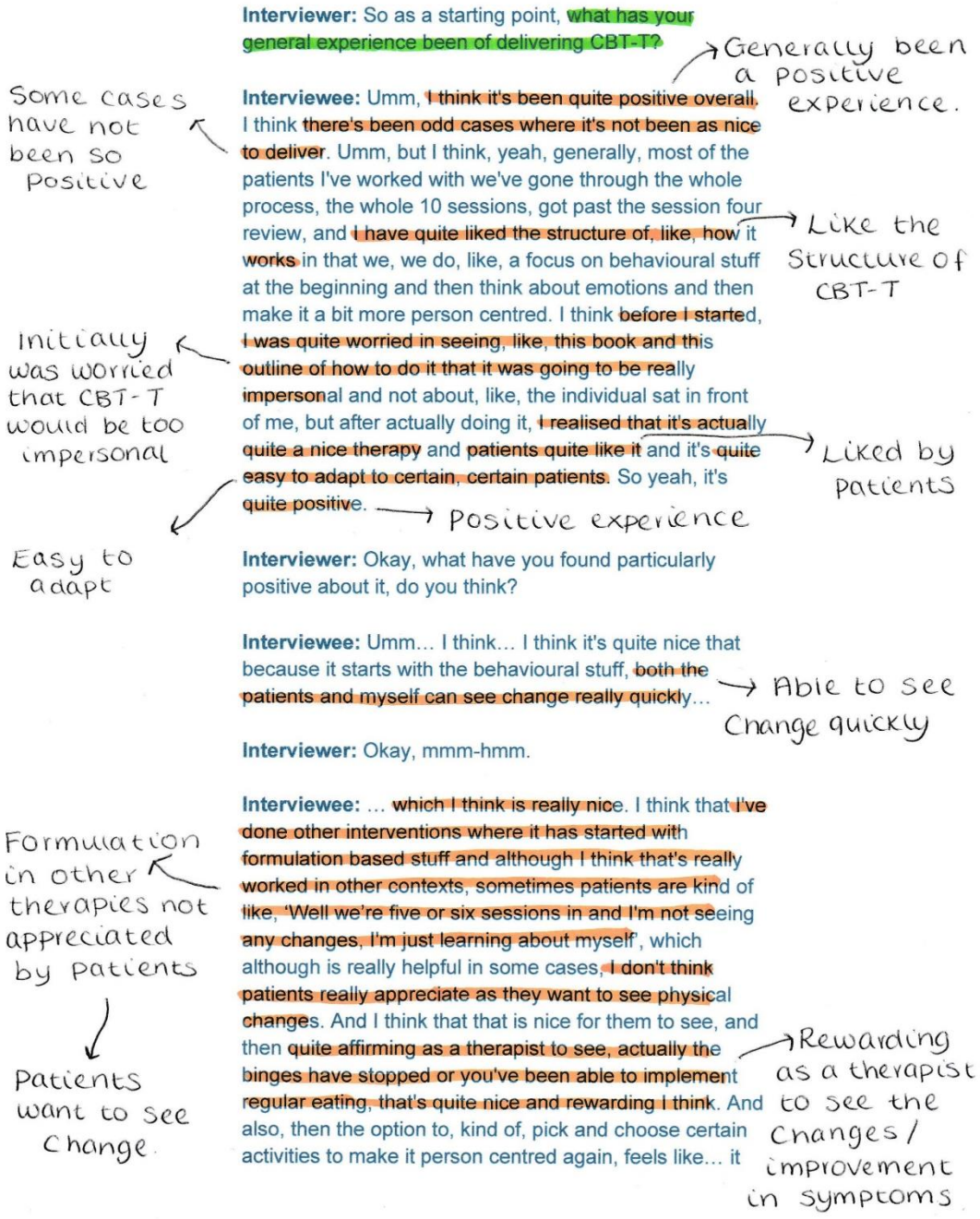
"Coding this interview felt like a bit of a breath of fresh air in comparison to the last couple of interviews I have coded. Going through the last couple of interviews has felt like there was a lot of text to go through, but in reality a lot of it was not especially relevant and there were big chunks of text where there was not anything of relevance I could code. This interview, however, seemed a lot more focused and I have been able to draw out a lot of codes, some of which I feel were coming up more than once. As with the other interviews, it is clear that the participant does veer away from the protocol at times, however that this feels more of a service-level decision as opposed to an individual decision in comparison to the other interviews. If services more generally aren't sticking to the protocol, this raises questions about why they feel that the protocol needs to be adapted and whether they have tried to deliver the protocol as it is written before making these decisions."

