

# Helpful and unhelpful aspects of eating disorders treatment involving psychological therapy

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*A meta-synthesis of qualitative research studies*

**Ladislav Timulak, Julia Buckroyd, Jan Klimas, Mary Creaner, David Wellsted, Frances Bunn, Siobhan Bradshaw and George Green**

**Note:**

This review was written in two stages by two different teams. Julia Buckroyd's team, comprising David Wellsted, Frances Bunn, Siobhan Bradshaw and George Green, undertook stage one. This involved writing the introduction, the first part of the method section, and the methodological aspects of the study referred to in the results section. Ladislav Timulak's team, comprising Jan Klimas and Mary Creaner, undertook stage two. This involved completing the write-up for the second part of the method section, and for writing the results section and the discussion. The main text has further details of each team's involvement.

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## Executive summary

Eating disorders (ED) represent considerable psychological and physical impairment to an individual and can have a chronic course and associated psychiatric and medical co-morbidities (Fairburn and Brownell, 2002). Evidence suggests that the treatment of EDs represents a considerable economic cost to society (Simon *et al*, 2005) and can have detrimental effects on family life (Hillege *et al*, 2006). The standardised mortality ratio for EDs is among the highest for any psychiatric condition (Harris and Barraclough, 1998).

Treatment of ED is complex, multifaceted and multidisciplinary in approach. With reference to psychological therapy intervention, evidence of the effectiveness of some psychological therapies exists; however, few studies take into account the patient's perspective of treatment interventions and what they experience as helpful or unhelpful in this regard. The contribution that service users can make to the development of treatments is increasingly being acknowledged and has been identified as a helpful and necessary component to effective implementation of treatments in health care as evidenced by the UK's Department of Health (2001; 2006). The service users' voices and concerns were at the heart of proposals that emphasised the fact that people should be given more choices and control over their treatment. Developing treatments that are accessible and acceptable to users has obvious benefits in their potential to reduce dropout and increase treatment compliance.

In summary, investigating patient and client perceptions of helpful and unhelpful aspects and impacts of ED treatments can provide useful information for developing and delivering treatments in future. Therefore, this report systematically reviews the qualitative studies and syntheses reported helpful and unhelpful aspects and impacts of ED treatments that involve psychological therapy.

### Aim

This meta-analysis sought to review and meta-analyse qualitative studies investigating helpful and unhelpful aspects of treatment that contain psychological therapy.

### Method

To answer our research question 'What aspects of eating disorders treatment that includes psychological therapy do clients find helpful or unhelpful?' we employed a method of qualitative meta-analysis. Qualitative meta-analysis is a form of secondary data analysis that meta-analyses findings from primary qualitative studies that were attempting to answer the same research question (Timulak, 2009; Timulak, in press). In meta-analysis, the findings from the original studies are treated as data for further qualitative analysis, which seeks to extract and classify similarities and differences in the original data. The ultimate goal is to provide a comprehensive picture of the studied phenomenon by using a rigorous qualitative method of analysis (Timulak, 2009; Timulak, in press).

In total, 25 papers (24 studies) were systematically reviewed to discover what clients with an ED diagnosis identified as helpful or unhelpful in their treatment. The studies involved 1,058 participants

with an age range of 11 to 50. There were seven studies conducted in the USA, nine in the UK, one in Canada, one in Hong Kong and one each in Australia, Sweden, South Africa, Norway, New Zealand, and one in both the UK and Australia.

### **Key findings**

With reference to the helpful aspects of treatment identified by clients/patients, six domains (containing 30 meta-categories) pertinent to their experience were identified:

- 1) Broader social support (this domain contained three meta-categories: *Support from co-patients; Sharing with others; Support from relatives, close ones and strangers*)
- 2) Relational support from mental health professional (*Trusting and supportive relationship with professional; Feeling understood/being listened to/having opportunity to talk; Being seen as a person; Feeling cared for*)
- 3) Important characteristics of mental health professional (*Mental health professional (therapist) as an expert; Mental health professional providing encouragement and guidance/modelling/validation*)
- 4) Important general characteristics of treatment (*Importance of psychological therapy/importance of addressing interpersonal issues; Client active in own treatment/treatment collaboration; Structure in the treatment; Client soliciting social and professional help; treatment's symptom focus; financial and other accessibility; Treatment focused on the whole family; Importance of follow-up interventions*)
- 5) Important specific characteristics of treatment (*Self-monitoring/monitoring; Behaviour change/experiments/gaining control; Cognitive restructuring; Nutritional knowledge/knowledge about detrimental effects of ED and ED itself; Emotional expression/emotional awareness; Importance of leisure activities/social distraction; Therapy providing holding space; Focus on interpersonal skills*)
- 6) Important in-treatment changes contributing to helpfulness of treatment (*Insight; Self-acceptance/self-worth; Learning about the self; Change in life circumstances/positive life events*).

Unhelpful events identified in the studies also rendered six domains (containing 18 meta-categories):

- 1) Perceived lack of broader social support (this domain contained two meta-categories: *Distressing or misleading influence of co-patients; Unsupportive family/friends*)
- 2) Perceived lack of relational support from mental health professional (*Being overlooked as a person/not cared for; Therapist or treatment programme hostile/punitive or lacking warmth and care; Lacking trust in others*)
- 3) Perceived deficiencies in important characteristics of mental health professional (*Lack of expertise/mental health professional missing important issues/mental health professional's own issues*)
- 4) Perceived deficiencies in important general characteristics of treatment (*Non-responsiveness of the treatment/treatment missing client's needs/treatment too rigid; Lack of continuity in treatment/lack of follow-up/inappropriate length and/or form of treatment; Focus of the treatment on eating and not on psychological needs and distress; Stigma of psychiatric setting/diagnosis; Lack of involvement in own treatment/loss of control; Psychological therapy superficial; Lack of structure in treatment/relying on the client's discipline*)

- 5) Perceived deficiencies in important specific characteristics of treatment (*Lack of information regarding ED and nutritional facts*)
- 6) Painful experiences contributing to the unhelpfulness of treatment (*experiences of hopelessness/low mood/shamed/vulnerability/self-judgment; Feeling alone*).

## Discussion

This meta-analysis identified a number of key observations for consideration in ED treatment planning, clinical practice and future inquiry. For instance, contextual factors such as co-patients as well as family and other significant people in the client's life (eg peers) may play a very important positive as well as a negative role in ED treatment. Awareness of the potential of involving co-patients (eg through offering mutual support and opportunities for sharing and learning) as well as offering a caution around their potential negative influence (through providing distressing or negatively influencing examples) is very important for the inpatient and group treatments that are often a treatment of choice for some ED problems.

The findings that refer to relational aspects of the treatment emphasised the crucial role of the mental health professionals' relational qualities and the detrimental impact on the client when these are absent. It was interesting to observe that clients appreciated the expertise of the mental health professional that is specific to EDs.

Furthermore, the findings demonstrated that psychological therapy, while appreciated and valued by clients, needs to be accessible and offered in a client-centred format that facilitates clients to play an active role in their treatment. This in turn may reinforce for the client their own motivation to change and enhance their engagement in therapy.

Specific helpful aspects of psychological treatments identified were interventions that are part of the current empirically based treatments for EDs, particularly cognitive-behavioural therapies.

Interestingly, clients valued emotion-focused aspects of treatment. They also appreciated a broader focus of the treatment: for example, that it involved group and family interventions (although these could also be experienced as difficult) or that it focused on the appropriate use of, for instance, leisure activities. The broader focus allowed for not focusing solely on eating which is a preoccupying theme for these clients. The clients also referred to the importance of appropriate follow-up for treatment success. Given the complexity of ED difficulties, this seems to be a crucial element supporting gains and recovery and for preventing relapse.

On reviewing the helpful and unhelpful aspects of the treatment reported in our meta-analysis it is noteworthy that clients valued both the *symptom focus* (ED focus) and the focus on the *underlying* personality and identity related *dynamic* that found expression in the disordered eating. Indeed, the absence of either of those two aspects was seen as unhelpful. This would suggest the usefulness of the combination of both aspects of the treatment. Attending to both aspects of treatment in clinical practice and future research is indicated when developing new treatments or when adjusting already existing treatments for EDs.

The findings emphasised the importance of changes achieved by the client during the treatment which then have a further impact on the treatment. Several studies referred to the helpfulness of insight and self-acceptance achieved by clients. Conversely, setbacks and negative experiences can increase the risk of dropout or failure of treatment. Experiences of hopelessness, shame and general distress are particularly threatening. The client's vulnerability to those feelings highlights the need for the compassionate, caring presence of the therapist who tries to reach out and connect with the client's emotional pain. It also highlights the importance of utilising the potential of the client's social support network (eg co-patients, peers) in ED treatment.



## Introduction

### Features and prevalence of eating disorders

Eating disorders represent considerable psychological and physical impairment to an individual and can have a chronic course and associated psychiatric and medical co-morbidities (Fairburn and Brownell, 2002). Evidence suggests that the treatment of EDs represents a considerable economic cost to society (Simon *et al*, 2005) and can have detrimental effects on family life (Hillegge *et al*, 2006). The standardised mortality ratio for EDs is among the highest for any psychiatric condition (Harris and Barraclough, 1998).

The two most common forms of ED are anorexia nervosa (AN) and bulimia nervosa (BN). AN has been recognised since the late 19<sup>th</sup> century, identified by two separate clinicians, the French physician Henri Laseque and the British physician William Gull in the 1870s (cited by Vandereycken, 2002). Self-starvation, however, seems to have been recognised as a phenomenon in many cultures, particularly throughout the Christian era (Bemporad, 1996; Brumberg, 1988, 2000). Early descriptions were clear that AN was perceived as a psychological condition and although there was a period from 1914 to about 1945 when endocrine abnormalities were thought to be involved, thereafter a psychological account of it prevailed (Vandereycken, 2002). BN was first described and named by Russell (1979) who originally suggested it was 'an ominous variant of anorexia nervosa' (p. 429) while also drawing out distinctions with people suffering from AN. According to Russell (1979) those who suffer from BN, despite self-enforced weight regulation, were still liable to be heavier.

Diagnostic definitions of AN and BN are included in the Diagnostic and Statistical Manual of Mental Disorders DSM-IV (2000), the American Psychiatric Association list of mental disorders, and in the International Classification of Diseases ICD-10 (1992), the corresponding World Health Organization list. Other variant EDs have been recognised by DSM-IV (APA, 2000) under the general heading of Eating Disorders Not Otherwise Specified (EDNOS) and include the best known of them, binge eating disorder (BED) (Fairburn and Wilson, 1993).

AN is characterised by self-imposed starvation. Patients with AN restrict eating, have less than 85 per cent of their expected body weight, have an intense fear of becoming fat, even though underweight, and are preoccupied with evaluation of their body shape. In addition, in postmenarchal females, amenorrhoea (an absence of at least three consecutive menstrual cycles) is also an indication of diagnosis according to the current DSM-IV (APA, 2000) diagnostic criteria (this criterion may be omitted in DSM-V, due for publication in May 2013). The physical consequences of these practices for AN and variants of this condition are loss of muscle and bone mass, which in serious cases are irreversible and may sometimes be fatal. The international prevalence of AN amongst females in late adolescence and early adulthood is estimated to be between 0.5 and one per cent (APA, 1994).

BN is characterised by recurrent episodes of binge eating. Bulimics engage in behaviours such as purging to prevent weight gain. To meet the DSM-IV (APA, 2000) criteria for BN, the bingeing and compensatory activities must occur at least twice a week for three months (again, DSM-V may bring changes to this criterion). Physical consequences of BN and variants of this condition include

electrolyte imbalance, erosion of dental enamel and damage to the digestive system. The international prevalence of BN has been estimated to involve approximately one to three per cent of adolescents and young adult females (APA, 1994). Both AN and BN occur more commonly in females than males (Hoek, 2006).

BED is defined as uncontrollable overeating without the compensatory purging or the excessive exercise characteristics of BN and therefore is associated with obesity (Hill and Pomeroy, 2001). It is estimated that 30 per cent of obese people seeking treatment are diagnosable with BED (Hsu *et al*, 2002). BED appears to affect an older age group, with a lesser difference in ratio of women to men than either AN or BN (Fairburn and Harrison, 2003). In a review of the prevalence of EDs, an average prevalence rate of at least one per cent was found for people diagnosed with BED (Hoek and van Hoeken, 2003).

### **NICE guidelines and quantitative research evidence**

There is considerable evidence that recovery rates for EDs are low, and relapse upon first receiving treatment is high (Herzog *et al*, 1999; Steinhausen, 2002; Strober *et al*, 1997). Herzog *et al* (1999) estimated that recovery rates of BN were 74 per cent and those of AN were 33 per cent at 90 months' follow-up but calculated that approximately one third of both anorexics and bulimics relapse after recovery. Recovery rates of 50-60 per cent at one-year follow-up have been demonstrated for BED (Wilfley *et al*, 2002). In 2004 the National Institute for Health and Clinical Excellence (NICE) published guidelines regarding the core interventions in the treatment and management of EDs for adults, adolescents and children aged eight years and upwards. The guidelines covered assessing, coordinating and managing care together with recommendations for pharmacological and psychological treatment. The recommendations relating to psychological treatment are summarised in Box 1.

Box 1: Summary of NICE guidelines for psychological treatment (pp. 64-65, 69, 71)

#### *Anorexia nervosa*

- Therapies to be considered include: cognitive analytic therapy (CAT), cognitive behaviour therapy (CBT), interpersonal psychotherapy (IPT), focal psychodynamic therapy and family interventions focused specifically on EDs.
- Patient preference should be taken into account in selecting the type of therapy.
- Aims of therapy should be to reduce risk, encourage weight gain and healthy eating, reduce other related symptoms and facilitate psychological and physical recovery.
- Management should usually be on an outpatient basis with treatment of six months' duration provided by a professionally competent healthcare professional.
- Dietary counselling should not be the sole treatment.
- For inpatients, a structured symptom-focused regimen should be provided with the aim of achieving weight restoration. Psychological treatment should focus on eating behaviour and attitudes to weight and shape with an expectation of weight gain.
- Outpatient psychological treatment should focus on eating behaviour and attitudes, and wider psychosocial issues, with regular risk monitoring for at least 12 months.

- For children and adolescents, family interventions should be offered that directly address the ED, however the child/adolescent should also be offered separate appointments.
- The therapeutic involvement of siblings and other family members should be considered in all cases of AN.

#### *Bulimia nervosa*

- A first step should be an evidence-based self-help programme, supplemented by direct encouragement and support from healthcare professionals.
- 16-20 sessions of CBT-BN, a specifically adapted form of CBT, should be offered to adults over a course of four to five months.
- Those not responding to, or not wishing to receive, CBT should be offered other psychological treatments.
- IPT should be considered as an alternative to CBT on the understanding that results should be expected over eight to 12 months.
- CBT-BN should be adapted as appropriate for adolescents.

#### *Atypical eating disorders*

- A first step should be an evidence-based self-help programme, supplemented by direct encouragement and support from healthcare professionals.
- CBT-BED, a specifically adapted form of CBT, should be offered to adults with a binge eating disorder.
- Other psychological treatments such as IPT and modified dialectical behaviour therapy may be offered to adults with persistent BED.
- Patients should be informed that psychological treatments for BED have limited effect on weight.

NICE guidelines seek to provide the best available evidence on interventions. Where possible this is based on evidence from systematic reviews and randomised controlled trials of quantitative research that are agreed by a Guideline Development Group (GDG) of experts in the field. Where evidence was not available, recommendations were based upon the consensus of the GDG. In the case of EDs, there was a lack of high quality (systematic review or randomised controlled trial) evidence. The majority of the guideline statements are therefore based on the recommendations made by expert committee reports or the clinical experiences of the members of the GDG. This is particularly the case for the treatment of AN where all the guideline statements were made in this way. Clearly, further high quality evidence is needed to demonstrate the effectiveness of treatment interventions for EDs.

While reference is made in the NICE guidelines (2004) to professional competence, as noted by Williams and Haverkamp (2010), few objective criteria currently exist for mental health practitioners to evaluate their competence in ED treatment intervention and provision.

In a Delphi study, which sought to identify core competencies for mental health professionals working psychotherapeutically with clients who presented with EDs, Williams and Haverkamp (2010) suggest that as a baseline, mental health professionals working in this context need to hold specific competencies in a number of key areas. These areas include 'core knowledge and skills,

interdisciplinary teamwork, specialised therapeutic relationship skills, professional responsibility, and therapist characteristics' (p. 105). Relational competencies as they pertained to the therapeutic relationship were seen as essential to positive treatment outcomes. The authors also recommend awareness of cultural factors for effective ED treatment. Provision of culturally relevant ED treatment is a point further endorsed in the literature (Smart, 2010; Talleyrand, 2012).

Since the publication of the NICE guidelines (2004), a number of quantitative studies and systematic reviews have been published (Berkman *et al*, 2007; Bulik *et al*, 2007; Brownley *et al*, 2007; Fisher *et al*, 2010; Hay *et al*, 2003; Hay *et al*, 2009; Shapiro *et al*, 2007; Waller, 2009). These have provided some further evidence on the effectiveness of psychological treatments for EDs. In summary, these suggest that psychological treatments have relatively low levels of impact on AN and there is no clear difference in outcome between treatments; psychological treatments for BN and BED are relatively effective with the best evidence for the effectiveness of CBT-BN and long-term effects for IPT; and patients with AN benefit more from family oriented treatment than treatment as usual (Fisher *et al*, 2010; Hay *et al*, 2003; Hay *et al*, 2009).

Although these studies provide evidence of the effectiveness of some psychological therapies, studies of the effectiveness of interventions may not take into account the patient's perspective of the treatment. Previous studies have highlighted a dissatisfaction from a patient's perspective with treatment for EDs, with one survey (Newton *et al*, 1993) stating that, 'existing services for individuals with eating disorders are inadequate, and that more, better and accessible services for the range of problems faced by this group of people must be provided' (p. 19). This survey rated the various forms of treatment experienced by AN sufferers and found that self-help groups were judged either slightly or very helpful by 84 per cent, followed by counselling at 80 per cent. By contrast, treatment by the family doctor was rated at 57 per cent while all other forms of treatment, including medication, behaviour therapy and other forms of talking therapy, were rated less satisfactory than self-help or counselling. In contrast 25 per cent said that inpatient treatment had made their problems worse and 19 per cent stated that inpatient treatment was unhelpful. Rosenvinge and Klusmeier (2000) replicated this study in a Norwegian setting and found that outpatient individual and group treatments as well as self-help activities were seen as the most helpful, while family therapy was seen as the least helpful.

Bell (2003) conducted a review of qualitative literature and consumer related studies for EDs. Twenty-three studies were included in the review, which concluded that support, understanding and empathic relationships are critical aspects of treatment. Psychological interventions such as counselling are perceived as the most helpful, whereas medical interventions and those that focus solely on weight gain were perceived as unhelpful. Bell (2003) also drew attention to a number of methodological weaknesses in the literature. These included biased samples involved in the studies, a lack of standardised measures for assessing satisfaction, small samples and poorly defined treatment categories preventing meaningful comparisons between studies.

An Eating Disorders Association paper published online by the chief executive of BEAT, the leading UK charity for people with EDs and their families, suggests that adolescents find it difficult to get help and support for their disorder (Ringwood, 2007). These findings taken together with the

recommendations provided in the Bell (2003) review suggest that consultation with service users regarding their experience of help-seeking may be useful to consider when developing and delivering treatment for sufferers. Obtaining the views of service users is further endorsed by NICE guidelines which recommend that clients' views should be taken into account when deciding which psychological treatments to offer (NICE, 2004). Subsequent research also suggested the need to find interventions that are both effective and acceptable to patients (Bulik *et al*, 2007; Brownley *et al*, 2007; Shapiro *et al*, 2007). The need to examine which components of complex therapies (such as CBT) are the active components has also been recommended (Bulik *et al*, 2007; Brownley *et al*, 2007; Shapiro *et al*, 2007). Although qualitative research examining the client's perspective on helpful and unhelpful aspects of treatment does not allow for establishing the active components of the treatment (as the clients may not be fully aware of them), it helps to provide the service user's perspective on the impact of various components of the treatment. Focusing on qualitative data and the patient's perspective may also shed light on the problem identified by Waller *et al* (2009) that relatively few patients who are referred to specialist services either make it through to treatment or complete treatment.

The contribution that service users can make to the development of treatments is increasingly being acknowledged and has been identified as a helpful and necessary component to effective implementation of treatments in health care as evidenced by the UK's Department of Health (2001; 2006). In these reports the people's voices and concerns were at the heart of proposals that emphasised the fact that people should be given more choice and control over their treatment. Developing treatments that are accessible and acceptable to users has obvious benefits in their potential to reduce dropout and increase treatment compliance.

In summary, investigating patient and client perceptions of helpful and unhelpful aspects and impacts of ED treatments can provide useful information for developing and delivering treatments in future. Therefore, this report systematically reviews the qualitative studies and synthesises reported helpful and unhelpful aspects and impacts of ED treatments that involve psychological therapy.

### **Overall aim**

The overall aim of this study was to review and meta-analyse qualitative studies investigating helpful and unhelpful aspects of treatment that contain psychological therapy. Consequently, we sought to answer the following research question: What aspects of eating disorder treatment that involves psychological therapy do clients find helpful or unhelpful?