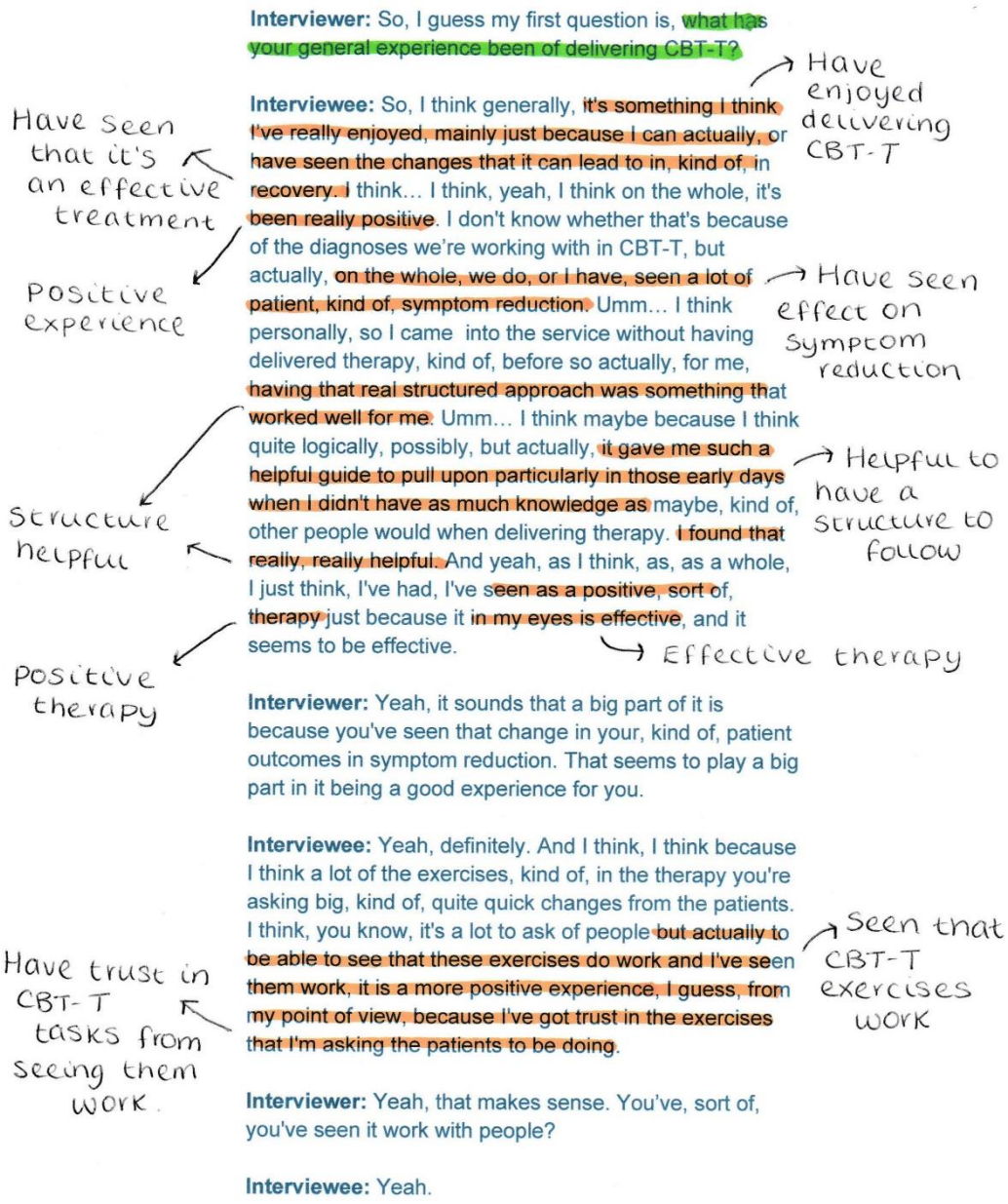
"There wasn't anything particularly of note that I have to say about coding this transcript. There was a lot said in the transcript, but lots of this was not really relevant or relating to how the participant experiences delivering CBT-T. I think I wrote about this person's personal experience of having an eating disorder after I did their interview, and again this is something that struck me at parts when coding their transcript about the impact that their own views have on treatment delivery. It certainly felt like this person felt they are more able to deliver CBT-T given their previous CBT training and that this has been of benefit to them – it would be interesting to know if other CBT therapists hold the same opinion, or equally whether people who have not had CBT training who deliver CBT-T would feel that this affects their ability. There were also ideas coming up about CBT-T having highlighted the importance of early change, but also feeling that CBT-T is not long enough when it feels there are more complexities to deal with. It is interesting as this is something that has come up when coding some of the other transcripts, particularly because CBT-T is designed to specifically be a treatment for eating disorders, not co-morbidities. I wonder if this is something that needs to be made more explicit in the training or protocol to emphasise that it's deliberately designed to solely focus on the eating disorder?"

Appendix U

Examples of Coding




Interviewer: So as a starting point, what has your general experience been of delivering CBT-T?
Generally been a positive experience.
Some cases have not been so positive
Interviewee: Umm, I think it's been quite positive overall. I think there's been odd cases where it's not been as nice to deliver. Umm, but I think, yeah, generally, most of the patients I've worked with we've gone through the whole process, the whole 10 sessions, got past the session four review, and I have quite liked the structure of, like, how it works in that we, we do, like, a focus on behavioural stuff at the beginning and then think about emotions and then make it a bit more person centred. I think before I started, I was quite worried in seeing, like, this book and this outline of how to do it that it was going to be really impersonal and not about, like, the individual sat in front of me, but after actually doing it, I realised that it's actually quite a nice therapy and patients quite like it and it's quite easy to adapt to certain, certain patients. So yeah, it's quite positive.
Like the Structure of CBT-T
Initially was worried that CBT-T would be too impersonal
Liked by patients
Positive experience
Easy to adapt
Interviewer: Okay, what have you found particularly positive about it, do you think?
Interviewee: Umm... I think... I think it's quite nice that because it starts with the behavioural stuff, both the patients and myself can see change really quickly...
Able to see Change quickly
Interviewer: Okay, mmm-hmm.
Interviewee: ... which I think is really nice. I think that I've done other interventions where it has started with formulation based stuff and although I think that's really worked in other contexts, sometimes patients are kind of like, 'Well we're five or six sessions in and I'm not seeing any changes, I'm just learning about myself', which although is really helpful in some cases, I don't think patients really appreciate as they want to see physical changes. And I think that that is nice for them to see, and then quite affirming as a therapist to see, actually the binges have stopped or you've been able to implement regular eating, that's quite nice and rewarding I think. And also, then the option to, kind of, pick and choose certain activities to make it person centred again, feels like... it
Formulation in other therapies not appreciated by patients
Patients want to see Change
Rewarding as a therapist to see the Changes / improvement in symptoms