## Method

### Design

To answer our research question ‘What aspects of eating disorders treatment that involves psychological therapy do clients find helpful or unhelpful?’ we employed a method of qualitative meta-analysis or meta-synthesis. Qualitative meta-analysis is a form of secondary data analysis that meta-analyses findings from primary qualitative studies that were attempting to answer the same research question (Dixon-Woods *et al*, 2006; Noblit and Hare, 1988; Kearney, 1998; Paterson *et al*, 2001; Sandelowski and Barroso, 2003; Schreiber *et al*, 1997; Stern and Harris, 1985; Thomas and Harden, 2008; Thorne *et al*, 2004; Timulak, 2009; Timulak, in press). In meta-analysis the findings from the original studies are treated as data for further qualitative analysis, which seeks to extract and classify similarities and differences in the original data. The ultimate goal is to provide a comprehensive picture of the studied phenomenon by using a rigorous qualitative method of analysis (Timulak, 2009; Timulak, in press).

### Procedure

The meta-synthesis of qualitative studies investigating the clients’ perceptions of helpful and unhelpful aspects of psychological treatments for EDs comprised several steps. Firstly, the relevant studies that qualitatively examined the client’s perception of helpful and unhelpful aspects of psychological treatment of EDs were searched for and selected. Secondly, the selected studies were assessed to determine how the methodology employed in the study impacted on the findings that were germane to our meta-synthesis. Thirdly, the selected studies were reviewed and any relevant findings pertinent to the question that led our meta-analysis were identified and summarised in the form of meaning units (ie short descriptions that summarised reported findings in the form of self-explanatory statements). Fourthly, the identified meaning units were further qualitatively analysed and clustered according to their similarity, which resulted in establishing meta-categories (meta-summaries). These were then systematically organised to comprehensively capture the phenomenon of the clients’ perceived helpful and unhelpful aspects of treatment. The entire analysis followed a descriptive-interpretative framework for qualitative meta-analysis (Timulak, 2009; Timulak, in press). Throughout the analysis credibility checks were employed (the details about the analysis, re-checking and auditing are provided below).

### Research team

The study was conducted in two phases by two different research teams. The first team led by Julia Buckroyd (comprising David Wellsted, Frances Bunn, Siobhan Bradshaw and George Green) selected the relevant studies and conducted an initial appraisal of their relevance and methodological quality. The second team led by Ladislav Timulak (comprising Jan Klimas and Mary Creaner) then reviewed the findings of the selected studies, prepared their summaries in the form of meaning units, analysed the meaning units (compared their similarities and differences), assigned them to meta-categories, organised the meta-categories and prepared the write-up of the findings of the meta-analysis.

### Selecting primary studies

Julia Buckroyd’s team selected the relevant qualitative studies (ie those that investigated the client’s perception of helpful and unhelpful aspects of ED treatment that involved psychological therapy). In

order to gain access to the largest possible number of studies in databases, several key texts were consulted (eg Barroso *et al*, 2003; Evans, 2002; McKibbin *et al*, 2006; Shaw *et al*, 2004) to help identify which search terms to use. Both thesaurus and free text searching were undertaken to obtain the most comprehensive results. Thesaurus terms were exploded and narrower terms examined to see whether any potential terms for EDs could be identified. No date restrictions were applied and all available years were searched on the following databases: ASSIA – Applied Social Sciences Index and Abstracts (from 1987 to 17/04/2007); Cinahl – Cumulative Index to Nursing and Allied Health Literature (from 1982 to 17/04/2007); PsycINFO (from 1806 to 17/04/2007); Pubmed (from 17/04/2007); Social Science Citation Index via Web of Knowledge (from 1970 to 17/04/2007). The database searches were repeated in November 2009, to identify any studies published between 2007 and 2009 whilst the review was in progress. (See Appendix A for search strategies.) Grey literature was identified via the SIGLE database and the National Research Register. The following websites were searched (01/02/2007): [www.ulrichsweb.com](http://www.ulrichsweb.com) for access to the International Journal of Qualitative Studies on Health and Well-being; the Qualitative Report at [www.nova.edu/ssss/QR/](http://www.nova.edu/ssss/QR/) and the Qualitative Research Journal at [www.latrobe.edu.au/aqr/index.php?option=contentandtask=viewandid=17andItemid=35](http://www.latrobe.edu.au/aqr/index.php?option=contentandtask=viewandid=17andItemid=35). Reference lists of potentially relevant papers were also checked. All citations identified by the above searches were downloaded into the EPPI-Centre London Website database and scanned for relevance against the inclusion and exclusion criteria (see below).

### **Inclusion criteria**

Studies were included if they met *all* the following criteria:

- they examined clients' perceptions of helpful or unhelpful factors involved in the reduction, removal or easing of the burden of EDs
- they involved counselling, psychotherapy or psychological treatment formally delivered by a trained helping professional
- they involved a client with an ED or recovered from an ED
- clients were above the age of 11
- clients were voluntarily attending treatment
- studies had to use qualitative research methods that involved qualitative examination by thematic analysis, grounded theory or any other form of qualitative analysis which included open (free response) questions
- studies had to be written in English.

### **Exclusion criteria**

Studies were excluded if they met *at least one* of the following criteria:

- they focused solely on pharmacotherapy, re-feeding and other medical procedures
- they used solely quantitative research methods (eg surveys with forced choice responses)
- they scored three or less during the initial critical appraisal process (see below).

### **Screening of the retrieved studies**

One reviewer screened the titles and abstracts of articles retrieved from the search according to inclusion/exclusion criteria (above). Any ambiguous studies were referred to a second reviewer for further opinion. Full papers were obtained for all studies that met the inclusion criteria at this stage. The full papers were further screened for relevance to the inclusion/exclusion criteria. Those deemed relevant were subject to initial study characteristics extraction and initial critical appraisal as described below.

### **Initial study characteristics extraction**

The data extraction process compiled details of the study including participant details, recruitment methods, methods of data collection and analysis, ED details, intervention characteristics and setting.

### **Initial critical appraisal**

To select sufficiently methodologically sound studies for further meta-analysis the broad guidelines set out by Harden *et al* (2004) were used as a basis for deriving a quality score for each study. The criteria included the availability of an explicit theoretical framework or literature review; a clear statement of aims, context, sample, data collection methods and analysis methods; an attempt to establish validity or reliability (or as it is normally referred to in qualitative research, credibility and trustworthiness, see Elliott *et al*, 1999; Morrow, 2005) and the inclusion of sufficient original data (see below for further details). These guidelines were used to calculate a quality score for each study, with one point being awarded for fulfilling each of the criteria (see Table 1). Studies that scored four or above were included in the review.

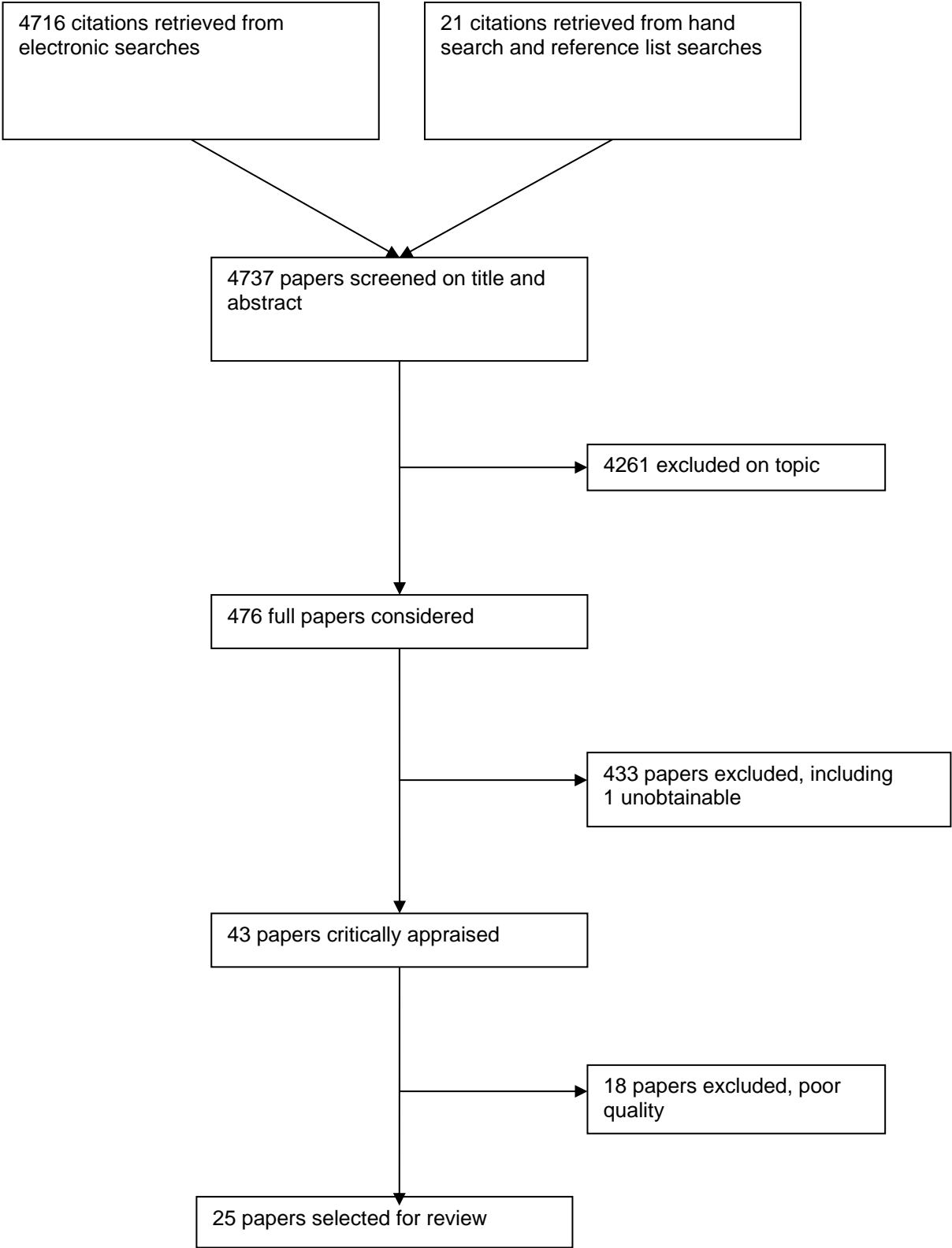
Two people independently appraised each study. Any differences of opinion were settled through discussion. For papers that reported on both quantitative and qualitative data, only the collection, analysis and reporting of the qualitative data was examined. Figure 1 explains how the studies passed through each stage of the searching, screening, extraction and critical appraisal process, which resulted in the selection of 32 studies. These were further inspected by the team who performed the meta-analytic part of the study. Studies that did not include clients' perspectives but solely those of their parents, or studies that on closer inspection did not contain analysis of helpful and unhelpful aspects of the treatment, were excluded. Studies that were reported in the form of unpublished dissertations were also excluded. One study was published in the form of two papers (Ma and Lai, 2006; Ma, 2008) reporting on different aspects; this was treated as a single study. The final analysis was based on 24 studies (25 papers; see Table 2).



Table 1: Criteria for initial critical appraisal and inclusion of studies on the basis of methodological quality

Criteria	Potential score
1. Is there an explicit theoretical framework and/or literature review?	1
2. Are the aims and objectives clearly stated?	1
3. Is there a clear description of the context?	1
4. Is there a clear description of the sample and how it was recruited?	1
5. Is there a clear description of methods used to collect and analyse data?	1
6. Are attempts made to establish the reliability or validity (credibility, trustworthiness) of data analysis?	1
7. Is there inclusion of sufficient original data (such as quotes from participants) to mediate between the data and interpretation?	1

**Figure 1: Flow chart of search and appraisal process**



**Appraisal of primary studies**

Once the studies were selected, they were assessed and the analytic team recorded the relevant information specifying the methodological aspects of the original studies. This included information on

the number of clients, the ED diagnoses, the type of therapy provided, the data collection method and the data analysis method. The analytic team also examined and recorded important methodological aspects of the original studies that could influence their results. These could have included the interpretative framework used in analysis; the data collection method influence on the analysis; the potential sampling and study location issues influencing analysis; and the credibility and trustworthiness of the analysis. Any important observations were recorded and their summary is presented in the results section. One observation at this stage was that in some instances studies contained information regarding the clients' perspectives on helpful and unhelpful aspects of the treatment that went beyond the helpful and unhelpful aspects of psychological therapy that was a part of the treatment (for instance, the client could comment on the helpfulness or unhelpfulness of their relatives, peers, co-patients, etc). We decided to include those helpful/unhelpful aspects in the analysis and observed that they were very informative and contributed to our understanding of helpful and unhelpful aspects of psychological therapies used in the treatment of EDs.

Table 2: Characteristics of selected studies

Study	N of clients	Sample	Therapy type	Data collection method	Data analysis method	Important methodological factors influencing results
Banasiak <i>et al</i> (2007)	36	BN – all; mean age 29.5; female. This refers to the whole sample (n=54) from which the sub-sample was studied. Participants were recruited from the community via newspaper advertisements, media announcements, and posters in GP waiting rooms, libraries and community centres. Also referrals from a community-based ED information centre.	Guided Self-Help (GSH) whereby a patient works through CBT self-help manual guided by GP. There were 9 treatment sessions of 20-30 minutes where support was provided by the GP at working through the manual over a 16-week period.	Data was collected from a questionnaire: Treatment Evaluation. Relevant open-ended questions: (1) What were (a) the most effective aspects of the GSH treatment approach, and (b) the least effective aspects of the GSH treatment approach? (2) What were (a) the most helpful aspects of working with the GP, and (b) the least helpful aspects of working with the GP?	Responses to each question were collated and subjected to a content analysis. Two authors independently reviewed responses; meaningful response categories were generated through discussion. Two independent raters, with an inter-rater reliability of 0.98, assigned responses to categories. Discussion and consensus resolved differences in coded responses.	The division of categories into subgroups is derived from the questionnaire. This is a 'customer satisfaction survey' or 'treatment evaluation' type of study.
Button and Warren (2001)	36	AN – all; mean age 27.9; female. Participants were from a cohort (83 female, 6 male) who had presented for treatment 7.5 years ago. Former patients (79) were contacted in writing by the consultant psychiatrist to enquire about their willingness to participate in the study.	A specialist service for the treatment of adults with ED. It was broadly psychotherapeutic in nature but medical interventions were also applied.	A semi-structured interview (up to 2 hours) was used and included diagnostic questionnaires. The relevant part of the interview comprised their views of (1) the disorder and (2) the treatment. Several questionnaires were used with a relatively large original sample size, so this was a mixed-methods study. Most interviews (26) were in hospital and 10 were interviewed in their home.	Methods of analysis are not described except for common themes identified during the interviews by direct quotes from individual subjects.	The study describes how people live with ED, 7.5 years after initial contact with specialist treatment. Relevant focus was: To further understand how the sufferer views the disorder and how they experienced treatment and help. Only text pertinent to this focus was coded. Authors offer common themes identified by direct quotes from individuals. The study is limited by the possibility that they may have selected quotes that back up the

Cockell <i>et al</i> (2004)	32	AN – 21, EDNOS – 11, of whom 9 were sub-threshold for AN; mean age (of entire sample) 27.9; female. Participants were those consecutively admitted to a 15-week residential ED treatment programme.	Details of the programme are not given (ie specific treatments, psychological theories etc are missing).	In-depth interviews were conducted.	A grounded theory approach, involving a systematic process of indexing, coding, categorising and writing, was used to analyse the data. As data collection progressed, more detailed questions were asked and reflections made to validate response and understanding.	authors' perspective. Focus on maintenance of therapeutic change following ED treatment (ie identify factors that help or hinder the maintenance of change during the six months immediately following ED treatment). Not specifically focused on helpful and non-helpful aspects of psychological therapy.
Colton and Pistrang (2004)	19	AN – all; age range 12-17; female. All patients who were receiving treatment were invited to participate in the study.	Unspecified inpatient treatment	A semi-structured interview which covered what participants found helpful and unhelpful about their treatment; how they felt about being with others in the same situation, and about being away from their 'normal', outside life; their relationships with staff on the unit; the amount of trust and responsibility they were given on the unit; and their experience of AN.	IPA performed by two authors, one in an auditor role.	Covered more than just helpful and unhelpful aspects but only the relevant parts were selected for the current study. The analysis seems to have face validity, with many quotes provided.
D'Abundo and Chally (2004)	20	AN/BN – not differentiated; age range 17-46; female. Ethnicity: 17 Caucasian, 2 Black, 1 Hispanic. Some, but not all, sought and received professional treatment. Participants were recruited through flyers at a university campus. Women attending a local support	Weekly, 90-minute support group for 9 months, facilitated by authors but participant led. Group size ranged from 4-10 participants with an average of 5-6. Prior to that, participants could have had a variety	17 semi-structured interviews (1-2 hours). Focus group of 5 participants (2 of whom took part in SSI). Participant observation in a support group, notes/ memos. Audiotaped and transcribed.	Grounded theory/constant comparative method. Data triangulated, peer examination, researchers and graduate assistant coded data separately and then compared results. Data generated a cyclical model of an	The paper focused on recovery. We distilled the results that had to do with treatment or could occur in the context of treatment.

Dunn <i>et al</i> (2006)	45 (the study had a bigger sample but only a portion completed the qualitative questionnaire)	group were invited to participate. A snowball technique was also used. BN – 21, BED – 25, sub-threshold BN – 6, sub-threshold BED – 8, EDNOS – 30. Whole sample: n=79. Age range 17-42, mean age 19 (SD=2.64); 79 women (87.8%), 11 men (12.2%). Ethnicity: Caucasian (59.6%), Asian/Pacific Islander (29.2%), Hispanic/Latino (4.5%), and other (6.7%). Participants were recruited through screening conducted in a campus-wide alcohol use study and via 'mass testing of the psychology subject pool'.	of treatments. Motivational enhancement therapy (MET). Approx. 45 min MET intervention session + 45 min introduction to manual.	An unspecified questionnaire (in the context of RCT) asking what was useful in MET and what was not.	ED. Debriefing/ comparison/peer auditing. No details provided.	This was an RCT comparing MET plus a self-help manual vs. self-help manual only. Included in the MET was a brief satisfaction questionnaire that asked about what was useful in MET and what was not. It is not fully clear whether it was a qualitative questionnaire but the cited examples suggest so.
Eivors <i>et al</i> (2003)	8	AN (who dropped out of treatment); age range 21-43; female. Most outpatient/MDT – others inpatient/day care. Eight unilaterally decided to drop out of therapy within assessment period (first 3 sessions n=3) or within therapy (n=5). Potential participants (28) who met with inclusion criteria were selected from records at the ED service and were sent a letter to invite them to participate.	Local EDs service. Mainly outpatient, but 2 also inpatient. Psychotherapy including CBT, personal construct and psychodynamic approaches with physical and social interventions.	Written narratives prior to interview (n=5 inc. 4 interviewed below). Set topic provided. Semi-structured interviews (n=7). Themes covered in SSI: (1) background information on ED onset and how they came into contact with services; (2) initial assessments and thoughts and feelings about engaging in therapy; (3) perceptions of the disorder; (4) expectations of therapy, the type received and their evaluations of this; (5) the process and experience of dropping out of services;	Grounded theory. Broad areas referring to the process were initially identified. Domains for analysis: (a) the onset of the ED; (b) initial contact with services; (c) treatment; (d) drop-out; (e) life after drop-out. The transcripts within each domain were read repeatedly by the first author to gain familiarity with the raw data. This led to a process of coding and categorisation of themes that emerged	The study focused on reasons for and experience of dropping out in the context of the overall AN experience. We distilled mainly the unhelpful aspects of treatment as well as some information on ambivalent aspects and what was missing in the treatment. A good quality study.

Krautter and Lock (2004)	32	<p>AN – all; age range 12-18, mean age 14.6. Adolescents (n=32) and parents/guardians (n=34) who are not included in this meta-analysis. Eligible subjects were family members of the first 43 families who completed treatment as part of an RCT of family based treatment for AN. Little information provided by authors regarding recruitment: 46 families 'were approached' to complete survey.</p>	<p>A manualised version of the Maudsley approach to family therapy for AN, which incorporated between 10 and 20 family sessions of 60 minutes duration over a 6-12 month treatment period.</p>	<p>(6) improvements and unmet needs; (7) the present day and effects of dropping out.</p>	<p>from the interviews and narratives.</p>	<p>An adolescent patient satisfaction survey using structured questionnaires with 7 open-ended questions (Was treatment a success? What were helpful and unhelpful aspects of treatment? What was missing in treatment? Would they recommend it? Did it bring a change? What else would they need?) aimed to assess the perspectives of families participating in a manual-driven family based treatment for adolescents. The qualitative results are presented under relevant items of the questionnaire. We considered only the qualitative part pertinent to helpfulness/unhelpfulness of the treatment from the perspective of adolescent patients. Very few illustrative quotes provided.</p>
Laberg <i>et al</i> (2001)	7	<p>BN – all; age range 21-30, mean age 23; female. Participants were those who had completed a group treatment.</p>	<p>CBT techniques with a strong emphasis on interpersonal issues, including 1-2 group therapy sessions per week for approximately 7 months. Complementary individual treatment</p>	<p>Semi-structured, 1-hour interviews. Questions included: How did you perceive the treatment? Which treatment components did you experience as positive? Which components did you experience as negative?</p>	<p>Grounded theory. Data analysed line by line resulting in tentative concept labelling, refined in second stage by comparing and grouping. Emphasis on verifying/refuting emerging hypotheses by referring back to</p>	<p>Relevant focus: How did you perceive the treatment? Which components did you experience as positive? Which components did you experience as negative? Data interpretation highly influenced by authors' theoretical orientation (CBT). Not all categories supported by quotes; some quotes not</p>

			sessions. Individual follow-up sessions approximately 3 months post-treatment.		the original data. Four independent reviewers corroborated the categories and their inter-relationships.	reflective of authors' interpretation. We extracted helpful and hindering aspects of the treatment across the result section regardless of categories.
Lamoureux and Bottorff (2005)	9	AN – all; age range 19-48; female. Participants recruited via postings in community newspapers; flyers circulated to self-help organisations and ED services.	The participants reported that the treatments received <i>during recovery</i> included: repeated hospitalisations, individual therapies, group therapies, and complementary therapies (eg yoga, meditation, therapeutic touch, body work, or all of these).	In-depth open-ended interviews conducted either by telephone or in person. The main questions were: (1) Tell me as much as you can about your recovery experience from anorexia (2) What would you say are some of the highlights of your recovery process? (3) What was important or significant about the events? (4) What is it like now without anorexia? Probes were used to clarify important information.	Grounded theory methods were used. Data was analysed line by line to identify words, phrases, paragraphs that reflected important ideas. Axial coding focused on identifying and proposing relationships between the categories. Three individuals reviewed preliminary findings and refinements were made based on their feedback.	Relevant focus: What would you say are some of the highlights of your recovery process? What was important or significant about the events? Only text (quotes) relevant to these two questions was used in our meta-analysis. The study does not focus on the treatment per se. However, it is inferred as it focuses on recovery process. Thus almost all of our data are implied impacts that did not have to be necessarily connected to treatment.
Le Grange and Gelman (1998)	21	AN –10, BN – 11; mean age 24.7 (SD=9.8); AN 18.4 (SD=3.78); BN 30.5 (SD=10.21); female. Little information on recruitment procedures. All participants were patients of the first author.	Either family counselling (n=7, 14-19 year olds), or cognitive-behavioural treatment (n=14). Patients initially seen weekly then fortnightly when symptoms reduced.	Clinical interview and semi-structured interview with open-ended questions regarding patients' perspectives on recovery, helpful or harmful aspects of therapy, whether the effects of treatment had lasted over time, termination of treatment, whether causes had been adequately dealt with, and whether treatment would be recommended to a friend with a similar problem.	Protocols examined for themes (frequency). Very little information provided.	Little information on methodology/method, particularly data analysis where no information was provided. We focused on helpful and unhelpful aspects of the treatment (2 different treatments). First author was the therapist.



Ma and Lai (2006) and Ma (2008)	24	AN – all; female. 18 adolescents, mean age at referral, 14 (SD=1.59); 6 young women, mean age at referral, 23.4 (SD=7.7). Little information on recruitment: 29 recovered patients and their families invited to participate.	Family therapy modified from Micucci's (1998) treatment model. 90-minute fortnightly sessions. Total number of sessions was 3-30 over 2-18 months.	The research team invited recovered patients and their families to attend post-treatment interviews. These were conducted by a nurse (PhD candidate) using open-ended questions as a loose guide. The natural flow of the family stories was more important than a rigid guide. Topic guide included: (1) perceived helpfulness of the treatment; (2) factors conducive to or hindering the recovery; the functions and roles of the therapist; (3) areas for improvement in clinical practice etc.	Important themes were identified for analysis (method not stated) and a second author reviewed the thematic summaries and supporting quotations.	<p><b>Ma and Lai (2006)</b> Interviews conducted in Chinese, transcribed and translated into English. Potential bias: the authors adopted a strength-oriented approach rather than a pathological view in conceptualising the difficulties and needs of each family. Not clear how long after treatment interviews were conducted, or how many family members participated in the interviews. Some data is not from the clients themselves and thus we omitted it. Relevant focus: (1) perceived helpfulness of treatment; (2) factors conducive to or hindering recovery; functions and roles of therapist; (3) areas for improvement in clinical practice. Study mainly focused on qualitative outcomes, often reported with helpful/unhelpful aspects of the treatment.</p> <p><b>(Ma, 2008)</b> Looked at some aspects of therapy, not necessarily helpful or unhelpful; helpfulness/unhelpfulness therefore deduced by team. Occasionally unclear which family member provided an account.</p>
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Maine (1985)	25	AN; age not stated; gender not stated. Participants recruited through articles in newspapers and announcements in newsletters of self-help organisations.	Psychological treatments included inpatient hospitalisation; management of starvation-related side effects; individual, group and family therapy; behavioural contracting; nutritional counselling.	An in-depth, semi-structured interview focused on development of and recovery from ED. Pertinent part focused on treatment.	Thematic content analysis (very little information provided) examining common factors in descriptions.	The study focuses on the recovery process. We only extracted findings related to helpfulness/unhelpfulness of treatment. It is an old study and did not follow current qualitative standards. Findings are reported unsystematically. The analysis is not well described and it is not clear who conducted it (most likely the researcher).
Malson <i>et al</i> (2004)	39	AN/BN; age range 14-45; 1 male, the rest female. All had been hospitalised at least once. 31 were current in-patients. In-patients recruited through specialist ED inpatient ward at a psychiatric hospital or adolescent medicine ward of a general hospital specialising in ED treatment. Those who were not inpatients at the time of the study were contacted via telephone, personal contact or via a local self-help group.	No specifics of treatment were given.	In-depth, 1-hour, semi-structured interviews with 4 broad areas: 1) the beginning of participants' problems and their initial diagnosis; 2) their history of previous interventions; 3) their current treatment; 4) views on their recovery and future. Topics number 2) and 3) are relevant for this review.	Discourse analytic methodology. In the preliminary stage of analysis transcripts were repeatedly re-read and prominent features (eg topics, themes and issues) recorded. Coding categories were used to systematically code the transcripts. Attention paid to specifics of participants' discourse and to variations and commonalities in how a particular topic, theme or issue was construed.	Only a few results referred specifically to un/helpful aspects of treatment. Many critical (or negative) findings in this study, although these were not specifically sought. Analysis and results appear to be focused on a single phenomenon, elaborated on in great detail (ie the pathologisation of the client, regarding the patient as a diagnosis rather than a person). Authors try to stay as close as possible to participant quotes/accounts in their narrations and explanations of results. Appears to be a detailed analysis of interviewer-participant interactions.
Moreno <i>et al</i> (1995)	7	AN – 2, BN – 3, obesity – 2; age range 26-50; female. Participants had been previously hospitalised for an ED where outpatient treatment took place. Therapists invited their	Psychodynamic psychotherapy group.	Three most helpful events of the session; significant events form (SEF); client-written accounts. Participants were invited to a 14-week group therapy investigation of 'significant events'.	Content analysis by 1) computing frequency distribution for words used by group members, and 2) sorting statements by subjective interpretation of	Establishment of types of significant events/impacts perceived by clients. The findings are not well supported by participant quotes. The description of the methodology is very brief and unclear.

		patients to participate.			thematic content; a co-therapist then examined themes.	
Offord <i>et al</i> (2006)	7	AN – all; age range 16-23; female. Participants recruited via past inpatient records from general adolescent units or via face-to-face contact with clinicians in adult outpatient ED services.	No specifics of treatment are given. All clients had received treatment for AN in a general adolescent inpatient unit.	Participants were interviewed using a semi-structured interview schedule.	Interview transcripts were coded and analysed thematically in accordance with the IPA principles. The primary researcher kept a research diary, to track development of ideas and maintain a 'reflexive stance'.	This study asked young adults for their views on AN treatment when admitted to a general adolescent psychiatric unit 2-5 years prior to the study. There were four main themes and other sub-themes, and all were seen as both helpful and unhelpful. Not all clients received psychotherapy.
Pettersen and Rosenvinge (2002)	48	AN – 10, BN – 10, BED – 8, mixed – 20; mean age 27.6; female. Little recruitment information.	No details provided. Participants recruited on the basis that they had received professional treatment for EDs.	Open interviews with two main questions: 1) What factors have been helpful to you in the recovery process? 2) What is the meaning of recovery for you?	Interviews were transcribed and data analysis identified all statements containing information about improvement and recovery. They were coded to a categorical system developed by consensus. One researcher blind to data categorisations acted as reliability check on 20 random uncoded interviews.	The study reported on three aspects of recovery: 1) professional treatment; 2) non-professional care; 3) positive life events and important people. We extrapolated helpful or unhelpful aspects of treatment from the recovery focused study.
Reid <i>et al</i> (2008)	20	AN or AN/BN; age range 17-41; 1 male, 19 female. Participants recruited during treatment, from outpatient NHS ED service.	Outpatient treatment, described as a broadly cognitive behavioural approach. Multi-professional staffing: psychiatrists, clinical psychologists and	Semi-structured interviews focused on how ED had affected them, experiences of treatment, perceptions of strengths and weaknesses of the service. Using the existing literature, the research team devised a list of open questions: 13 about life history relevant to EDs and treatment, and	Thematic analysis: one author did initial coding, one author did further coding, and two authors reviewed the analysis in depth. Themes were informed by interview questions.	Very brief descriptions of context, data collection and participants. A brief attempt to establish reliability was provided, in that various authors checked and rechecked coding framework and thematic analysis. It is not clear how themes were informed by interview questions.

			nurses.	13 about experiences of services.		
Rorty <i>et al</i> (1993)	40	BN – all; mean age 25.65; female. Participants recruited via newspaper ads and referrals from local care providers.	No specific details given; 90 per cent of the sample had received some professional treatment.	Data collection comprised semi-structured interviews (45-120 minutes) as part of 4-5 hours of clinical assessment conducted by a trained graduate student. The study aimed to investigate factors believed to be related to the recovery process looking at professional and non-professional treatments used and specific helpful and harmful elements in treatment.	Audiotaped interviews transcribed and coded according to a categorical system developed by consensus. One author coded all 40 tapes and another coded a random 10 to check for reliability. Where categories overlapped or applied to too few subjects, these categories were collapsed.	Part of a larger study, women had recovered from BN at least 1 year before. Spontaneous answers were coded from audiotaped interviews – resembling content analysis with frequency counts. Only one quote from the interviews. Analysis presented in format similar to quantitative study. Findings are presented in 6 headings (questions) about recovery process. Three are relevant for this review: What stimulated recovery process? What treatments were utilised and how happy were they with them? How did important people in their life help or hinder recovery? Five tables give an impression of a quantitative rather than qualitative study.
Rother and Buckroyd (2004)	6	Self-defined past ED sufferers. No further sample description. Past service users of a particular voluntary agency during their adolescence. A flyer was displayed at the agency and mailed to former service users.	Counselling and support services to people suffering from ED (offered by a voluntary sector agency) + previous experiences.	Semi-structured interviews were carried out by a qualified counsellor with experience and specialist training within the field of EDs. Interviews were tape recorded and transcribed and the transcriptions were returned to the participants for any further comments, additions or corrections that they felt were necessary.	Thematic qualitative analysis (Huberman and Miles, 1988); no further details of how the data was coded or analysed.	Interviews with recovered adults to establish their experiences of services received as adolescents. Low response rate of 18 per cent (34 letters sent out). Relevant focus: 1) what they felt about any help they might have received at that time and on a continuing basis; 2) what they would have liked at that time. The agency soliciting the survey was perceived as helpful, while many hindering

Roy <i>et al</i> (2006)	68	Mixed EDs; mean age unknown; gender unknown. The sample group were service users; no recruitment details provided.	Community ED service	Written responses to questionnaires (developed within the service), with open-ended questions used during 3-year period. Questions related to: 1) satisfaction with a range of aspects of the service, such as type, frequency and length of treatment; 2) feedback on the overall quality of treatment; 3) aspects of the service that were particularly helpful or unhelpful; 4) suggestions for service improvement.	Content analysis, allowing data to be allocated to categories following a systematic procedure (Marshall and Roseman, 1989). All raw data initially categorised into themes until all items exhausted. A second rater then allocated responses to one of the previously identified categories. Raters match - Kappa .812	aspects of health care in general were reported. The study used qualitative data from a routinely administered satisfaction questionnaire (212 qualitative responses, 8 themes). Main finding: retain flexibility and choice in service delivery. No direct quotes from participants, only percentages of comments. It does not appear as a qualitative study (written questionnaires, percentages) but as a mixed qualitative-quantitative study.
Swain-Campbell <i>et al</i> (2001)	120	Mixed EDs; mean age 27; female. Three months following first contact with the service, a consumer satisfaction survey was posted out.	A specialised inpatient hospital-based EDs unit. Most patients proceed to outpatient treatment, a smaller number received more intensive day patient or inpatient treatment.	The consumer satisfaction questionnaire consisted of 13 questions, 3 of which had an open-ended format inviting commentary about improvements and the best/worst aspects.	For the qualitative part an in-depth analysis was conducted. All three authors analysed data to generate meaningful categories; these were then refined and defined through consensus.	A consumer satisfaction questionnaire with 3 relevant open-ended questions describing the perceived best and worst aspects following consultation with the service. Significantly more helpful (best) than hindering (worst) aspects. Only a few quotes provided in the results.
Tierney (2008)	10	AN – all; mean age 17, range 11-18; 9 female, 1 male. Participants at various treatment stages. A letter of invitation sent by ward manager of adolescent inpatient psychiatric unit. Self-help network posted study details on website.	Inpatient and outpatient treatment, including some form of psychological intervention.	Semi-structured interviews with undisclosed questions.	Thematic analysis conducted by two researchers. ATLAS-ti software and reflexive journal used.	The analysis quite descriptive, with many quotes provided.

Whitney <i>et al</i> (2008)	19	AN – all; mean age 30.3; female. Recruitment methods unclear, all receiving treatment on inpatient unit at the time.	Manualised cognitive remediation therapy (CRT): 10 sessions over 6-8 weeks, delivered by 6 trained therapists who met weekly for group supervision. Inpatient EDs unit receiving national and local referrals.	Guided feedback letter outlining experience after ninth session; one gave feedback via videotaped interview. Verbal instructions on what to write about: what was useful/not useful about treatment, what they enjoyed/did not enjoy, if and how the intervention was applicable to everyday life, whether they would recommend it to others, and how it could be improved.	Grounded theory using the constant comparative method. The first eight letters were collected and examined by the first author. The second author then reviewed these. Both authors discussed their analyses.	The feedback letters from a few lines to several pages. This study was piloting a new treatment in one setting. The analysis consists of a highly structured set of categories illustrated by many supportive quotes. We have selected helpful and hindering aspects from the quotes and descriptions in those categories.
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## Data preparation

After the selected studies were appraised as to how the findings reported in them could be influenced by the methodological aspects of particular studies, a member of the analytic team (JK or MC) reviewed each study and extracted all findings reported in it that focused on helpful or unhelpful aspects of treatment that involved a psychological therapy. While the studies could have a broader focus beyond helpful and unhelpful aspects of the ED treatment, the analytic team focused only on those parts of the original studies that pertained to helpful/unhelpful aspects of the treatment. The extracted findings were then summarised in the form of meaning units. A meaning unit is a summary of the finding in the form of a brief statement or paragraph that can independently convey the meaning of the reported finding contained within it (Elliott and Timulak, 2005). A clear cross-referencing system was used so that each meaning unit could be easily tracked to the original study's report of the finding. Another member of the analytic team (LT) then reviewed all summaries reported in the form of meaning units and crosschecked them against the findings reported in the original studies. If necessary the meaning units were adjusted so they would clearly fit the findings reported in the original study. Any changes had to be accepted by the member of the team that reviewed the study in the first instance. The original studies reported findings, in the form of summarising meaning units, then became the data for the qualitative meta-analysis (Timulak, 2009; Timulak, in press).

## Data analysis

The data analysis followed procedures for conducting qualitative meta-analysis outlined by Timulak (2009; in press). These procedures use a generic descriptive-interpretative framework for analysing qualitative data (see Elliott and Timulak, 2005). In this approach the meaning units that were prepared in the data preparation stage were then further meta-analysed. One member of the analytic team (LT) compared all meaning units and clustered them according to the similarities in their meaning. The meaning units that were clustered together then formed *Meta-analytic categories*. It subsequently transpired that some meta-analytic categories referred to a similar aspect of treatment (eg relational aspects, aspects referring to the qualities of the mental health professional, etc). Therefore, the final meta-analytic categories were presented in a clear format whereby it would be clear from the individual meta-categories as to which aspect of the treatment they referred (eg relational aspects, aspects referring to the qualities of the mental health professional, etc). The meta-categories could then be presented in the form of particular domains of the treatment to which they pertained (eg relational aspects, aspects referring to the qualities of the mental health professional, etc).

Although typically the domains are prepared before the categories are delineated so the underlying structure in the data is visible (cf Elliott and Timulak, 2005; Timulak, 2009; Timulak, in press), it was not the case in this meta-analysis. Indeed, it was initially assumed that there would be only two main domains (helpful and unhelpful aspects of the treatment). However, the meta-analysis yielded a substantial number of meta-categories. For the sake of clarity, LT and subsequently the whole analytic team decided to organise them according to which part of the treatment the helpful or unhelpful aspects applied.

Once the meta-analytic categories were formed, a brief description defining each category was prepared, clearly cross-referencing the definitions with the findings reported in the original studies. The meta-analytic categories, their definitions, and their presentation, according to the particular domains, were prepared by a member of the analytic team (LT) and then audited by the other two members of the analytic team (JK and MC).

When the data was initially clustered the meaning as reported in the original studies was taken into account, which almost exclusively used common sense descriptions of what the clients reported. No particular theoretical framework was applied to inform the interpretation of findings reported in the original study (this appeared to be the case also for the researchers in the original studies). The reading of the data could, however, be influenced by the background of the researchers involved (a counselling psychologist with humanistic theoretical preferences, a research psychologist with an interest in addictions and a psychotherapist with humanistic preferences). None of the original studies applied a declared interpretative framework for presenting the data (eg psychoanalytic interpretative framework) with the exception of one discourse analytic study (further information on this study is available in the Results section below) that looked at the positioning of the clients and mental health professionals in the discourse used. Apart from that exception, the original studies appeared to report the findings in a theoretical common sense manner that seemed to present the clients' perspectives close to their own words. The theoretical preferences of the original researchers that could influence their reading of the clients' accounts were, however, often not reported. (Further information on this is available in the Results section.)



## Results

### Methodological features of primary studies

The meta-analysis presented below is based on the analysis of 25 papers (24 studies as Ma and Lai, 2006 and Ma, 2008 reported on the same research; see the overview of all included studies in Table 2). The studies involved 1,058 participants with an age range of 11 to 50. There were seven studies conducted in the USA, nine in the UK, one in Canada, one in Hong Kong and one each in Australia, Sweden, South Africa, Norway, New Zealand and one in both the UK and Australia. The majority of studies comprised all female participants with the exception of six studies, which included a small number of males (Cockell *et al*, 2004; Dunn *et al*, 2006; Krautter and Lock, 2004; Malson *et al*, 2004; Reid *et al*, 2008; Tierney, 2008). Nine studies included solely patients with AN (Button and Warren, 2001; Eivors *et al*, 2003; Krautter and Lock, 2004; Lamoureux and Botorff, 2005; Ma and Lai, 2006 and Ma, 2008; Maine, 1985; Offord *et al*, 2006; Tierney, 2008; Whitney *et al*, 2008), three included solely patients with BN (Banasiak *et al*, 2007; Laberg *et al*, 2001; Rorty *et al*, 1993) and the remainder included participants with a combination of diagnoses or where the ED was not specified.

With regard to the psychological therapy involved in the treatment there were three studies that involved cognitive-behavioural therapy (Laberg *et al*, 2001; Le Grange and Gelman, 1998; Reid *et al*, 2008) with a further study looking at a cognitive behavioural guided self-help manual (Banasiak *et al*, 2007) and two studies that looked at family therapy (Krautter and Lock, 2004; Ma and Lai, 2006 and Ma, 2008), although Le Grange and Gelman (1998) also included participants who had had family counselling. One study looked at motivational enhancement therapy (Dunn *et al*, 2006), one looked at psychodynamic psychotherapy group therapy (Moreno *et al*, 1995), and one examined cognitive remediation therapy (Whitney *et al*, 2008). The remainder did not report specific interventions that participants had received or they included a combination of treatments (for more detail see Table 2).