Interviewer: So, I guess my first question is, what has your general experience been of delivering CBT-T?
Have enjoyed delivering CBT-T
Interviewee: So, I think generally, it's something I think I've really enjoyed, mainly just because I can actually, or have seen the changes that it can lead to in, kind of, in recovery. I think... I think, yeah, I think on the whole, it's been really positive. I don't know whether that's because of the diagnoses we're working with in CBT-T, but actually, on the whole, we do, or I have, seen a lot of patient, kind of, symptom reduction. Umm... I think personally, so I came into the service without having delivered therapy, kind of, before so actually, for me, having that real structured approach was something that worked well for me. Umm... I think maybe because I think quite logically, possibly, but actually, it gave me such a helpful guide to pull upon particularly in those early days when I didn't have as much knowledge as maybe, kind of, other people would when delivering therapy. I found that really, really helpful. And yeah, as I think, as, as a whole, I just think, I've had, I've seen as a positive, sort of, therapy just because it in my eyes is effective, and it seems to be effective.
Have seen that it's an effective treatment
Positive experience
Have seen effect on symptom reduction
Structure helpful
Helpful to have a structure to follow
Positive therapy
Effective therapy
Interviewer: Yeah, it sounds that a big part of it is because you've seen that change in your, kind of, patient outcomes in symptom reduction. That seems to play a big part in it being a good experience for you.
Interviewee: Yeah, definitely. And I think, I think because I think a lot of the exercises, kind of, in the therapy you're asking big, kind of, quite quick changes from the patients. I think, you know, it's a lot to ask of people but actually to be able to see that these exercises do work and I've seen them work, it is a more positive experience, I guess, from my point of view, because I've got trust in the exercises that I'm asking the patients to be doing.
Seen that CBT-T exercises work
Have trust in CBT-T tasks from seeing them work
Interviewer: Yeah, that makes sense. You've, sort of, you've seen it work with people?
Interviewee: Yeah.

Interviewer: Are there any particular interventions in CBT-T that you think are more difficult to deliver than others?

Interviewee: I don't think so. I really value the body image sessions. I'm now using them within phase three of FBT when we hit the body image, I now transfer the skills from CBT-T because I find it really effective. The behavioural experiments, just the general, you know, the really, kind of, general chat, the mirror exercise, all very appropriate if it's led by the patient of what they need. And I think what's nice about it is you're only delivering those bits if they hit the criteria for avoidance or, you know, the mind reading. You're not going to be just delivering them. It's very patient-centered and I love that about the surveys, and I like that about the mirror exercises and the behavioural experiments, so you're led by them really. But I definitely feel that they're very, kind of, I don't find them difficult to deliver, I think you build your confidence up with them. And the mirror exposure in particular is one of the things where actually doing it is actually a lot easier than the thought of doing it with a patient. But no, I don't find them difficult to deliver. I actually think keep it quite straightforward, it doesn't need to be complicated.

Interviewer: Yeah, okay. So you briefly mentioned session four but as you know, that's the point where we're reviewing the progress of the first four sessions and making that decision of are we going to continue with therapy or not. What's been your experience of session four?

Interviewee: Generally very positive. You know, it's, you are always reviewing them each session, that' how I see it anyway. And you're, I think it gives them, like, quite a nice overview of what they've been doing since session one. So you've got, like, a really good opportunity and space to chat about how they feel it's gone and look at the changes, look at their goals, and look at a weight trend. It feels like you've got a good amount of time, it feels like you've established a rapport with your patients. So I always find session four is quite a good point really,