The majority of studies (n=17) used semi-structured interviews to obtain data. A small number used questionnaires with open-ended questions, sometimes as part of a wider quantitative study (Banasiak *et al*, 2007; Dunn *et al*, 2006; Krautter and Lock, 2004; Roy *et al*, 2006; Swain-Campbell *et al*, 2001). One study included focus groups alongside the interviews (D'Abundo and Chally, 2004). One study asked participants also to prepare a narrative prior the interview (Eivors *et al*, 2003). One study used the clients' written accounts of significant events in their group therapy (Moreno *et al*, 1995) and Whitney *et al* (2008) asked participants to provide a letter of feedback on their experiences and views of the treatment. The data was collected during the treatment (Colton and Pistrang, 2004; Moreno *et al*, 1995; Malson *et al*, 2004; Reid *et al*, 2008; Tierney, 2008; Whitney *et al*, 2008), at the end of the treatment (Banasiak *et al*, 2007; D'Abundo and Chally, 2004; Dunn *et al*, 2006; Krautter and Lock, 2004; Ma and Lai, 2006 and Ma, 2008; Malson *et al*, 2004; Pettersen and Rosenvinge, 2002; Roy *et al*, 2006), or retrospectively sometime after the treatment ended (Cockell *et al*, 2004; Laberg *et al*, 2001; Lamoureux and Botorff, 2005; Le Grange and Gelman, 1998; Maine, 1985; Offord *et al*, 2006; Pettersen and Rosenvinge, 2002; Rorty *et al*, 1993; Rother and Buckroyd, 2004), when clients dropped out from treatment (Eivors *et al*, 2003), three months after the initial contact (Swain-Campbell *et al*, 2001) or it could not be determined (Button and Warren, 2001). For more details see Table 2.

What could be observed was that the studies (eg Dunn *et al*, 2006; Moreno *et al*, 1995; Krautter and Lock, 2004; Swain-Campbell *et al*, 2001) that used written accounts provided much 'thinner' and less substantive findings (eg one- or two-word categories such as 'emotional expression' were provided without a thorough description thus rendering the meaning unclear). Such findings/data was occasionally hard to compare to the rest of the data, particularly if no example of the participants' verbatim quotes was provided. Such data had then to be inferred more tentatively than the data with a clear and thorough description.

The type of analysis conducted in the original studies varied. Some studies (n=11) used an established method of qualitative data analysis (eg grounded theory or interpretative phenomenological analysis, IPA) and used credibility checks (Cockell *et al*, 2004; Colton and Pistrang, 2004; D'Abundo and Chally, 2004; Eivors *et al*, 2003; Krautter and Lock, 2004; Laberg *et al*, 2001; Lamoureux and Bottorff, 2005; Malson *et al*, 2004; Moreno *et al*, 1995; Offord *et al*, 2006; Whitney *et al*, 2008). Other studies (n=8) seemed to apply an ad hoc method of content analysis (Banasiak *et al*, 2007; Ma and Lai, 2006 and Ma, 2008; Pettersen and Rosenvinge, 2002; Reid *et al*, 2008; Rorty *et al*, 1993; Roy *et al*, 2006; Swain-Campbell *et al*, 2001; Tierney, 2008) but still performed credibility checks. A number of studies (n=5) (Button and Warren, 2001; Dunn *et al*, 2006; Le Grange and Gelman, 1998; Maine, 1985; Rother and Buckroyd, 2004) provided very little information on how the analysis was performed, which raised questions about the quality of those studies and the trustworthiness of their findings, particularly on whether or not some findings may have been missed. Some studies also contained quantitative elements that counted frequencies of categories or calculated 'reliability' among raters (Banasiak *et al*, 2007; Roy *et al*, 2006; Swain-Campbell *et al*, 2001). All studies, bar the discourse analytic study of Malson *et al* (2004), used some version of a descriptive-interpretative analysis (eg grounded theory, IPA, content analysis, thematic analysis) that looked for similarities in the data and used minimal interpretation of them (as did our meta-analysis), with the purpose of 'staying close to the voice of the participants'. Those studies, however, in general did not disclose the theoretical preferences of the analysts, which could shape the analysts' reading of the data. The only exception was the study of Laberg *et al* (2001) that reflected on a potential influence of the theoretical leanings of the analysts (eg CBT orientation of the analysts).

Malson *et al*'s (2004) discourse analytic study used an approach typical for discourse analysis and focused on the construction of participants' talk, particularly on one phenomenon (how clients are seen through the lenses of pathology) and examples of its variation in the discursive accounts of the participants. Nevertheless, the study provided data particularly on the unhelpful aspects of treatment that could be included in the meta-analysis as it had a descriptive-interpretative focus and looked at similarities and differentiations in the data.

### **Helpful aspects of eating disorder treatment involving psychological therapy**

Twenty-three of the meta-analysed studies contained findings referring to helpful aspects of treatment that involved a psychological therapy. One exception was the study of Eivors *et al*, (2003) which contained only unhelpful aspects. The meta-analysis yielded 30 meta-categories summarising findings of the original studies that captured helpful aspects of treatment involving psychological therapy.

These 30 meta-categories covered six domains pertinent to the treatment: 1) Broader social support,

2) Relational support from mental health professional, 3) Important characteristics of mental health professional, 4) Important general characteristics of treatment, 5) Important specific characteristics of treatment, and 6) Important in-treatment changes contributing to helpfulness of treatment. Each meta-category of the helpful aspects of therapy domain by domain is described in further detail below and presented in Table 3.

Table 3: Helpful aspects of eating disorder treatment involving psychological therapy

Domain	Meta-category	Primary studies findings
Broader social support	Support from co-patients	Support of co-patients (Colton and Pistrang, 2004; Laberg <i>et al</i> , 2001; Moreno <i>et al</i> , 1995; Offord <i>et al</i> , 2006; Rorty <i>et al</i> , 1993; Tierney, 2008), helpfulness of their perspective (Laberg <i>et al</i> , 2001; Lamoureux and Bottorff, 2005), helpfulness of their understanding (Colton and Pistrang, 2004; Moreno <i>et al</i> , 1995), attunement (Moreno <i>et al</i> , 1995), acceptance by others (Moreno <i>et al</i> , 1995), connection with them (Banasiak <i>et al</i> , 2007; Moreno <i>et al</i> , 1995), similarity of experience-identification (Banasiak <i>et al</i> , 2007; Moreno <i>et al</i> , 1995; Offord <i>et al</i> , 2006; Pettersen and Rosenvinge, 2002), presence of co-patients (Offord <i>et al</i> , 2006; Rorty <i>et al</i> , 1993; Roy <i>et al</i> , 2006), learning from co-patients (Offord <i>et al</i> , 2006), sense of community (as opposite to isolation) and friendship with co-patients (Laberg <i>et al</i> , 2001; Offord <i>et al</i> , 2006; Roy <i>et al</i> , 2006) (10 out of 24 studies contributed to this meta-category; 10/24)
	Sharing with others (less isolated, alone)/normalising	Sharing with co-sufferers (Cockell <i>et al</i> , 2004; Laberg <i>et al</i> , 2001; Moreno <i>et al</i> , 1995; Pettersen and Rosenvinge, 2002; Rother and Buckroyd, 2004), feeling not alone (Banasiak <i>et al</i> , 2007; Laberg <i>et al</i> , 2001; Moreno <i>et al</i> , 1995; Offord <i>et al</i> , 2006), connection (opportunity to relate) (Moreno <i>et al</i> , 1995; Maine, 1985), identification (Banasiak <i>et al</i> , 2007; Moreno <i>et al</i> , 1995; Offord <i>et al</i> , 2006), normalisation (Banasiak <i>et al</i> , 2007; Laberg <i>et al</i> , 2001), learning from the others (Offord <i>et al</i> , 2006; Pettersen and Rosenvinge, 2002; Rother and Buckroyd, 2004), comparing different perspectives (Dunn <i>et al</i> , 2006; Laberg <i>et al</i> , 2001; Lamoureux and Bottorff, 2005), opening up (Laberg <i>et al</i> , 2001), getting hope through seeing others (Pettersen and Rosenvinge, 2002) (10/24)
	Support from relatives, close ones and strangers	Support from the people around the client (Cockell <i>et al</i> , 2004; D'Abundo and Chally, 2004; Maine, 1985; Pettersen and Rosenvinge, 2002; Rorty <i>et al</i> , 1993; Tierney, 2008), bringing the client to the treatment (Pettersen and Rosenvinge, 2002; Rother and Buckroyd, 2004; Tierney, 2008), providing an opportunity to share and being understood (Cockell <i>et al</i> , 2004; Krautter and Lock, 2004; Ma and Lai, 2006), showing concern/emotional support and practical support (Ma and Lai, 2006; Maine, 1985; Pettersen and Rosenvinge, 2002), making the client feeling trusted/accepted (D'Abundo and Chally, 2004; Ma and Lai, 2006; Pettersen and Rosenvinge, 2002), making the client feeling empowered/confident/worthy, and having hope as a result (D'Abundo and Chally, 2004; Lamoureux and Bottorff, 2005; Ma and Lai, 2006; Maine, 1985; Pettersen and Rosenvinge, 2002), sometimes offering more support than professionals (Maine, 1985) (10/24)
Relational support from mental health professional	Trusting and supportive relationship with professional	Trusting and supportive relationship with the professional (D'Abundo and Chally, 2004; Cockell <i>et al</i> , 2004; Lamoureux and Bottorff, 2005; Krautter and Lock, 2004; Le Grange and Gelman, 1998; Ma, 2008; Ma and Lai, 2006; Maine, 1985; Reid <i>et al</i> , 2008; Roy <i>et al</i> , 2006; Swain-Campbell <i>et al</i> , 2001), having an opportunity to talk [openly] (Banasiak <i>et al</i> , 2007; Button and Warren 2001; Cockell <i>et al</i> , 2004; Le Grange and Gelman, 1998; Ma, 2008; Reid <i>et al</i> , 2008; Roy <i>et al</i> , 2006), the relaxed relationship with the professional (Ma, 2008; Offord <i>et al</i> , 2006; Whitney <i>et al</i> , 2008), validation/acceptance provided by the mental health professional (Ma and Lai, 2006; Maine, 1985), warmth (Dunn <i>et al</i> , 2006; Le Grange and Gelman, 1998; Ma, 2008; Ma and Lai, 2006; Whitney <i>et al</i> , 2008), genuineness (Ma and Lai, 2006), caring/concerned presence (Ma, 2008; Ma and Lai, 2006; Reid <i>et al</i> , 2008; Whitney <i>et al</i> , 2008), provision of a sense of security (Le Grange and Gelman, 1998; Ma, 2008), friendliness/approachability (Ma, 2008; Roy

		<i>et al</i> , 2006; Whitney <i>et al</i> , 2008), calmness (Ma, 2008), and provision of an empathic and-understanding presence by the professional (Banasiak <i>et al</i> , 2007; Dunn <i>et al</i> , 2006; Le Grange and Gelman, 1998; Ma, 2008; Reid <i>et al</i> , 2008; Roy <i>et al</i> , 2006; Whitney <i>et al</i> , 2008), appropriate neutral/non-judgmental stance (Dunn <i>et al</i> , 2006; Le Grange and Gelman, 1998; Ma, 2008; Maine, 1985; Roy <i>et al</i> , 2006), professionally appropriate disclosures (Rother and Buckroyd, 2004), lead to self-exploration, sense of intimacy, sharing, interdependence (Maine, 1985) (16/24)
	Feeling understood/ being listened to/ having opportunity to talk	Feeling understood (Banasiak <i>et al</i> , 2007; Button and Warren 2001; Cockell <i>et al</i> , 2004; Colton and Pistrang, 2004; Dunn <i>et al</i> , 2006; Moreno <i>et al</i> , 1995; Rorty <i>et al</i> , 1993; Roy <i>et al</i> , 2006), being heard (Colton and Pistrang, 2004), being empathically listened to (Banasiak <i>et al</i> , 2007; Colton and Pistrang, 2004; Dunn <i>et al</i> , 2006); Le Grange and Gelman, 1998; Ma, 2008; Offord <i>et al</i> , 2006; Reid <i>et al</i> , 2008; Rorty <i>et al</i> , 1993; Roy <i>et al</i> , 2006), having opportunity to talk [openly] to the mental health professional (Banasiak <i>et al</i> , 2007; Button and Warren 2001; Cockell <i>et al</i> , 2004; le Grange and Gelman, 1998; Reid <i>et al</i> , 2008; Roy <i>et al</i> , 2006), could reduce isolation and loneliness (Banasiak <i>et al</i> , 2007; Colton and Pistrang, 2004) (12/24)
	Being seen as a person	Having a sense of being seen as a person (not anorectic/bulimic) (Colton and Pistrang, 2004; Button and Warren, 2001), feeling accepted (Moreno <i>et al</i> , 1995), treated normally (Offord <i>et al</i> , 2006), feeling not blamed (Ma and Lai, 2006), and cared for (Reid <i>et al</i> , 2008; Swain-Campbell <i>et al</i> , 2001) (7/24)
	Feeling cared for	Sense of being cared for (Colton and Pistrang, 2004; Ma, 2008; Swain-Campbell <i>et al</i> , 2001), accepted (Moreno <i>et al</i> , 1995) (4/24)
Important characteristics of mental health professional	Mental health professional (therapist) as an expert	Therapist (mental health professional) being an expert on ED (being experienced in working with ED) (Banasiak <i>et al</i> , 2007; Button and Warren, 2001; Cockell <i>et al</i> , 2004; Krautter and Lock, 2004; Laberg <i>et al</i> , 2001; Offord <i>et al</i> , 2006; Reid <i>et al</i> , 2008; Tierney, 2008), being a confident professional (Ma, 2008), and knowledgeable (Banasiak <i>et al</i> , 2007; Whitney <i>et al</i> , 2008) (9/24)
	Mental health professional providing encouragement and guidance/modelling/validation	Mental health professional (providing encouragement and guidance/modelling/validation) (Banasiak <i>et al</i> , 2007; Laberg <i>et al</i> , 2001; Ma, 2008 and Ma and Lai, 2006; le Grange and Gelman, 1998; Whitney <i>et al</i> , 2008), patience (Whitney <i>et al</i> , 2008), which as a result brought confidence in treatment and/or self (Laberg <i>et al</i> , 2001; Ma and Lai, 2006; Whitney <i>et al</i> , 2008) (5/24)
Important general characteristics of treatment	Importance of psychological therapy/importance of addressing interpersonal issues	Seeing psychological therapy and the focus on interpersonal/emotional/psychological (underlying) issues as central to ED (Cockell <i>et al</i> , 2004; Colton and Pistrang, 2004; Offord <i>et al</i> , 2006; Reid <i>et al</i> , 2008; Rorty <i>et al</i> , 1993; Rother and Buckroyd, 2004; Whitney <i>et al</i> , 2008), the fact of having psychological therapy was seen as helpful (Button and Warren, 2001) (8/24)
	Client active in own treatment/treatment collaboration	Client's active involvement in their own treatment and collaboration with the mental health professional (Colton and Pistrang, 2004; D'Abundo and Chally, 2004; Dunn <i>et al</i> , 2006; Krautter and Lock, 2004; Offord <i>et al</i> , 2006; Reid <i>et al</i> , 2008), treatment could be the client led/controlled (D'Abundo and Chally, 2004; Offord <i>et al</i> , 2006, Ma, 2008; Reid <i>et al</i> , 2008), could bring increased treatment adherence (Banasiak <i>et al</i> , 2007), a sense of empowerment (Offord <i>et al</i> , 2006) (8/24)
	Structure in the treatment	Structure of the treatment (Banasiak <i>et al</i> , 2007; Colton and Pistrang, 2004; Offord <i>et al</i> , 2006), regularity and organisation (Banasiak <i>et al</i> , 2007; Dunn <i>et al</i> , 2006; Krautter and Lock, 2004), eating incorporated into treatment (Banasiak <i>et al</i> , 2007; Cockell <i>et al</i> , 2004; Offord <i>et al</i> , 2006; Rother and Buckroyd, 2004; Tierney, 2008), time-limits used (Banasiak <i>et al</i> , 2007) (8/24)
	Client soliciting social and professional help	Client's capability of acknowledging the problem and receptivity to the treatment (Cockell <i>et al</i> , 2004; D'Abundo and Chally, 2004; Maine, 1985; Whitney <i>et al</i> , 2008), ability to seek/solicit help (Cockell <i>et al</i> , 2004), a spiritual experience highlighting the problem and the need to seek help (D'Abundo and Chally, 2004) (5/24)

	Treatment's symptom focus	Treatment focusing on symptoms (Banasiak <i>et al</i> , 2007; Cockell <i>et al</i> , 2004; Offord <i>et al</i> , 2006; Reid <i>et al</i> , 2008), nutrition and psychological dynamic (Cockell <i>et al</i> , 2004), eating and/or eating related behaviour (Banasiak <i>et al</i> , 2007; Cockell <i>et al</i> , 2004), coping with ED symptoms (Reid <i>et al</i> , 2008) (4/24)
	Financial and other accessibility	Financial and other accessibility of treatment (Banasiak <i>et al</i> , 2007; Krautter and Lock, 2004; Roy <i>et al</i> , 2006; Swain-Campbell <i>et al</i> , 2001) flexibility of the service delivery (Roy <i>et al</i> , 2006) (4/24)
	Treatment focused on the whole family	Working with the family (not just the ED patient) (Ma and Lai, 2006; Maine, 1985; Offord <i>et al</i> , 2006), helpful impact it had on the family (Offord <i>et al</i> , 2006), increased mutual openness (communication), understanding and support (Ma and Lai, 2006 and Ma, 2008; Maine, 1985), ED is a whole family issue (Ma and Lai, 2006), family can be a strength (Ma, 2008) (3/24)
	Importance of follow-up interventions	Follow-up interventions and possibility of staying in touch with mental health professionals (Cockell <i>et al</i> , 2004; Offord <i>et al</i> , 2006) (2/24)
Important specific characteristics of treatment	Self-monitoring/ monitoring	Monitoring and/or self-monitoring as a part of the treatment (Banasiak <i>et al</i> , 2007; Krautter and Lock, 2004; Lamoureux and Bottorff, 2005; le Grange and Gelman, 1998; Offord <i>et al</i> , 2006; Rother and Buckroyd, 2004; Roy <i>et al</i> , 2006; Swain-Campbell <i>et al</i> , 2001), journaling/keeping diary (Banasiak <i>et al</i> , 2007; Lamoureux and Bottorff, 2005), following a meal plan (Cockell <i>et al</i> , 2004; Laberg <i>et al</i> , 2001; Rother and Buckroyd, 2004), realising that what the clients eat does not correspond with what they thought they ate (le Grange and Gelman, 1998; Rother and Buckroyd, 2004) (10/24)
	Behaviour change/ experiments/gaining control	Working on behavioural change (Moreno <i>et al</i> , 1995; le Grange and Gelman, 1998; Rorty <i>et al</i> , 1993), using behavioural experiments/ techniques (Cockell <i>et al</i> , 2004; le Grange and Gelman, 1998; Swain-Campbell <i>et al</i> , 2001), achieving mastery/control through behavioural techniques (Banasiak <i>et al</i> , 2007; D'Abundo and Chally, 2004; le Grange and Gelman, 1998), planning and problem solving (Banasiak <i>et al</i> , 2007; Offord <i>et al</i> , 2006), broadening of behavioural repertoire (Whitney <i>et al</i> , 2008) (9/24)
	Cognitive restructuring	Cognitive restructuring (addressing dysfunctional thinking, attitudes and beliefs) (Banasiak <i>et al</i> , 2007; Cockell <i>et al</i> , 2004; Krautter and Lock, 2004; Lamoureux and Bottorff, 2005; le Grange and Gelman, 1998; Tierney, 2008; Whitney <i>et al</i> , 2008), broadening of perspective (Cockell <i>et al</i> , 2004; Lamoureux and Bottorff, 2005), practical information (Banasiak <i>et al</i> , 2007), observing 'normal' people's meals (Cockell <i>et al</i> , 2004) (7/24)
	Nutritional knowledge/ knowledge about detrimental effects of ED and ED itself	Provision of nutritional knowledge and/or knowledge about detrimental effects of ED and ED itself as a part of treatment (Banasiak <i>et al</i> , 2007; Cockell <i>et al</i> , 2004; Krautter and Lock, 2004; Laberg <i>et al</i> , 2001; Lamoureux and Bottorff, 2005; Ma and Lai, 2006; Offord <i>et al</i> , 2006), through which the client learned about the food and body (Cockell <i>et al</i> , 2004; Laberg <i>et al</i> , 2001; Lamoureux and Bottorff, 2005; Ma and Lai, 2006) (7/24)
	Emotional expression/ emotional awareness	Emotional expression/emotional awareness as a part of psychological therapy (Cockell <i>et al</i> , 2004; le Grange and Gelman, 1998; Moreno <i>et al</i> , 1995; Lamoureux and Bottorff, 2005; Petersen and Rosenvinge, 2002) (5/24)
	Importance of leisure activities/ social distraction	Leisure activities and distraction as a part of treatment (Cockell <i>et al</i> , 2004; Laberg <i>et al</i> , 2001; Lamoureux and Bottorff, 2005), exercise/ yoga (Button and Warren 2001; Cockell <i>et al</i> , 2004; Lamoureux and Bottorff, 2005), volunteering (Cockell <i>et al</i> , 2004), socialising (Button and Warren 2001; Cockell <i>et al</i> , 2004; D'Abundo and Chally, 2004; Laberg <i>et al</i> , 2001; Lamoureux and Bottorff, 2005) (5/24)
	Therapy providing holding space	Treatment providing a holding space (Ma, 2008; Swain-Campbell <i>et al</i> , 2001), neutral space (Krautter and Lock, 2004; Ma, 2008; Petersen and Rosenvinge, 2002), space for reflection (Krautter and Lock, 2004; Ma,