Value body image part of treatment

Transfer skills from CBT-T to other therapies

CBT-T is person centred

Led by the patient

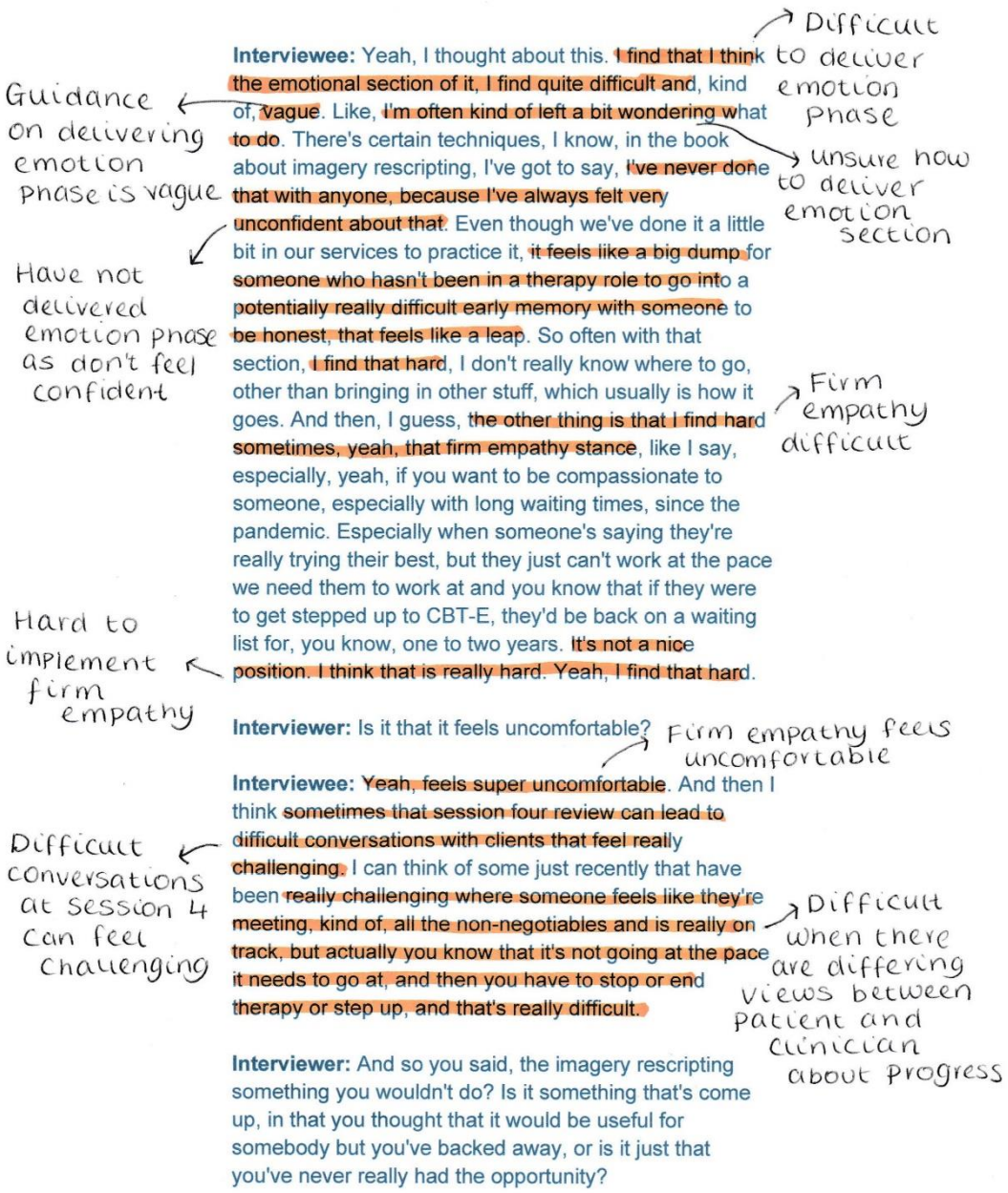
Build up confidence with delivering particular interventions

mirror exposure easier to deliver than expected

Generally had a positive experience of session 4.

Session 4 is useful to review progress

Established rapport by session 4



Interviewee: Yeah, I thought about this. I find that I think the emotional section of it, I find quite difficult and, kind of, vague. Like, I'm often kind of left a bit wondering what to do. There's certain techniques, I know, in the book about imagery rescripting, I've got to say, I've never done that with anyone, because I've always felt very unconfident about that. Even though we've done it a little bit in our services to practice it, it feels like a big dump for someone who hasn't been in a therapy role to go into a potentially really difficult early memory with someone to be honest, that feels like a leap. So often with that section, I find that hard, I don't really know where to go, other than bringing in other stuff, which usually is how it goes. And then, I guess, the other thing is that I find hard sometimes, yeah, that firm empathy stance, like I say, especially, yeah, if you want to be compassionate to someone, especially with long waiting times, since the pandemic. Especially when someone's saying they're really trying their best, but they just can't work at the pace we need them to work at and you know that if they were to get stepped up to CBT-E, they'd be back on a waiting list for, you know, one to two years. It's not a nice position. I think that is really hard. Yeah, I find that hard.

Interviewer: Is it that it feels uncomfortable?