		2008), that allowed the needed distance (Pettersen and Rosenvinge, 2002) (4/24)
	Focus on interpersonal skills	Treatment focusing on interpersonal skills/communication (Krautter and Lock, 2004; Laberg <i>et al</i> , 2001) (2/24)
Important in-treatment changes contributing to helpfulness of treatment	Insight	Client achieving insight/new awareness/new perspective/new realisation (Banasiak <i>et al</i> , 2007; D'Abundo and Chally, 2004; Laberg <i>et al</i> , 2001; Lamoureux and Botorff, 2005; le Grange and Gelman, 1998; Ma and Lai, 2006; Maine, 1985; Malson <i>et al</i> , 2004; Moreno <i>et al</i> , 1995; Offord <i>et al</i> , 2006; Pettersen and Rosenvinge, 2002; Rorty <i>et al</i> , 1993; Rother and Buckroyd, 2004; Whitney <i>et al</i> , 2008), insight/ awareness could relate to a realisation: of the need for support (Moreno <i>et al</i> , 1995), of the unhelpfulness of ED related behaviour and/or of its impact (Banasiak <i>et al</i> , 2007; D'Abundo and Chally, 2004; Lamoureux and Botorff, 2005; le Grange and Gelman, 1998; Maine, 1985; Malson <i>et al</i> , 2004; Offord <i>et al</i> , 2006; Rother and Buckroyd, 2004), of ED dynamic (Laberg <i>et al</i> , 2001), of own potential (Pettersen and Rosenvinge, 2002), of own perfectionism (Maine, 1985); admission of the problem (Pettersen and Rosenvinge, 2002; Maine, 1985), understanding others (Ma and Lai, 2006), and it could lead to further involvement in therapy (Whitney <i>et al</i> , 2008) (14/24)
	Self-acceptance/ self-worth	Clients' experiences of self-acceptance/self-worth while in treatment (Banasiak <i>et al</i> , 2007; Cockell <i>et al</i> , 2004; Lamoureux and Botorff, 2005; Maine, 1985), a sense of being a better person/having value (Cockell <i>et al</i> , 2004; Lamoureux and Botorff, 2005), being confident/empowered (Banasiak <i>et al</i> , 2007; Lamoureux and Botorff, 2005; Offord <i>et al</i> , 2006; Roy <i>et al</i> , 2006), independent (Lamoureux and Botorff, 2005), not being a perfectionist (Lamoureux and Botorff, 2005; Maine, 1985), having a sense of achievement (Whitney <i>et al</i> , 2008) (6/24)
	Learning about the self	Learning about the self (Lamoureux and Botorff, 2005; Moreno <i>et al</i> , 1995; Pettersen and Rosenvinge, 2002), helpfulness of self-understanding (Laberg <i>et al</i> , 2001; Lamoureux and Botorff, 2005; Pettersen and Rosenvinge, 2002), self-discoveries (Lamoureux and Botorff, 2005), self-motivation (Pettersen and Rosenvinge, 2002) (3/24)
	Change in life circumstances/ positive life events	Change in life circumstances and/or experiencing positive life events (Cockell <i>et al</i> , 2004; Pettersen and Rosenvinge, 2002; Rorty <i>et al</i> , 1993), such as attaining an important personal goal (Rorty <i>et al</i> , 1993) (3/24)

### Broader social support

This domain contained three meta-categories (*Support from co-patients; Sharing with others (less isolated, alone)/normalising; Support from relatives, close ones and strangers*) that refer to the social context of the client's treatment, either within the institution where they received treatment (eg inpatient treatment) or within the client's own circle of friends, peers and family. The meta-categories in this domain highlight the importance of social context for overall ED treatment. This domain was based on the findings reported in 15 out of 24 meta-analysed studies. Each of the meta-categories will be presented briefly below and will refer to the findings from the original studies that have contributed to this meta-category.

#### *Support from co-patients*

This meta-category was based on the findings reported in 10 out of 24 meta-analysed studies. These helpful aspects usually related to the support of other co-patients (Colton and Pistrang, 2004; Laberg *et al*, 2001; Moreno *et al*, 1995; Offord *et al*, 2006; Rorty *et al*, 1993; Tierney, 2008), the helpfulness of their perspective (Laberg *et al*, 2001; Lamoureux and Botorff, 2005), the helpfulness of their understanding (Colton and Pistrang, 2004; Moreno *et al*, 1995), attunement to their experience (Moreno *et al*, 1995), acceptance by them (Moreno *et al*, 1995), and connection with them (Banasiak

et al, 2007; Moreno *et al*, 1995). In addition, similarity of their experience (identification with them) (Banasiak *et al*, 2007; Moreno *et al*, 1995; Offord *et al*, 2006; Pettersen and Rosenvinge, 2002), their presence (Offord *et al*, 2006; Rorty *et al*, 1993; Roy *et al*, 2006), learning from them (Offord *et al*, 2006), a sense of community (as opposite to isolation) and friendship with them (Laberg *et al*, 2001; Offord *et al*, 2006; Roy *et al*, 2006) were also identified.

#### *Sharing with other sufferers (less isolated, alone)/normalising*

This meta-category was based on the findings reported in 10 out of 24 meta-analysed studies. These helpful aspects usually related to the helpfulness of sharing with other co-sufferers (Cockell *et al*, 2004; Laberg *et al*, 2001; Moreno *et al*, 1995; Pettersen and Rosenvinge, 2002; Rother and Buckroyd, 2004), and thus feeling not alone (Banasiak *et al*, 2007; Laberg *et al*, 2001; Moreno *et al*, 1995; Offord *et al*, 2006). Other helpful aspects identified here included, feeling connection with (opportunity to relate) (Moreno *et al*, 1995; Maine, 1985), feeling identification with (Banasiak *et al*, 2007; Moreno *et al*, 1995; Offord *et al*, 2006), having their own experience normalised (Banasiak *et al*, 2007; Laberg *et al*, 2001), learning from the others (Offord *et al*, 2006; Pettersen and Rosenvinge, 2002; Rother and Buckroyd, 2004), comparing different perspectives (Dunn *et al*, 2006; Laberg *et al*, 2001; Lamoureux and Bottorff, 2005 – note see above), opening up to others (Laberg *et al*, 2001), and getting hope through seeing others (Pettersen and Rosenvinge, 2002).

#### *Support from relatives, close ones and strangers*

This meta-category was based on the findings reported in 10 out of 24 meta-analysed studies. These helpful aspects generally referred to the helpfulness of support from the people (parents, friends and others) around the client (Cockell *et al*, 2004; D'Abundo and Chally, 2004; Maine, 1985; Pettersen and Rosenvinge, 2002; Rorty *et al*, 1993; Tierney, 2008). For instance, in bringing the client to the treatment (Pettersen and Rosenvinge, 2002; Rother and Buckroyd, 2004; Tierney, 2008), in providing an opportunity to share and be understood (Cockell *et al*, 2004; Krautter and Lock, 2004; Ma and Lai, 2006), and in showing concern/emotional support and practical support (Ma and Lai, 2006; Maine, 1985; Pettersen and Rosenvinge, 2002). Furthermore, in making the client feeling trusted/accepted (D'Abundo and Chally, 2004; Ma and Lai, 2006; Pettersen and Rosenvinge, 2002), in making the client feeling empowered/confident/worthy, and having hope as a result (D'Abundo and Chally, 2004; Lamoureux and Bottorff, 2005; Ma and Lai, 2006; Maine, 1985; Pettersen and Rosenvinge, 2002), and sometimes offering more support than professionals (Maine, 1985). An example of a participant's quote in this context comes from the study of Ma and Lai (2006, p. 67): "*The family communicated with one another during treatment, eg we learned from each other's views. We had mutual understanding and mutual support.*"

#### **Relational support from mental health professional**

This domain contained three meta-categories (*Trusting and supportive relationship with professional; Feeling understood/being listened to/having opportunity to talk; Being seen as a person; Feeling cared for*) that refer to the relational qualities provided by a mental health professional and the subsequent impact on the client that contributes to the client's engagement in treatment. This domain was based on the findings reported in 16 out of 24 meta-analysed studies.

### *Trusting and supportive relationship with professional*

This meta-category was based on the findings reported in 16 out of 24 meta-analysed studies. These helpful aspects pointed to the helpfulness of trusting and supportive relationship with the professional (D'Abundo and Chally, 2004; Cockell *et al*, 2004; Lamoureux and Bottorff, 2005; Krautter and Lock, 2004; le Grange and Gelman, 1998; Ma, 2008; Ma and Lai, 2006; Maine, 1985; Reid *et al*, 2008; Roy *et al*, 2006; Swain-Campbell *et al*, 2001). They also covered (see also above) the helpfulness of having an opportunity to talk [openly] (Banasiak *et al*, 2007; Button and Warren 2001; Cockell *et al*, 2004; le Grange and Gelman, 1998; Ma, 2008; Reid *et al*, 2008; Roy *et al*, 2006). The helpful aspects of this category also referred to the relaxed relationship with the professional (Ma, 2008; Offord *et al*, 2006; Whitney *et al*, 2008), and the validation/acceptance provided by the mental health professional (Ma and Lai, 2006; Maine, 1985). The personal characteristics of the mental health professional identified as helpful refer to his or her warmth (Dunn *et al*, 2006; le Grange and Gelman, 1998; Ma, 2008; Ma and Lai, 2006; Whitney *et al*, 2008), genuineness (Ma and Lai, 2006), caring/concerned presence (Ma, 2008; Ma and Lai, 2006; Reid *et al*, 2008; Whitney *et al*, 2008), provision of a sense of security (le Grange and Gelman, 1998; Ma, 2008), friendliness/ approachability (Ma, 2008; Roy *et al*, 2006; Whitney *et al*, 2008), calmness (Ma, 2008), and provision of an empathic and understanding presence by the professional (Banasiak *et al*, 2007; Dunn *et al*, 2006; le Grange and Gelman, 1998; Ma, 2008; Reid *et al*, 2008; Roy *et al*, 2006; Whitney *et al*, 2008). The professional stance of the practitioner was also seen as helpful in terms of appropriate neutral/non-judgmental stance (Dunn *et al*, 2006; le Grange and Gelman, 1998; Ma, 2008; Maine, 1985; Roy *et al*, 2006), and professionally appropriate disclosures (Rother and Buckroyd, 2004). Those relational qualities could then lead to self-exploration, a sense of intimacy, sharing and interdependence (Maine, 1985). Examples of the participants' quotes from the original studies include: "*She showed acceptance for what we've said; and [She] trusted me and encouraged me; She made me feel confident*" (Ma, 2008, p. 13). "*I found the therapist very warm and caring. She was very encouraging and I felt comfortable doing the sessions with her. I think this was an important aspect of being able to learn things*" (Whitney *et al*, 2008, p. 547). "*Just the love and support and that they [staff] care about you*" (Reid *et al*, 2008, p. 959).

### *Feeling understood/being listened to/having opportunity to talk*

This meta-category was based on the findings reported in 12 out of 24 meta-analysed studies. These helpful aspects related to the helpfulness of feeling understood by the mental health professional (Banasiak *et al*, 2007; Button and Warren 2001; Cockell *et al*, 2004; Colton and Pistrang, 2004; Dunn *et al*, 2006; Moreno *et al*, 1995; Rorty *et al*, 1993; Roy *et al*, 2006), being heard (Colton and Pistrang, 2004), and being empathically listened to by the mental health professional (Banasiak *et al*, 2007; Colton and Pistrang, 2004; Dunn *et al*, 2006; le Grange and Gelman, 1998; Ma, 2008; Offord *et al*, 2006; Reid *et al*, 2008; Rorty *et al*, 1993; Roy *et al*, 2006). In addition, having the opportunity to talk [openly] to the mental health professional (Banasiak *et al*, 2007; Button and Warren 2001; Cockell *et al*, 2004; le Grange and Gelman, 1998; Reid *et al*, 2008; Roy *et al*, 2006) could reduce isolation and loneliness (Banasiak *et al*, 2007; Colton and Pistrang, 2004). An example of a participant's quote in this meta-category comes from the study of Reid *et al* (2008, p. 958): "*You get a chance to talk about what you are going through, to be really open . . . It's actually having someone who's listening to what I say.*" Another example comes from Dunn *et al* (2006, p. 47): "*. . . repeating the points that I made to show that she understood*".



### *Being seen as a person*

This meta-category was based on the findings reported in seven out of 24 meta-analysed studies. These helpful aspects illustrated the helpfulness of the participant having a sense of being seen as a person (not anorectic/bulimic) (Colton and Pistrang, 2004; Button and Warren, 2001), feeling accepted (Moreno *et al*, 1995), treated normally (Offord *et al*, 2006), feeling not blamed (Ma and Lai, 2006), and cared for (Reid *et al*, 2008; Swain-Campbell *et al*, 2001).

### *Feeling cared for*

This meta-category was based on the findings reported in four out of 24 meta-analysed studies. These helpful aspects pointed to the helpfulness of the participant's sense of being cared for (Colton and Pistrang, 2004; Ma, 2008; Swain-Campbell *et al*, 2001), and accepted (Moreno *et al*, 1995) (see also the category above). As articulated by a participant in Swain-Campbell *et al* (2001, p. 101): "*I felt valued and cared about*".

## **Important characteristics of mental health professional**

This domain contained two meta-categories (*Mental health professional (therapist) as an expert*; *Mental health professional providing encouragement and guidance/modelling/validation*) that complemented the domain *Relational support from mental health professional* and focused on professional aspects of the therapist's (mental health professional's) behaviour. This domain was based on the findings reported in 10 out of 24 meta-analysed studies.

### *Mental health professional (therapist) as an expert*

This meta-category was based on the findings reported in nine out of 24 meta-analysed studies. These helpful aspects related to the helpfulness of the therapist (or other mental health professional) being an expert on ED (being experienced in working with ED) (Banasiak *et al*, 2007; Button and Warren, 2001; Cockell *et al*, 2004; Krautter and Lock, 2004; Laberg *et al*, 2001; Offord *et al*, 2006; Reid *et al*, 2008; Tierney, 2008), being a confident professional (Ma, 2008), and knowledgeable (Banasiak *et al*, 2007; Whitney *et al*, 2008). Examples of quotes from participants in the original study include: "*The therapist saw the problem in a professional way. After bringing out the problem, we needed to solve it. She [T] heightened our awareness on the seriousness of the problem and encouraged us to resolve it. When we avoided the problem, she asked us firmly but politely to face it and think of a way to resolve it.*" (Ma, 2008, p. 14)

### *Mental health professional providing encouragement and guidance/modelling/validation*

This meta-category was based on the findings reported in five out of 24 meta-analysed studies. These helpful aspects pointed to the helpfulness of the mental health professional (typically a therapist) providing encouragement and guidance/modelling/validation (Banasiak *et al*, 2007; Laberg *et al*, 2001; Ma, 2008 and Ma and Lai, 2006; le Grange and Gelman, 1998; Whitney *et al*, 2008), and patience (Whitney *et al*, 2008), which as a result brought confidence in treatment and/or self (Laberg *et al*, 2001; Ma and Lai, 2006; Whitney *et al*, 2008). The participants' quotes from the original studies included: "*She [the therapist] looked at me with a warm smile and in a firm tone, said that she had confidence in me and I could make it. That was unforgettable. I was no longer confused and lost. She [therapist] had given me the direction.*" (Ma, 2008, p. 13) "*I found the therapist very warm and caring.*

*She was very encouraging and I felt comfortable doing the sessions with her. I think this was an important aspect of being able to learn things.” (Whitney et al, 2008, p. 547)*

### **Important general characteristics of treatment**

This domain contained eight meta-categories (*Importance of psychological therapy/importance of addressing interpersonal issues; Client active in own treatment/treatment collaboration; Structure in the treatment; Client soliciting social and professional help; Treatment’s symptom focus; Financial and other accessibility; Treatment focused on the whole family; Importance of follow-up interventions*) that referred to general (broad, overall) aspects of the treatment that included more global strategies or conditions and non-specific interventions. This domain was based on the findings reported in 17 out of 24 meta-analysed studies.

#### *Importance of psychological therapy/importance of addressing interpersonal issues*

This meta-category was based on the findings reported in eight out of 24 meta-analysed studies. These helpful aspects related to the helpfulness of seeing psychological therapy and the focus on interpersonal/emotional/psychological (underlying) issues as central to ED (Cockell et al, 2004; Colton and Pistrang, 2004; Offord et al, 2006; Reid et al, 2008; Rorty et al, 1993; Rother and Buckroyd, 2004; Whitney et al, 2008), and in one case even the fact of having psychological therapy was seen as helpful (Button and Warren 2001).

#### *Client active in own treatment/treatment collaboration*

This meta-category was based on the findings reported in eight out of 24 meta-analysed studies. These helpful aspects pointed to the helpfulness of the client’s active involvement (motivation) in their own treatment and collaboration with the mental health professional (Colton and Pistrang, 2004; D’Abundo and Chally, 2004; Dunn et al, 2006; Krautter and Lock, 2004; Offord et al, 2006; Reid et al, 2008), it showed that the treatment could be the client led/controlled (D’Abundo and Chally, 2004; Offord et al, 2006, Ma, 2008; Reid et al, 2008), and as a result it could bring increased treatment adherence (Banasiak et al, 2007), and a sense of empowerment (Offord et al, 2006). An illustrative example comes from Reid et al (2008, p. 958): *“But here I’m in control of what I want . . . I feel as though I’m in control of my treatment but I feel as though I’m steered in the right path and motivated to do certain things.”*

#### *Structure in the treatment*

This meta-category was based on the findings reported in eight out of 24 meta-analysed studies. These helpful aspects pointed to the helpfulness of the structure of the treatment (Banasiak et al, 2007; Colton and Pistrang, 2004; Offord et al, 2006), regularity and organisation (Banasiak et al, 2007; Dunn et al, 2006; Krautter and Lock, 2004), for instance that eating was incorporated into treatment (Banasiak et al, 2007; Cockell et al, 2004; Offord et al, 2006; Rother and Buckroyd, 2004; Tierney, 2008), or that time limits were used (Banasiak et al, 2007).

#### *Client soliciting social and professional help*

This meta-category was based on the findings reported in five out of 24 meta-analysed studies. These helpful aspects pointed to the helpfulness of the client’s capability of acknowledging the problem and

receptivity to the treatment (Cockell *et al*, 2004; D'Abundo and Chally, 2004; Maine, 1985; Whitney *et al*, 2008), ability to seek/solicit help (Cockell *et al*, 2004), which in one study was connected to having a spiritual experience highlighting the problem and the need to seek help (D'Abundo and Chally, 2004). Examples of quotes feeding into this category come from the study of D'Abundo and Chally (2004, p. 1000-1): "*I was working with young girls . . . and didn't want them to feel the way that I did about my size.*" "*I collapsed on the beach . . . and I basically accepted that this is not healthy.*"

#### *Treatment's symptom focus*

This meta-category was based on the findings reported in four out of 24 meta-analysed studies. These helpful aspects denoted the helpfulness of the treatment focusing on symptoms (Banasiak *et al*, 2007; Cockell *et al*, 2004; Offord *et al*, 2006; Reid *et al*, 2008), nutrition and psychological dynamic (Cockell *et al*, 2004), eating and/or eating related behaviour (Banasiak *et al*, 2007; Cockell *et al*, 2004), and coping with ED symptoms (Reid *et al*, 2008). An example of a participant valuing the work on coping with an ED symptom comes from Reid *et al* (2008, p. 958): "*Say like I thought I was going to have a binge and then we've got to think of something that might distract you so if it's something like having a walk or it's just doing a bit of gardening or something like that.*"

#### *Financial and other accessibility*

This meta-category was based on the findings reported in four out of 24 meta-analysed studies. These helpful aspects pointed to the helpfulness of financial and other accessibility of treatment (Banasiak *et al*, 2007; Krautter and Lock, 2004; Roy *et al*, 2006; Swain-Campbell *et al*, 2001) and flexibility of the service delivery (Roy *et al*, 2006).

#### *Treatment focused on the whole family*

This meta-category was based on the findings reported in three out of 24 meta-analysed studies. These helpful aspects were in reference to the helpfulness of working with the family (not just the ED patient) (Ma and Lai, 2006; Maine, 1985; Offord *et al*, 2006), and they pointed at the helpful impact it had on the family (Offord *et al*, 2006), such as increased mutual openness (communication), understanding and support (Ma and Lai, 2006 and Ma, 2008; Maine, 1985), it was valued that ED is a whole family issue (Ma and Lai, 2006), and that family can be a strength (Ma, 2008). An example of a participant quote comes from the study of Ma (2008, p. 14): "*She [Therapist] would tell us to try to see things from a different point of view. When she was with me [Client], she asked me to look at the matter from my parents' point of view. When T was with my parents, she asked them to look at the matter from my point of view. This allowed us to know each other's difficulties and our relations.*"

#### *Importance of follow-up interventions*

This meta-category was based on the findings reported in two out of 24 meta-analysed studies. These helpful aspects indicated the helpfulness of follow-up interventions and possibility of staying in touch with mental health professionals (Cockell *et al*, 2004; Offord *et al*, 2006).

### **Important specific characteristics of treatment**

This domain contained eight meta-categories (*Self-monitoring/monitoring; Behaviour change/experiments/gaining control; Cognitive restructuring; Nutritional knowledge/knowledge about*

*detrimental effects of ED and ED itself; Emotional expression/emotional awareness; Importance of leisure activities/social distraction; Therapy providing holding space; Focus on interpersonal skills*) that referred to specific interventions that were experienced as helpful. This domain was based on the findings reported in 15 out of 24 meta-analysed studies.