Interviewee: Yeah, feels super uncomfortable. And then I think sometimes that session four review can lead to difficult conversations with clients that feel really challenging. I can think of some just recently that have been really challenging where someone feels like they're meeting, kind of, all the non-negotiables and is really on track, but actually you know that it's not going at the pace it needs to go at, and then you have to stop or end therapy or step up, and that's really difficult.

Interviewer: And so you said, the imagery rescripting something you wouldn't do? Is it something that's come up, in that you thought that it would be useful for somebody but you've backed away, or is it just that you've never really had the opportunity?

kinder way than that, but, I guess, those were my worries at first.

Interviewer: Okay. Has your experience of delivering CBT-T changed over time?

Interviewee: Yeah, I think I've felt so much more confident delivering it and as I've started to deliver other therapies as well, which are a bit more out of my comfort zone, I think CBT-T as a, like, really familiar, safe treatment. So yes, I would say. And I guess then as well, just, sort of, the things that we've already discussed. So taking into account the fact that that's a little bit more risk now, and probably more, complexities. Those things have changed it also. But from my experience, I guess more confidence.

Interviewer: Yeah. Why do you think that's been the case?

Interviewee: I think that familiarity, and I think seeing such a mixture of people as well has helped because then it hasn't thrown me if similar situations have come up. Yeah, more diverse, sort of, clients and familiarity, I would say. Yeah.

Interviewer: In your experience, which elements of treatment are most helpful to patients?

Interviewee: I think the food diaries for most people are very helpful, and getting that regular eating pattern in place. I think testing out fear foods has been really, really helpful when people have had a history of yoyo dieting and lots of really strict rules around foods, I think that's been really, really helpful. And, I guess, just behavioural experiments as well around vomiting, over-exercise, like, you know, people when they come back so certain 'I know my weight is going to be this much higher this week' and it isn't then that's such a shock. I think that's such physical evidence. And then, as I said, I've actually been so surprised about how helpful the surveys have been, how much I've seen people come back in their follow-up appointments and say like, at the time it was interesting, but I've been dwelling over that over the last

Improved confidence over time

CBT-T feels safe to deliver

Become more confident over time.

Seeing a variety of presentations has aided confidence

Patients find food diaries helpful

Regular eating helpful

Behavioural experiments useful

Surveys useful

Surprised by this

this treatment is it worth carrying on when it's making me really uncomfortable that you're not benefiting from it'. Having that early chance is definitely really helpful. Sometimes, as well, it's a great opportunity to reinforce people who are doing really well. It's just in the middle ground in between these two gets a bit difficult and sometimes, particularly without regular supervision, I would imagine that it's really difficult when to know where to draw that boundary between pushing for more of taking a step back and ending at that point.

Session 4 particuarly difficult when patient has made changes, but you're unsure if it's enough

Supervision aids decision making

Interviewer: There's that sort of grey area, isn't there? People that are doing it, but are they doing quite enough.

Interviewee: Yeah.

Interviewer: What is session four like with those sorts of people?

Interviewee: I think it… it depends really, I guess, on how… what the… I'm not too sure, really, but generally, it can feel quite uncomfortable but generally, at the end of the session, generally that's, on reflection, it feels like it's been quite positive. I think as uncomfortable as that feels in the moment beforehand, and I imagine for patient as well as for myself because, in particular now, I really understand the rationale for it and I have seen that rationale in happening. I think it helps me to then put that across and helps them to accept why what's happening at that session four, if we are deciding to stop or if we do need to really step things up if we want to continue. So, generally, that ends up feeling positive, but certainly to begin with, the first few times I've had to have those conversations at session four, that, perhaps was a bit trickier.

Understanding and experiencing evidence that supports the treatment rationale aids with delivery.

Session 4 used to be more difficult

Experience reduces anxiety

Interviewer: Yeah, it sounds like because you've, kind of, you now have, sort of, seen the rationale for it in practice, that that helps with that experience of seeing why helps you to, kind of, do it, whereas perhaps in the beginning that you a bit more tentative with it.

Interviewee: Yes. And it's really helped me explain it, as well, in a really compassionate way, whereas perhaps