#### *Self-monitoring/monitoring*

This meta-category was based on the findings reported in 10 out of 24 meta-analysed studies. These helpful aspects pointed to the helpfulness of having monitoring and/or self-monitoring as a part of the treatment (Banasiak *et al*, 2007; Krautter and Lock, 2004; Lamoureux and Bottorff, 2005; le Grange and Gelman, 1998; Offord *et al*, 2006; Rother and Buckroyd, 2004; Roy *et al*, 2006; Swain-Campbell *et al*, 2001), journaling/keeping a diary (Banasiak *et al*, 2007; Lamoureux and Bottorff, 2005), and following a meal plan (Cockell *et al*, 2004; Laberg *et al*, 2001; Rother and Buckroyd, 2004). It could for instance lead to realising that what the client eats does not correspond with what they thought they ate (le Grange and Gelman, 1998; Rother and Buckroyd, 2004). An example of the usefulness of keeping a diary comes from le Grange and Gelman's (1998, p. 185) study: ". . . *helpful to write everything [I ate] down. It made me realise that what I had eaten was not as much as I thought it was.*"

#### *Behaviour change/experiments/gaining control*

This meta-category was based on the findings reported in nine out of 24 meta-analysed studies. These helpful aspects demonstrated the helpfulness of working on behavioural change (Moreno *et al*, 1995; le Grange and Gelman, 1998; Rorty *et al*, 1993), using behavioural experiments/techniques (Cockell *et al*, 2004; le Grange and Gelman, 1998; Swain-Campbell *et al*, 2001), achieving mastery/control through behavioural techniques (Banasiak *et al*, 2007; D'Abundo and Chally, 2004; le Grange and Gelman, 1998), planning and problem solving (Banasiak *et al*, 2007; Offord *et al*, 2006), and broadening of behavioural repertoire (Whitney *et al*, 2008). An example of a participant's quote is in the le Grange and Gelman (1998, p. 184) study: "*Therapy gave me coping strategies. If I had a binge feeling, therapy helped me to do other things instead.*"

#### *Cognitive restructuring*

This meta-category was based on the findings reported in seven out of 24 meta-analysed studies. These helpful aspects referred to the helpfulness of cognitive restructuring (addressing dysfunctional thinking, attitudes and beliefs) (Banasiak *et al*, 2007; Cockell *et al*, 2004; Krautter and Lock, 2004; Lamoureux and Bottorff, 2005; le Grange and Gelman, 1998; Tierney, 2008; Whitney *et al*, 2008), broadening of perspective (Cockell *et al*, 2004; Lamoureux and Bottorff, 2005), practical information (Banasiak *et al*, 2007), and observing 'normal' people's meals (Cockell *et al*, 2004). Examples of quotes come from le Grange and Gelman (1998, p. 185-6): "*Therapy helped me realise that eating three times a day is not a crime and is not going to make me fat . . . it . . . also taught me that not everything which one puts in one's mouth turns immediately into fat . . . helped me to think in different ways and therefore to act in different ways . . . made me see things about myself in different ways, and helped me eat better.*"

#### *Nutritional knowledge/knowledge about detrimental effects of ED and ED itself*

This meta-category was based on the findings reported in seven out of 24 meta-analysed studies. These helpful aspects pointed to the helpfulness of the provision of nutritional knowledge and/or knowledge about detrimental effects of ED and ED itself as a part of treatment (Banasiak *et al*, 2007; Cockell *et al*, 2004; Krautter and Lock, 2004; Laberg *et al*, 2001; Lamoureux and Botorff, 2005; Ma and Lai, 2006; Offord *et al*, 2006), through which the client learned about food and the body (Cockell *et al*, 2004; Laberg *et al*, 2001; Lamoureux and Botorff, 2005; Ma and Lai, 2006).

#### *Emotional expression/emotional awareness*

This meta-category was based on the findings reported in five out of 24 meta-analysed studies. These helpful aspects were in reference to the helpfulness of emotional expression/emotional awareness as a part of psychological therapy (Cockell *et al*, 2004; le Grange and Gelman, 1998; Moreno *et al*, 1995; Lamoureux and Botorff, 2005; Pettersen and Rosenvinge, 2002). An example of a participant's quote is from the study of le Grange and Gelman (1998, p. 185): "*Writing down emotions helped me to get in touch [with feelings].*"

#### *Importance of leisure activities/social distraction*

This meta-category was based on the findings reported in five out of 24 meta-analysed studies. These helpful aspects pointed to the helpfulness of having leisure activities and distraction as a part of treatment (Cockell *et al*, 2004; Laberg *et al*, 2001; Lamoureux and Botorff, 2005), such as exercise/yoga (Button and Warren 2001; Cockell *et al*, 2004; Lamoureux and Botorff, 2005), volunteering (Cockell *et al*, 2004), and socialising (Button and Warren 2001; Cockell *et al*, 2004; D'Abundo and Chally, 2004; Laberg *et al*, 2001; Lamoureux and Botorff, 2005).

#### *Therapy providing holding space*

This meta-category was based on the findings reported in four out of 24 meta-analysed studies. These helpful aspects referred to the helpfulness of treatment providing a holding space (Ma, 2008; Swain-Campbell *et al*, 2001), neutral space (Krautter and Lock, 2004; Ma, 2008; Pettersen and Rosenvinge, 2002), space for reflection (Krautter and Lock, 2004; Ma, 2008), and space that allowed the needed distance (Pettersen and Rosenvinge, 2002).

#### *Focus on interpersonal skills*

This meta-category was based on the findings reported in two out of 24 meta-analysed studies. These helpful aspects pointed to the helpfulness of treatment focusing on interpersonal skills/communication (Krautter and Lock, 2004; Laberg *et al*, 2001).

### **Important in-treatment changes contributing to helpfulness of treatment**

This domain contained four meta-categories (*Insight; Self-acceptance/self-worth; Learning about the self; Change in life circumstances/positive life events*) that referred to changes achieved while in treatment that were seen as important helpful aspects of the treatment. This domain was based on the findings reported in 15 out of 24 meta-analysed studies.

### *Insight*

This meta-category was based on the findings reported in 14 out of 24 meta-analysed studies. These helpful aspects pointed to the helpfulness of the client achieving insight/new awareness/new perspective/new realisation (Banasiak *et al*, 2007; D'Abundo and Chally, 2004; Laberg *et al*, 2001; Lamoureux and Bottorff, 2005; le Grange and Gelman, 1998; Ma and Lai, 2006; Maine, 1985; Malson *et al*, 2004; Moreno *et al*, 1995; Offord *et al*, 2006; Pettersen and Rosenvinge, 2002; Rorty *et al*, 1993; Rother and Buckroyd, 2004; Whitney *et al*, 2008). The insight/awareness could relate to a realisation: of the need for support (Moreno *et al*, 1995), of the unhelpfulness of ED-related behaviour and/or of its impact (Banasiak *et al*, 2007; D'Abundo and Chally, 2004; Lamoureux and Bottorff, 2005; le Grange and Gelman, 1998; Maine, 1985; Malson *et al*, 2004; Offord *et al*, 2006; Rother and Buckroyd, 2004), of ED dynamic (Laberg *et al*, 2001), of own potential (Pettersen and Rosenvinge, 2002), of own perfectionism (Maine, 1985), admission of the problem (Maine, 1985; Pettersen and Rosenvinge, 2002), understanding others (Ma and Lai, 2006), and it could lead to further involvement in therapy (Whitney *et al*, 2008). Examples of participants' quotes representing this category include: "Seeing somebody that wasn't very well motivated [client, helped me] to carry on because I didn't want to go back again" (Offord *et al*, 2006, p. 384); "Example of other group members helped: when I heard about how ill she was and how much she couldn't do, it reminded me of how ill I had been and how it is not worth being that thin" (Rother and Buckroyd, 2004, p. 158); "Therapy helped me realise that eating three times a day is not a crime and is not going to make me fat . . . it . . . also taught me that not everything which one puts in one's mouth turns immediately into fat" (le Grange and Gelman, 1998, p. 185), etc.

### *Self-acceptance/self-worth*

This meta-category was based on the findings reported in six out of 24 meta-analysed studies. These helpful aspects indicated the helpfulness of the clients' experiences of self-acceptance/self-worth while in treatment (Banasiak *et al*, 2007; Cockell *et al*, 2004; Lamoureux and Bottorff, 2005; Maine, 1985), a sense of being a better person/having value (Cockell *et al*, 2004; Lamoureux and Bottorff, 2005), being confident/empowered (Banasiak *et al*, 2007; Lamoureux and Bottorff, 2005; Offord *et al*, 2006; Roy *et al*, 2006), independent (Lamoureux and Bottorff, 2005), not being a perfectionist (Lamoureux and Bottorff, 2005; Maine, 1985), and having a sense of achievement (Whitney *et al*, 2008).

### *Learning about the self*

This meta-category was based on the findings reported in three out of 24 meta-analysed studies. These helpful aspects pointed to the helpfulness of learning about the self (Lamoureux and Bottorff, 2005; Moreno *et al*, 1995; Pettersen and Rosenvinge, 2002), helpfulness of self-understanding (Laberg *et al*, 2001; Lamoureux and Bottorff, 2005; Pettersen and Rosenvinge, 2002), self-discoveries (Lamoureux and Bottorff, 2005), and self-motivation (Pettersen and Rosenvinge, 2002).

### *Change in life circumstances/positive life events*

This meta-category was based on the findings reported in three out of 24 meta-analysed studies. These helpful aspects pointed to the helpfulness of experiencing a change in life circumstances and/or experiencing positive life events (Cockell *et al*, 2004; Pettersen and Rosenvinge, 2002; Rorty *et al*, 1993), such as attaining an important personal goal (Rorty *et al*, 1993). An example is the quote from

the Pettersen and Rosenvinge (2002, p. 67) study: “When I got pregnant I knew that my eating disorder was a thing of the past.”

### Other helpful aspects of treatment

There were few findings that were reported only in one study. These included comments on the helpfulness of medication (Rorty *et al*, 1993), art and other supplementary therapies (Rorty *et al*, 1993), fun and entertainment as a part of treatment (Whitney *et al*, 2008), and use of own internal resources in combination with the use of a professional service (Roy *et al*, 2006).

### Unhelpful aspects of eating disorder treatment involving psychological therapy

Twenty-three of the meta-analysed studies contained findings referring to unhelpful aspects of treatment that involved a psychological therapy. One exception was the study of Moreno *et al* (1995) that contained only helpful aspects. The meta-analysis yielded 18 meta-categories summarising findings of the original studies that capture unhelpful aspects of treatment that involved a psychological therapy. These 18 meta-categories covered six domains pertinent to the treatment: 1) Perceived lack of broader social support, 2) Perceived lack of relational support from mental health professional, 3) Perceived deficiencies in important characteristics of mental health professional, 4) Perceived deficiencies in important general characteristics of treatment, 5) Perceived deficiencies in important specific characteristics of treatment, and 6) Painful experiences contributing to the unhelpfulness of treatment. Each meta-category is presented below domain by domain and also detailed in Table 4.

Table 4: Unhelpful aspects of eating disorder treatment involving psychological therapy

Domain	Meta-category	Primary Studies Findings
Perceived lack of broader social support	Distressing or misguiding influence of co-patients	Distressing or misguiding influence of co-patients (Cockell <i>et al</i> , 2004; Colton and Pistrang, 2004; Offord <i>et al</i> , 2006), by competing about who is thinner or learning self-harming or ED promoting behaviour (Colton and Pistrang, 2004; Eivors <i>et al</i> , 2003; Offord <i>et al</i> , 2006; Tierney, 2008), being distressed at seeing others/comparing self to them (Colton and Pistrang, 2004; Laberg <i>et al</i> , 2001; Offord <i>et al</i> , 2006), hindering aspects of group treatment (Roy <i>et al</i> , 2006), ashamed when realising where the client now belongs (among ED patients) (Eivors <i>et al</i> , 2003) (7 out of 24 studies contributed into this meta-category; 7/24)
	Unsupportive family/friends	Unhelpfulness of family and or/friends (Cockell <i>et al</i> , 2004; Colton and Pistrang, 2004; Krautter and Lock, 2004; Maine, 1985; Offord <i>et al</i> , 2006; Rorty <i>et al</i> , 1993), experienced lack of support or sense of rejection (Cockell <i>et al</i> , 2004; Colton and Pistrang, 2004; Offord <i>et al</i> , 2006), family therapy not being supportive or missing (Krautter and Lock, 2004; Maine, 1985; Tierney, 2008), lack of understanding or insensitivity from partner, friends, or family (Rorty <i>et al</i> , 1993), experiences of active sabotage by the close ones (Rorty <i>et al</i> , 1993), feeling powerless in family (Maine, 1985) (7/24)
Perceived lack of relational support from mental health professional	Being overlooked as a person/not cared for	Being overlooked as a person (Banasiak <i>et al</i> , 2007; Button and Warren, 2001; Colton and Pistrang, 2004; Malson <i>et al</i> , 2004; Offord <i>et al</i> , 2006; Tierney, 2008), being seen as another anorexic, and therefore, neglected, overlooked, judged (Colton and Pistrang, 2004; Malson <i>et al</i> , 2004; Offord <i>et al</i> , 2006; Rother and Buckroyd, 2004; Swain-Campbell <i>et al</i> , 2001; Tierney, 2008) (8/24)
	Therapist or treatment	Mental health professional or treatment programme being hostile/punitive or lacking warmth and care (Banasiak <i>et al</i> , 2007; Button and

programme hostile/punitive or lacking warmth and care	Warren, 2001; Colton and Pistrang, 2004; Maine, 1985; Offord <i>et al</i> , 2006; Rother and Buckroyd, 2004; Tierney, 2008), similarly like family (Maine, 1985), interpreting the client from the position of power [eg psychodynamic approach] (Offord <i>et al</i> , 2006), using unclear rules (Offord <i>et al</i> , 2006), pressuring the client (Swain-Campbell <i>et al</i> , 2001), this could lead to clients fighting back (Offord <i>et al</i> , 2006), feeling isolated, cut off (Maine, 1985) (8/24)
Not feeling understood/listened to	Feeling not understood, not listened to, not validated, or misunderstood (Banasiak <i>et al</i> , 2007; Button and Warren, 2001; Cockell <i>et al</i> , 2004; Maine, 1985; Malson <i>et al</i> , 2004; Tierney, 2008) (6/24)
Lacking trust in others	Lack of trust in others (Cockell <i>et al</i> , 2004; Laberg <i>et al</i> , 2001; Lamoureux and Bottorff, 2005; Offord <i>et al</i> , 2006), feeling vulnerable to open up (Cockell <i>et al</i> , 2004; Krautter and Lock, 2004; Laberg <i>et al</i> , 2001), mental health professional violating trust (eg confidentiality), being controlling (Lamoureux and Bottorff, 2005; Offord <i>et al</i> , 2006), which could lead to lying to the professionals (Lamoureux and Bottorff, 2005; Offord <i>et al</i> , 2006) (5/24)
Perceived deficiencies in important characteristics of mental health professional	Lack of expertise/mental health professional missing important issues/mental health professional's own issues Mental health professional lacking expertise with ED (Banasiak <i>et al</i> , 2007; Cockell <i>et al</i> , 2004; Maine, 1985; Rother and Buckroyd, 2004), due to the professional's own issues around their weight (Banasiak <i>et al</i> , 2007), due to the professional missing the seriousness of the problems or important issues (Maine, 1985; Offord <i>et al</i> , 2006; Rother and Buckroyd, 2004; Tierney, 2008), due to the professional not being skilful communicator (Roy <i>et al</i> , 2006; Swain-Campbell <i>et al</i> , 2001) (8/24)
Perceived deficiencies in important general characteristics of treatment	Non-responsiveness of the treatment/treatment missing client's needs/treatment too rigid Treatment was non-responsive, rigid and/or missing aspects relevant for the client (Banasiak <i>et al</i> , 2007; Button and Warren 2001; Eivors <i>et al</i> , 2003; Krautter and Lock, 2004; le Grange and Gelman, 1998; Ma and Lai, 2006; Maine, 1985; Offord <i>et al</i> , 2006; Rorty <i>et al</i> , 1993; Roy <i>et al</i> , 2006; Swain-Campbell <i>et al</i> , 2001; Whitney <i>et al</i> , 2008), perceived inadequacies of CBT strategies (not addressing the reasons for bulimia) (Banasiak <i>et al</i> , 2007), failure to adequately address body image concerns (Banasiak <i>et al</i> , 2007; Maine, 1985), failure to provide nutritional information (Banasiak <i>et al</i> , 2007), failure to provide advice regarding meal planning (Banasiak <i>et al</i> , 2007; Button and Warren 2001), absence of individualised care (Offord <i>et al</i> , 2006), treatment not matching cognitive and developmental abilities of clients (Offord <i>et al</i> , 2006; Whitney <i>et al</i> , 2008), treatment too controlling (Eivors <i>et al</i> , 2003; le Grange and Gelman, 1998; Maine, 1985; Offord <i>et al</i> , 2006; Reid <i>et al</i> , 2008; Swain-Campbell <i>et al</i> , 2001), duration/frequency unsuitable (Krautter and Lock, 2004), family therapy not needed (Ma and Lai, 2006), relevance of treatment was unclear (Whitney <i>et al</i> , 2008) (13/24)
Lack of continuity in treatment/lack of follow-up/inappropriate length and/or form of treatment	Lack of continuity in treatment (eg change in therapist) (Offord <i>et al</i> , 2006; Roy <i>et al</i> , 2006; Tierney, 2008), a lack of follow-up or preparation for discharge (that could lead to a sense of abandonment) (Banasiak <i>et al</i> , 2007; Laberg <i>et al</i> , 2001; Offord <i>et al</i> , 2006; Reid <i>et al</i> , 2008), an inappropriate length/frequency of therapy (Krautter and Lock, 2004; Laberg <i>et al</i> , 2001; Reid <i>et al</i> , 2008; Whitney <i>et al</i> , 2008), an inappropriate form of treatment (eg lack of individual therapy, constrictions of group format) (Dunn <i>et al</i> , 2006; Krautter and Lock, 2004; Laberg <i>et al</i> , 2001), waiting lists/high threshold for admission (Reid <i>et al</i> , 2008; Rother and Buckroyd, 2004), environment that was too much like a hospital (Eivors <i>et al</i> , 2003) (12/24)
Focus of the treatment on eating and not on psychological needs and distress	Treatment focusing on eating rather than on the psychological needs and distress (emotions, thoughts) (Button and Warren, 2001; Colton and Pistrang, 2004; Eivors <i>et al</i> , 2003; Krautter and Lock, 2004; le Grange and Gelman, 1998; Offord <i>et al</i> , 2006; Tierney, 2008), enforced weight-gain (Button and Warren, 2001; Eivors <i>et al</i> , 2003; Offord <i>et al</i> , 2006; Tierney, 2008), or food and thus inadvertently contributing to ED (Eivors <i>et al</i> , 2003) (7/24)
Stigma of psychiatric setting/diagnosis	Stigma of being in a psychiatric setting (Button and Warren, 2001; Eivors <i>et al</i> , 2003; Krautter and Lock, 2004; Malson <i>et al</i> , 2004), mental health professionals contributing to stigmatisation (Malson <i>et al</i> , 2004; Offord <i>et al</i> , 2006), stigma of the diagnosis of ED (Eivors <i>et al</i> , 2003; Malson <i>et al</i> , 2004; Rorty <i>et al</i> , 1993) (6/24)



	Lack of involvement in own treatment/loss of control	Client having a sense of not being included/involved in own treatment or the client having a sense of the loss of control-autonomy (Colton and Pistrang, 2004; Eivors <i>et al</i> , 2003; Maine, 1985; Malson <i>et al</i> , 2004; Offord <i>et al</i> , 2006), lack of own initiative (Banasiak <i>et al</i> , 2007), fighting the non-collaborative treatment (Offord <i>et al</i> , 2006) (6/24)
	Psychological therapy superficial	Psychological therapy perceived as superficial (Banasiak <i>et al</i> , 2007; le Grange and Gelman, 1998; Rother and Buckroyd, 2004), perceived inadequacies of CBT strategies (not addressing the reasons for bulimia) (Banasiak <i>et al</i> , 2007; le Grange and Gelman, 1998), lack of attention paid to emotional and self-esteem issues (Banasiak <i>et al</i> , 2007; le Grange and Gelman, 1998), or ED issues (Maine, 1985), difficulty to see connection of the treatment and real life (Whitney <i>et al</i> , 2008), underlying causes not dealt with (le Grange and Gelman, 1998; Rother and Buckroyd, 2004) (5/24)
	Lack of structure in treatment/relying on the client's discipline	Lacking structure in treatment (eg around food, exercise) (Cockell <i>et al</i> , 2004; Laberg <i>et al</i> , 2001), treatment relying too much on the client (Offord <i>et al</i> , 2006) (3/24)
Perceived deficiencies in important specific characteristics of treatment	Lack of information regarding ED and nutritional facts	Not having specialised information regarding ED (Krautter and Lock, 2004; Laberg <i>et al</i> , 2001; Rother and Buckroyd, 2004; Whitney <i>et al</i> , 2008) or nutritional facts (Krautter and Lock, 2004) (4/24)
Painful experiences contributing to the unhelpfulness of treatment	Experiences of hopelessness/low mood/shamed/vulnerability/self-judgment	Setbacks (feelings of falling into hopelessness, lower mood, feelings of being ashamed, vulnerable, overwhelmed, self-judgmental) (Banasiak <i>et al</i> , 2007; Cockell <i>et al</i> , 2004; Offord <i>et al</i> , 2006; Pettersen and Rosenvinge, 2002), perception of no change (symptoms too powerful) or lack of change (Banasiak <i>et al</i> , 2007; D'Abundo and Chally, 2004; le Grange and Gelman, 1998), experiences of non-accepting increased body weight (Banasiak <i>et al</i> , 2007), feeling bad about dropping out from treatment (Banasiak <i>et al</i> , 2007) (6/24)
	Feeling alone	Feeling alone while in treatment (Cockell <i>et al</i> , 2004; Maine, 1985), perceiving little support (Cockell <i>et al</i> , 2004; Laberg <i>et al</i> , 2001; Maine, 1985), feeling isolated while in hospital (Offord <i>et al</i> , 2006; Maine, 1985), and having a sense of being different (Pettersen and Rosenvinge, 2002), ongoing sense of isolation (Maine, 1985) (5/24)

### Perceived lack of broader social support

This domain contained two meta-categories (*Distressing or misleading influence of co-patients; Unsupportive family/friends*) that referred to unhelpful influences of the social environment on the client's treatment. This domain was based on the findings reported in 10 out of 24 meta-analysed studies.

#### *Distressing or misleading influence of co-patients*

This meta-category was based on the findings reported in seven out of 24 meta-analysed studies. These unhelpful aspects pointed to the unhelpfulness of distressing or misleading influence of co-patients (Cockell *et al*, 2004; Colton and Pistrang, 2004; Offord *et al*, 2006), for instance by competing about who is thinner or learning self-harming or ED-promoting behaviour (Colton and Pistrang, 2004; Eivors *et al*, 2003; Offord *et al*, 2006; Tierney, 2008). It also included experiences of being distressed at seeing others/comparing self to them (Colton and Pistrang, 2004; Laberg *et al*, 2001; Offord *et al*, 2006), hindering aspects of group treatment (Roy *et al*, 2006), and ashamed when realising where the client now belongs (among ED patients) (Eivors *et al*, 2003), an example of which was expressed by a

participant in the Eivors *et al* (2003, p. 98) study: “When I first arrived at the hospital I was so ashamed, I was far too fat to be at a clinic like this, I thought I would be laughed at.”

#### *Unsupportive family/friends*

This meta-category was based on the findings reported in seven out of 24 meta-analysed studies. These unhelpful aspects referred to the unhelpfulness of family and or/friends (Cockell *et al*, 2004; Colton and Pistrang, 2004; Krautter and Lock, 2004; Maine, 1985; Offord *et al*, 2006; Rorty *et al*, 1993), the experienced lack of support or sense of rejection by them (Cockell *et al*, 2004; Colton and Pistrang, 2004; Offord *et al*, 2006), feeling powerless in family (Maine, 1985), experiences of family therapy not being supportive or missing (Krautter and Lock, 2004; Maine, 1985; Tierney, 2008), experiencing lack of understanding or insensitivity from partner, friends, or family (Rorty *et al*, 1993), and even experiences of active sabotage by the close ones (Rorty *et al*, 1993).

#### **Perceived lack of relational support from mental health professional**

This domain contained four meta-categories (*Being overlooked as a person/not cared for; Therapist or treatment programme hostile/punitive or lacking warmth and care; Lacking trust in others*) that referred to perceived unhelpful relational characteristics of the mental health professional or to the issues on the client part that prevented the client in forming a good relationship with the professional. This domain was based on the findings reported in 13 out of 24 meta-analysed studies.

#### *Being overlooked as a person/not cared for*

This meta-category was based on the findings reported in eight out of 24 meta-analysed studies. These unhelpful aspects pointed to the unhelpfulness of the clients' experiences of being overlooked as a person (Banasiak *et al*, 2007; Button and Warren, 2001; Colton and Pistrang, 2004; Malson *et al*, 2004; Offord *et al*, 2006; Tierney, 2008), for instance by being seen as another anorexic and therefore neglected, overlooked or judged (Colton and Pistrang, 2004; Malson *et al*, 2004; Offord *et al*, 2006; Rother and Buckroyd, 2004; Swain-Campbell *et al*, 2001; Tierney, 2008). An example of a quote is: “It’s sort of like speaking to him [a doctor] is like bashing your head up against a wall. Everything you say is part of the disease. No matter what it is, it’s part of the disease . . . And you’re like: I’m a person. There’s a personality in here you know? I’m not just anorexic kind of thing, which is really tough (and destructive).” (Malson *et al*, 2004, p. 481)

#### *Therapist or treatment programme hostile/punitive or lacking warmth and care*

This meta-category was based on the findings reported in eight out of 24 meta-analysed studies. These unhelpful aspects pointed to the unhelpfulness of the mental health professional or treatment programme being hostile/punitive or lacking warmth and care (Banasiak *et al*, 2007; Button and Warren, 2001; Colton and Pistrang, 2004; Maine, 1985; Offord *et al*, 2006; Rother and Buckroyd, 2004; Tierney, 2008), similarly hostile like family (Maine, 1985), for instance by interpreting the client from the position of power (eg psychodynamic approach) (Offord *et al*, 2006), or using unclear rules (Offord *et al*, 2006), or pressuring the client (Swain-Campbell *et al*, 2001). One study also showed that this could lead to clients fighting back (Offord *et al*, 2006) or feeling isolated and cut off (Maine, 1985). An example of a quote representing this meta-category comes from Banasiak *et al*'s (2007, p. 32) study: “[therapist] not very encouraging, lacked warmth and empathy . . . didn’t appear to be interested

*in me . . .*; “arrogant . . . a bit distant emotionally . . . just going through the motions”; “expressed negative attitudes, for example: ‘You’re getting older – you’ve got to expect a weight increase’”; and “made critical comments”.

#### *Not feeling understood/listened to*

This meta-category was based on the findings reported in six out of 24 meta-analysed studies. These unhelpful aspects related to the unhelpfulness of experiences of feeling not understood, not listened to, not validated, or misunderstood (Banasiak *et al*, 2007; Button and Warren, 2001; Cockell *et al*, 2004; Maine, 1985; Malson *et al*, 2004; Tierney, 2008). An example of an illustrative quote comes from Malson *et al*'s (2004, p. 482) study: “Everything I say he [a doctor] laughs at you kind of thing. Like you say one thing and he just laughs and he goes: ‘Oh it’s not her talking, it’s the illness’.”

#### *Lacking trust in others*

This meta-category was based on the findings reported in five out of 24 meta-analysed studies. These unhelpful aspects pointed to the unhelpfulness of experiencing the lack of trust in others (Cockell *et al*, 2004; Laberg *et al*, 2001; Lamoureux and Bottorff, 2005; Offord *et al*, 2006), for instance in feeling vulnerable to open up (Cockell *et al*, 2004; Krautter and Lock, 2004; Laberg *et al*, 2001), or experiencing the mental health professional violating trust (eg confidentiality), being controlling (Lamoureux and Bottorff, 2005; Offord *et al*, 2006), which some studies showed could lead to lying to the professionals (Lamoureux and Bottorff, 2005; Offord *et al*, 2006).

### **Perceived deficiencies in important characteristics of mental health professional**

This domain contained one meta-category (*Lack of expertise/mental health professional missing important issues/mental health professional’s own issues*) that supplemented unhelpful relational characteristics of the mental health professional mentioned above and focused rather on the problems with the perceived expertise of the mental health professional. This domain was based on the findings reported in eight out of 24 meta-analysed studies.

#### *Lack of expertise/mental health professional missing important issues/mental health professional’s own issues*

This meta-category was based on the findings reported in eight out of 24 meta-analysed studies. These unhelpful aspects pointed to the unhelpfulness of the mental health professional due to their lack of expertise with ED (Banasiak *et al*, 2007; Cockell *et al*, 2004; Maine, 1985; Rother and Buckroyd, 2004), due to the professional’s own issues around their weight (Banasiak *et al*, 2007), due to the professional missing the seriousness of the problems or important issues (Maine, 1985; Offord *et al*, 2006; Rother and Buckroyd, 2004; Tierney, 2008), and due to the professional not being a skilful communicator (Roy *et al*, 2006; Swain-Campbell *et al*, 2001). The lack of expertise and skill could then (as was suggested in one study) undermine confidence in the treatment (Banasiak *et al*, 2007).

### **Perceived deficiencies in important general characteristics of treatment**

This domain contained seven meta-categories (*Non-responsiveness of the treatment/treatment missing client’s needs/treatment too rigid; Lack of continuity in treatment/lack of follow-up/*

*inappropriate length and/or form of treatment; Focus of the treatment on eating and not on psychological needs and distress; Stigma of psychiatric setting/diagnosis; Lack of involvement in own treatment/loss of control; Psychological therapy superficial; Lack of structure in treatment/relying on the client's discipline*) that referred to general unhelpful aspects of the treatment and included more global strategies or conditions of the treatment and non-specific interventions. This domain was based on the findings reported in 19 out of 24 meta-analysed studies.

*Non-responsiveness of the treatment/treatment missing client's needs/treatment too rigid*

This meta-category was based on the findings reported in 13 out of 24 meta-analysed studies. These unhelpful aspects related to the unhelpfulness of treatment that was non-responsive, rigid and/or missing aspects relevant for the client (Banasiak *et al*, 2007; Button and Warren 2001; Eivors *et al*, 2003; Krautter and Lock, 2004; le Grange and Gelman, 1998; Ma and Lai, 2006; Maine, 1985; Offord *et al*, 2006; Rorty *et al*, 1993; Roy *et al*, 2006; Swain-Campbell *et al*, 2001; Whitney *et al*, 2008). Individual studies reported perceived inadequacies of CBT strategies (not addressing the reasons for bulimia) (Banasiak *et al*, 2007), failure to adequately address body image concerns (Banasiak *et al*, 2007; Maine, 1985), failure to provide nutritional information (Banasiak *et al*, 2007) and failure to provide advice regarding meal planning (Banasiak *et al*, 2007; Button and Warren 2001). They further reported an absence of individualised care (Offord *et al*, 2006), treatment not matching cognitive and developmental abilities of the clients (Offord *et al*, 2006; Whitney *et al*, 2008), treatment too controlling (Eivors *et al*, 2003; le Grange and Gelman, 1998; Maine, 1985; Offord *et al*, 2006; Reid *et al*, 2008; Swain-Campbell *et al*, 2001), duration/frequency that was seen as unsuitable (Krautter and Lock, 2004), family therapy that was not what was needed (Ma and Lai, 2006), or that the relevance of treatment was unclear (Whitney *et al*, 2008). One example of a quote depicting a finding from an original study that fed to this category is: *"Even though I came to accept that the tasks were not that important in the great scheme of things, my heart would sink when you got me to do that particular one! I guess I hate doing anything I know I am going to fail at."* (Whitney *et al*, 2008, p. 547)

*Lack of continuity in treatment/lack of follow-up/inappropriate length and/or form of treatment*

This meta-category was based on the findings reported in 12 out of 24 meta-analysed studies. These unhelpful aspects referred to the unhelpfulness of experiencing a lack of continuity in treatment (eg change in therapist) (Offord *et al*, 2006; Roy *et al*, 2006; Tierney, 2008), a lack of follow-up or preparation for discharge (that could lead to a sense of abandonment) (Banasiak *et al*, 2007; Laberg *et al*, 2001; Offord *et al*, 2006; Reid *et al*, 2008), an inappropriate length/frequency of therapy (Krautter and Lock, 2004; Laberg *et al*, 2001; Reid *et al*, 2008; Whitney *et al*, 2008), an inappropriate form of treatment (eg lack of individual therapy, constrictions of group format) (Dunn *et al*, 2006; Krautter and Lock, 2004; Laberg *et al*, 2001), waiting lists/high threshold for admission (Reid *et al*, 2008; Rother and Buckroyd, 2004), and an environment that was too much like a hospital (Eivors *et al*, 2003). Examples of quotes from the original studies include: *"I'm nearly at the end [of treatment]. And I'm scared shitless about it."* (Reid *et al*, 2008, p. 959) *"It was like 12 weeks [of waiting on the waiting list] and it was . . . a long time and I was getting really, I can't believe this" . . . "I wasn't entirely happy to begin with . . . she mentioned the [bulimia] group which wasn't going to start until next term [six months]."* (Reid *et al*, 2008, p. 959)

### *Focus of the treatment on eating and not on psychological needs and distress*

This meta-category was based on the findings reported in seven out of 24 meta-analysed studies. These unhelpful aspects pointed to the unhelpfulness of the treatment focusing on eating rather than on the psychological needs and distress (emotions, thoughts) (Button and Warren, 2001; Colton and Pistrang, 2004; Eivors *et al*, 2003; Krautter and Lock, 2004; le Grange and Gelman, 1998; Offord *et al*, 2006; Tierney, 2008). It could also focus on enforced weight-gain (Button and Warren, 2001; Eivors *et al*, 2003; Offord *et al*, 2006; Tierney, 2008), or food and thus inadvertently contributing to ED (Eivors *et al*, 2003). Examples of participants' quotes include: "*There was too much emphasis on eating and I wanted to know why I got an eating disorder.*" (le Grange and Gelman, 1998, p. 185) "*They were just putting weight on me and they weren't solving anything. They just thought, 'Oh once she's put on weight she'll be fine' and that weren't the case.*" (Eivors *et al*, 2003, p. 99)

### *Stigma of psychiatric setting/diagnosis*

This meta-category was based on the findings reported in six out of 24 meta-analysed studies. These unhelpful aspects referred to the unhelpfulness of experiencing the stigma of being in a psychiatric setting (Button and Warren, 2001; Eivors *et al*, 2003; Krautter and Lock, 2004; Malson *et al*, 2004). In some instances the mental health professionals contributed to this stigmatisation (Malson *et al*, 2004; Offord *et al*, 2006). Stigma could be connected also to the diagnosis of ED (Eivors *et al*, 2003; Malson *et al*, 2004; Rorty *et al*, 1993). With reference to the original studies, indicative participants' quotes include: "*I wasn't sick before I came here. I was, like, healthy. I was just like any other normal teenager . . . I feel, well, like I just think why the hell am I here [in hospital]?*" (Malson *et al*, 2004, p. 480) "*It wasn't the fact that it was an eating disorder . . . it was just . . . the fact that it was a mental health hospital and I obviously thought they were saying there was something wrong with me in the head.*" (Eivors *et al*, 2003, p. 97)

### *Lack of involvement in own treatment/loss of control*

This meta-category was based on the findings reported in six out of 24 meta-analysed studies. These unhelpful aspects pointed to the unhelpfulness of the client having a sense of not being included/involved in their own treatment or the client having a sense of the loss of control-autonomy (Colton and Pistrang, 2004; Eivors *et al*, 2003; Maine, 1985; Malson *et al*, 2004; Offord *et al*, 2006), which could also be present in the form of the lack of own initiative (Banasiak *et al*, 2007), which could result in fighting the non-collaborative treatment (Offord *et al*, 2006). An example of participants' quotes belonging to this category includes "*I felt I didn't have any control with both [inpatient services], because you couldn't go out for a walk if you wanted to, and it's almost like you have to do that, you have to go by the rules.*" (Eivors *et al*, 2003, p. 98)

### *Psychological therapy superficial*

This meta-category was based on the findings reported in five out of 24 meta-analysed studies. These unhelpful aspects pointed to the unhelpfulness of psychological therapy that was perceived by the clients as superficial (Banasiak *et al*, 2007; le Grange and Gelman, 1998; Rother and Buckroyd, 2004). The clients commented on: perceived inadequacies of CBT strategies (not addressing the reasons for bulimia) (Banasiak *et al*, 2007; le Grange and Gelman, 1998), lack of attention paid to

emotional and self-esteem issues (Banasiak *et al*, 2007; le Grange and Gelman, 1998), or ED issues (Maine, 1985), difficulty to see connection of the treatment and real life (Whitney *et al*, 2008). They also commented that they felt that underlying causes were not dealt with (le Grange and Gelman, 1998; Rother and Buckroyd, 2004). Examples of comments include: “*There was too much emphasis on eating and I wanted to know why I got an eating disorder . . . we started to deal with it [causes] on the surface level, but never in depth . . . [we] dealt with symptoms, not with causes . . . [I] wanted emotional issues to be dealt with and to progress further than the cognitive stuff.*” (le Grange and Gelman, 1998, pp. 185, 187)

#### *Lack of structure in treatment/relying on the client’s discipline*

This meta-category was based on the findings reported in three out of 24 meta-analysed studies. These unhelpful aspects referred to the unhelpfulness of lacking structure in the treatment (eg around food, exercise) (Cockell *et al*, 2004; Laberg *et al*, 2001), or relying too much on the client (Offord *et al*, 2006).

#### **Perceived deficiencies in important specific characteristics of treatment**

This domain contained one meta-category (*Lack of information regarding ED and nutritional facts*) that referred to a specific intervention that was missing in therapy. This domain was based on the findings reported in four out of 24 meta-analysed studies.

#### *Lack of information regarding ED and nutritional facts*

This meta-category was based on the findings reported in four out of 24 meta-analysed studies. These unhelpful aspects referred to the unhelpfulness of not having specialised information regarding ED (Krautter and Lock, 2004; Laberg *et al*, 2001; Rother and Buckroyd, 2004; Whitney *et al*, 2008) or nutritional facts (Krautter and Lock, 2004) as a part of treatment. An example of the participant quote from the Whitney *et al* (2008, p. 547) study illustrates this meta-category: “*I don’t think it will help me with the eating problem . . . with the eating it’s hard, it’s a fear thing, so it’s not really tackling that, or the hate of yourself when you eat food . . . I don’t know if you could have some examples related to food. Because they’re not really very food orientated. This then again, in some ways is nice.*”

#### **Painful experiences contributing to the unhelpfulness of treatment**

This domain contained two meta-categories (*Experiences of hopelessness/low mood/shamed/vulnerability/self-judgment; Feeling alone*) that covered painful experiences particularly while in treatment, but also in a follow-up that were experienced as very unhelpful setbacks for the overall treatment. This domain was based on the findings reported in eight out of 24 meta-analysed studies.

#### *Experiences of hopelessness/low mood/shamed/vulnerability/self-judgment*

This meta-category was based on the findings reported in six out of 24 meta-analysed studies. These unhelpful aspects relate to the unhelpfulness of experiencing setbacks [feelings of falling into hopelessness, lower mood, feelings of being ashamed, vulnerable, overwhelmed, self-judgmental] (Banasiak *et al*, 2007; Cockell *et al*, 2004; Offord *et al*, 2006; Pettersen and Rosenvinge, 2002), perception of no change [symptoms too powerful] or lack of change (Banasiak *et al*, 2007; D’Abundo

and Chally, 2004; le Grange and Gelman, 1998), experiences of non-accepting increased body weight (Banasiak *et al*, 2007), or feeling bad about dropping out from treatment (Banasiak *et al*, 2007).

### *Feeling alone*

This meta-category was based on the findings reported in five out of 24 meta-analysed studies. These unhelpful aspects relate to the unhelpfulness of the client feeling alone while in treatment (Cockell *et al*, 2004; Maine, 1985), perceiving little support (Cockell *et al*, 2004; Laberg *et al*, 2001; Maine, 1985), feeling isolated while in hospital (Maine, 1985; Offord *et al*, 2006), ongoing sense of isolation (Maine, 1985;), and having a sense of being different (Pettersen and Rosenvinge, 2002).

### **Other unhelpful aspects of treatment**

There were few findings that were reported only in one study. These could include the clients' accounts of the unhelpfulness of interpersonal conflicts and social pressure around the ED (Cockell *et al*, 2004), missing out on everyday life (Offord *et al*, 2006), unrealistic expectations about recovery (underestimating the problem) (Cockell *et al*, 2004), lack of prevention (Rother and Buckroyd, 2004), dependency on the therapist (Lamoureux and Botorff, 2005), and practical obstacles (such as travel distance) (Krautter and Lock, 2004).

### **Ambivalent (at the same time helpful and unhelpful) aspects of treatment**

Some studies reported findings that pointed to the aspects of therapy/treatment that were on one hand helpful and on the other unhelpful. Dominant among these was the treatment structure, which could be seen as simultaneously helpful and unhelpful (Colton and Pistrang, 2004; Offord *et al*, 2006; Malson *et al*, 2004; Reid *et al*, 2008; Roy *et al*, 2006). Other ambivalent aspects included treatment compliance (Colton and Pistrang, 2004), starting work straight after therapy (Cockell *et al*, 2004), building the relationship with professionals (Button and Warren 2001), treatment duration (Laberg *et al*, 2001), and acknowledgment of the problem (Eivors *et al*, 2003).

### **Suggested improvements**

Some studies gathered information on what was missing in the treatment and what could improve the treatment. The suggested improvements could refer to the form of treatment (increased length and frequency, complimenting the individual, group and family treatment, providing a follow-up, flexibility and accessibility of delivery, offering psychoeducation to relatives) (Banasiak *et al*, 2007; Button and Warren 2001; Krautter and Lock, 2004; Ma and Lai, 2006; Maine, 1985; Swain-Campbell *et al*, 2001), the skills of the staff (ED specific, but also general communication skills) (Banasiak *et al*, 2007; Eivors *et al*, 2003), the relational qualities of the staff (Button and Warren 2001; Eivors *et al*, 2003), the specifics of treatment (eg focus on underlying depression, use of nutritional information) (Banasiak *et al*, 2007), increasing information on treatment options (Banasiak *et al*, 2007), and organising contact with former patients (Eivors *et al*, 2003).

## Discussion

When considering the findings of our meta-analysis the reader needs to be aware that they relate to the clients' *perceptions* of what they found helpful or unhelpful in treatment and not about what actually is helpful or unhelpful in treatment in a causal sense. Nevertheless, it is reasonable to suggest that to know about the helpful and unhelpful aspects of treatment as perceived by clients is useful as it can explicate what aspects of treatment are deemed important by the clients, so they could be more involved and engaged in their treatment. Therefore, when developing psychological treatments for EDs, it may be particularly useful to take into account what the studies, that investigated the clients' perspectives in an open-ended format, are saying. The qualitative format of the studies facilitates clients to highlight aspects that are important to them without the researcher first priming them about what they should consider. Thus, qualitative studies that use the clients' accounts offer a unique perspective and significantly contribute to our knowledge. The qualitative meta-analysis, meta-synthesis, then offers a unique way of summarising and conceptualising what individual studies examining the clients' perspectives on the helpful and unhelpful aspects of the treatment have discovered.

Before we discuss the findings of our meta-analysis in more detail, we need to highlight several issues that need to be borne in mind by the reader when considering the reported findings. Firstly, as we mentioned in the method section, that although the meta-analysis wanted to examine helpful and unhelpful aspects of psychological therapies for EDs, its focus was broadened as the meta-analysis was carried out to include more general aspects of the treatment that involved psychological therapies. The rationale for this was based on the fact that psychological therapies for EDs are often offered as a part of a complex, multidisciplinary treatment, particularly in the case of AN, and often in the form of at least partial inpatient treatment (see the meta-analysed studies characteristics Table 2; see also NICE, 2004), sometimes including self-help and support groups elements. It was therefore meaningful to look at the helpful/unhelpful aspects more broadly. In fact, it was sometimes difficult to distil whether the clients' perspectives referred to a narrowly defined psychological therapy or to psychological principles of the overall treatment. This was also the reason why we typically use the term 'treatment' rather than 'psychological therapy' (psychotherapy or counselling) as well as the term 'mental health professional' rather than 'therapist' or 'counsellor'. We, however, believe that it did not make our meta-analysis less informative, but rather the contrary as virtually all reported elements are very relevant for psychological therapy.

Secondly, we want to comment on the fact that, as can be seen in the results section, the helpful and unhelpful 'aspects' sometime referred to the aspects of treatment (eg cognitive restructuring) or the mental health professional's behaviour (eg expertness in ED), while sometimes they referred to the 'impacts' of the treatment or the impact the mental health professional had on the client. Indeed, some qualitative studies differentiate between the two and report the aspects of the treatment that were helpful or unhelpful separately from the impacts to which those aspects led (cf. Richards and Timulak, 2012). We did not do so, as the original studies were not doing so systematically. One has to however bear in mind this distinction because, for instance, some impacts such as insight can be achieved by several aspects of the treatment such as cognitive restructuring, provision of information, or a behavioural experiment. Nevertheless, we argue that despite the fact that some of the 'aspects'



reported here could also be considered as 'impacts' (eg insight, self-acceptance) as they imply a consequence of treatment (eg 'being seen as a person' implies that there is somebody who treats the client as a person), they can also be considered as experiences that are important 'aspects' of treatment in the broader sense.

Thirdly, we would like to indicate to the reader that our meta-analysis did not differentiate between the type of ED diagnosis the clients had when we meta-analysed the studies that reported on the clients' perspectives on the helpful/unhelpful aspects of the treatment they underwent. We are mentioning this fact because the studies reviewing evidence for the ED treatment typically differentiate between the evidence for different types of diagnosis (cf. NICE, 2004; Fisher *et al*, 2010; Hay *et al*, 2003; Hay *et al*, 2009). This differentiation stems from the fact that the treatment effectiveness for different disorders varies (BN having better response to treatment than AN, see NICE, 2004; Fisher *et al*, 2010; Hay *et al*, 2003; Hay *et al*, 2009), and the treatment itself varies (AN more likely to be treated in the inpatient setting), etc. We did not differentiate between the diagnoses, because most studies used a combined sample across various ED diagnoses. On the other hand, we did not inspect whether the presence of a sole diagnosis such as AN (eight studies) would suggest different patterns of findings in comparison to another sole diagnosis such as BN (three studies).

Finally, a caution has also to be made with reference to the broad age span of the clients in the original studies (between 11 and 50). This is relevant because some forms of treatment such as family therapy are more likely to be available for younger clients as is recommended for instance by NICE guidelines (NICE, 2004). Thus, some of the findings may refer more readily to some client groups (particularly the ones referring to family therapy or the support or lack of support from significant others, which for younger clients often meant support or lack of it from parents).

### **Methodological aspects of the meta-analysed studies**

The meta-analysed studies in general used established methods of qualitative research (qualitative analysis) or used generic methods of qualitative thematic/content analysis that employed a variety of credibility checks. Only a minority of the studies did not use an established method or credibility checks (see the Results section). The notable exception to this positive trend was an absence of any clear statement on the theoretical preferences of the data analysts, which was missing in the majority of studies (only two studies provided clear information about the analysts' theoretical leanings). This is somewhat alarming given that almost all studies (with the exception of one discourse analytic study) used a variation of a descriptive-interpretative approach (Elliott and Timulak, 2005) that attempts to give a voice to participants, while still applying the analysts' interpretative lenses to the reading of the data. Thus, we do not know much about what could have influenced the researchers' reading of the participants' accounts. On the other hand, looking at the reported findings and the quotes from the clients that were provided as examples, one can infer that the researchers were leaning towards a more descriptive analysis and synthesis of the data as they tried to stay close to the participants' accounts.

Indeed, this can be seen as another criticism of the original studies as the more descriptive form of qualitative data analysis that aims to give a voice to participants may be less useful for the

development of therapeutic approaches, as descriptive summaries of participants' accounts may not directly link with the existing or developing theory of psychological therapy and change. Therefore, we recommend to researchers that future studies could be of a more interpretative character which would allow the clients' accounts to be related to a specific theory of change and treatment. (For an example of a theoretically laden qualitative analysis see O'Brien *et al*, 2012, who employed an emotion-focused therapy theoretical framework to analysing clients' in-session presentation.)

Finally, as we also mention below in the comments on the method and limitations, some studies, particularly ones that used a written form of data collection, run the risk of providing 'thin' data that are more difficult to interpret and logically also to meta-analyse. Therefore, we urge the researchers to maximise the main strength of qualitative research, namely its focus on detailed, rich description, which can probably be better obtained from a verbal, dialogically stimulating, data collection method. Alternatively, if the data are collected in a written form, significant attention should be paid to strategies that could enrich the information sought and provided in the participants' accounts.

### **Helpful and unhelpful aspects of eating disorder treatment involving psychological therapy**

There were several interesting findings that transpired through our meta-analysis. For instance, the findings highlighted the fact that contextual factors such as co-patients as well as family and other close people (eg peers) may play a very important positive as well as a negative role in ED treatment. These factors are not much focused on in the evidence-based guidelines such as those produced by NICE (2004). Awareness of the potential of using the co-patients (eg through offering mutual support and opportunities for sharing and learning) as well as offering a caution around their potential negative influence (through providing distressing or negatively influencing examples) is very important for the inpatient and group treatments that are often a treatment of choice for some of the ED problems.

The findings that refer to relational aspects of the treatment, as in many other psychotherapy research studies (Norcross, 2011), emphasised the crucial role of the mental health professionals' relational qualities such as warmth, caring, respect, understanding, providing presence that can bring a sense of trust, and feelings of being understood, listened to, respected and cared for on the client part. These findings concur with the findings from psychotherapy research in general that emphasise that it is the therapeutic relationship that works (cf Norcross, 2011) and emphasis on competency in this regard has also been highlighted in ED treatment (Williams and Haverkamp, 2010). It is important that these findings are voiced because, again, they are not necessarily accentuated in the summaries of evidence-based informed recommendations (cf. NICE, 2004; Fisher *et al*, 2010; Hay *et al*, 2003; Hay *et al*, 2009). One must also remember the potentially detrimental effects of behaviour that not only does not provide those fruitful relational conditions but also indeed shows the exactly opposite tendencies such as behaving in a hostile manner or being punitive. Some of the studies that we meta-analysed indicated that clients do report these issues and find them unhelpful.

An interesting finding is the observation that the clients appreciated the expertise of the mental health professional that is specific to EDs. Expertise in EDs and their treatment complements the relational conditions and together with the observed helpfulness of the mental health professional offering a firm, specialised, guidance echoes the NICE (2004) recommendations and emphasis on specialised ED

treatment. This is further supported in the literature with reference to the need for specialised competence development for mental health practitioners (Williams and Haverkamp, 2010; Jones and Lerner, 2004) and also with reference to the need for practitioners to develop multicultural competence in this regard (Horrell, 2008; Smart, 2010; Talleyrand, 2012). In the meta-analysis, some client quotes were particularly poignant as they showed that the client may see the professional as underestimating their problems (Tierney, 2008) or naïve and thus easily manipulated (Offord *et al*, 2006), which paradoxically undermined the client's confidence in the treatment.

It was reassuring to note that clients appreciated and valued psychological therapy. The findings, however, also stress that such therapy has to be accessible and not offered in a rigid manner but rather that it needs to be offered in a client-centred format so the client can play an active role in it. This finding corresponds with the overwhelming evidence suggesting the importance of the active role of the client for the effectiveness of therapy (Bohart and Talmann, 1999; 2010; Bohart and Greaves Wade, 2013). The findings also showed that when treatment allows the clients to play an active role in it, the clients then also recognise the importance of their own motivation to change and engage in therapy. This highlights the importance of considering the motivation and its enhancement, for instance, through using interventions developed in motivational interviewing treatment (Miller and Rollnick, 2002; 2013) that are not only attempting to enhance the intrinsic motivation that is present in clients, but also actively engage clients in a way that allows them to control most of their treatment.

What could also be observed was that among the specific helpful aspects of psychological treatments were interventions that are part of the current empirically based treatments for EDs (Wilson and Fairburn, 2007), particularly cognitive-behavioural therapies (Fairburn, 2008; Fairburn *et al*, 2008; Waller *et al*, 2007). The clients actively pointed to the many aspects of the standard CBT treatments such as structured approach, use of monitoring tasks, use of cognitive restructuring, behavioural activities and experiments, the use of psychoeducation, and providing information on EDs and nutrition. In addition, the clients valued emotion-focused aspects of treatment (for a new development in this area see for instance Dolhanty and Greenberg, 2007; 2009). What clients also appreciated was a broader focus of the treatment; for example, that it involved group and family interventions (although these could also be difficult) or that it focused on the appropriate use of leisure activities and distractions. The broader focus allowed for not focusing solely on eating which is a preoccupying theme for these clients. The clients also referred to the importance of appropriate follow-up for treatment success. Given the complexity of ED difficulties, this seems to be a crucial element supporting gains and recovery and for preventing relapse.

On reviewing the helpful and unhelpful aspects of the treatment reported in our meta-analysis it is noteworthy that both the *symptom focus* (ED focus) as well as the focus on the *underlying* personality and identity related *dynamic* that found expression in the disordered eating, was valued by the clients. Indeed, the absence of either of those two aspects was seen as unhelpful. This would suggest the usefulness of the combination of both aspects of the treatment. This is suggested by some integrative approaches; for example, Grawe's (2004) *psychological therapy*. This approach is, however, not developed specifically for EDs. Specifically, in ED-focused psychotherapies, the symptom focus is traditionally more typical for cognitive-behavioural therapies (Fairburn, 2008; Fairburn *et al*, 2008),

while the focus on more underlying factors is more typical for psychodynamic, interpersonal and experiential approaches (Zerbe, 2010; Fairburn, 1992; Dolhanty and Greenberg, 2007). However, the more recent literature suggests that approaches that were traditionally more symptom focused are paying more attention to the underlying mechanisms (Fairburn *et al*, 2008; Fairburn *et al*, 2003), and the approaches traditionally focusing on the underlying mechanisms are focusing more on the symptom and the psychoeducational aspects of the treatment, at least in routine practice (Thompson-Brenner *et al*, 2009). It is probably prudent to suggest that paying attention to both aspects of treatment deserves more attention in research and clinical practice when developing new treatments or when adjusting already existing treatments for EDs.

The results emphasised the importance of achieved changes during the treatment that have a further impact on the treatment. Several studies referred to the helpfulness of insight and self-acceptance achieved by clients. There are several interventions that may contribute to those changes. Insight is probably more likely to be achieved by cognitive interventions, behavioural experiments and psychoeducation. However, an emotion-focused exploration may also lead to insight (for evidence in the context of other than ED problems see Timulak and McElvaney, in press). Self-acceptance can also be achieved by a multitude of interventions and relational experiences in therapy; however, it is likely that corrective emotional experiences that are either relational or intrapersonal play a central role (see Castonguay and Hill, 2012; Berman *et al*, 2012) and this is clearly an area for further investigation.

Similarly, as change experiences can contribute to the client's engagement in therapy and the overall outcome of therapy (Timulak, 2010), setbacks and negative experiences can increase the risk of dropout or failure of treatment. Experiences of hopelessness, shame and general distress extracted by our meta-analysis are particularly threatening. Some therapeutic approaches are quite explicit about it and suggest that the treatment of an ED is postponed in times of crisis and transition, and that the focus needs to be on the crisis first (Fairburn *et al*, 2008). Interestingly, few studies pointed to the negative impact of feeling alone, the feeling that is in the centre of psychopathology and human suffering in general (Cacioppo and Patrick, 2008). The client's vulnerability to those feelings highlights the need for the compassionate, caring presence of the therapist who tries to reach out and connect with the client's emotional pain. It also highlights the importance of utilising the potential of the social support from co-patients and close ones.

### **Comment on the method and limitations of the study**

The method of qualitative meta-analysis, or meta-synthesis as it is more often referred to (Timulak, 2009; Timulak, in press), has in itself several problems. Firstly, the method can be criticised for the fact that it wants to provide a comprehensive picture by suppressing natural differences among the studies that are hidden in the local condition in which they were conducted (the specifics of the sample, of the data collection method, of the data analysis method with particular analysts' mindsets). Thus our analysis may be losing some of the detail and may be smoothing the differences by overemphasising the 'bigger picture' and commonalities across the studies. Indeed, we did not study conditions that could be responsible for the fact that each meta-category covered findings only from a subgroup and

not all studies (ie methodological factors could be responsible for the fact that one study reports a particular finding, while another study does not).

One has to also bear in mind that the meta-analysed studies differed in their quality and richness of the findings they provided. Thus, some studies contributed to the final outlook of the meta-analysis more, because they provided richer data (richer findings). However, some of those could have methodological limitations that may have been overlooked in the final analysis of the current study. The reader also needs to bear in mind that the meta-analysed findings do not provide the definitive or only way to structure or conceptualise the original studies' findings. The analysis was definitely influenced by the research experience, professional experience, and theoretical and personal leanings of the three meta-analysts (LT, JK and MC). A team of other meta-analysts would offer a different conceptualisation, although the same data (the extracted findings from the original studies) would again be present in it in some form. We are, however, confident that while we do not offer the only conceptualisation of what the studies examining the clients' perspectives on helpful and unhelpful aspects of the treatment containing psychological therapy report, we offer a credible and trustworthy account that followed a rigorous, systematic and clearly described procedure.

In addition, our review as well as the original studies includes many limitations that are embedded in any research and in any qualitative research study. These include limitations pertaining to the sample characteristics, including the types of treatment with which the participants were involved, and limitations pertaining to the data collection method – we mainly focused on the limitations of obtaining the data from the written accounts. However, there are further limitations, many inherent to any research, such as interviewing quality, the time of data collection (during treatment, post-treatment or at follow-up), and particularly data analysis (we know very little about the theoretical preferences of the analysts in the original studies – information that is crucial in qualitative research); and credibility checks were also not used exhaustively. The presentation of findings in the original studies could also be skewed as many qualitative studies struggle to communicate the richness of their findings in the format of research papers with a limited word-count.

## **Conclusion**

In this qualitative meta-analysis, which sought to identify from the client's perspective, the helpful and unhelpful aspects of ED treatment that involved psychological therapy, a number of key areas for consideration in clinical practice and future inquiry were indicated. In summary, the findings highlighted the potential benefits of the following, which also provide a focus for further research:

- Improving access to ED treatment for clients/patients
- Involving the client/service user more centrally in designing and evaluating their treatment to enhance their motivation and optimise treatment outcomes
- Developing flexible interventions in collaboration with the client/patient
- Supporting recovery via a wider support system; for example, consideration of the benefits of co-patient involvement and the involvement of clients' support networks, as appropriate, in treatment provision

- Developing evidence-based treatment approaches that combine ED symptom focus as well as focusing on underlying dynamics and emotional aspects of ED
- Identifying strategies and developing ED interventions that enhance client insight and self-acceptance
- Attending to appropriate treatment follow-up with clients
- Supporting ongoing competence and expertise development for mental health professionals including emphasis on the therapeutic relationship and the necessary relational qualities of the practitioner.

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## Appendix A

### Database search strategies

**Table 1: Search table for databases and number of hits**

Database	Dates searched	Hits
PsycINFO (via OVID)	1806-17/04/2007	1071
CINAHL(via OVID)	1982-17/04/2007	535
Social Science Citation Index (via Web of Knowledge)	1970-17/04/2007	1832
PubMed	17/04/2007 (searched all dates available)	2227
ASSIA (Applied Social Sciences Index and Abstracts)	1987-17/04/2007	205

### Search strategies

#### PsycINFO and CINAHL via OVID – 17/04/2007

1. (“eating disorder\*” or anorexi\* or “binge eating” or bulimi\* or “compulsive eating” or dysphagia or hyperphagia or purging or EDNOS or “night eating syndrome”) in AB
2. (“action research” or “audiorecording” or “cluster sample” or “colaizzi” or “constant comparative method” or “constant comparative method” or “content analysis” or “content analysis or thematic analysis” or “data saturation” or “discourse analysis” or “discourse analysis” or “ethnography” or “ethnological research” or “ethnonursing” or “field research” or “field stud\*” or “focus groups” or “giorgi” or “grounded research” or “grounded stud\*” or “grounded theory” or “heidegger” or “hermaneutic\*” or “human science” or “husserl” or “interview\*” or “life experiences” or “lived experience\*” or “narrative analysis” or “narrative analysis” or “observational method\*” or “observational method\*” or “open ended” or “participant observation” or “phenomenolog\*” or “purposive sample” or “qualitative” or “semi structured” or “spiegelberg” or “thematic analysis” or “theoretical sample” or “videotape\*”) in AB
3. 1 and 2

Date ranges: CINAHL 1982-4/2007; PsycINFO 1806-4/2007

#### Social Science Citation Index via Web of Knowledge – 17/04/2007

1. TS=(“eating disorder\*” or anorexi\* or “binge eating” or bulimi\* or “compulsive eating” or dysphagia or hyperphagia or purging or EDNOS or “night eating syndrome”)
2. TS=(“action research” or “audiorecording” or “cluster sample” or “colaizzi” or “constant comparative method” or “constant comparative method” or “content analysis” or “content analysis or thematic analysis” or “data saturation” or “discourse analysis” or “discourse analysis” or “ethnography” or “ethnological research” or “ethnonursing” or “field research” or “field stud\*” or “focus groups” or “giorgi” or “grounded research” or “grounded stud\*” or “grounded theory” or “heidegger” or “hermaneutic\*” or “human science” or “husserl” or “interview\*” or “life experiences” or “lived experience\*” or “narrative analysis” or “narrative analysis” or “observational method\*” or “observational method\*” or “open ended” or “participant observation” or “phenomenolog\*” or “purposive sample” or “qualitative” or “semi structured” or “spiegelberg” or “thematic analysis” or “theoretical sample” or “videotape\*”)
3. 1 and 2

Date range: 1970-2007 (all available)

#### PubMed – 17/04/2007

(action research[TIAB] OR audiorecording[TIAB] OR cluster sample[TIAB] OR colaizzi[TIAB] OR constant comparative method[TIAB] OR content analysis[TIAB] OR thematic analysis[TIAB] OR data saturation[TIAB] OR discourse analysis[TIAB] OR ethnography[TIAB] OR ethnological research[TIAB] OR ethnonursing[TIAB] OR field research[TIAB] OR field stud\*[TIAB] OR focus groups[TIAB] OR giorgi[TIAB] OR grounded research[TIAB] OR grounded stud\*[TIAB] OR grounded theory[TIAB] OR heidegger[TIAB] OR hermaneutic\*[TIAB] OR human science[TIAB] OR husserl[TIAB] OR interview\*[TIAB] OR life experiences[TIAB] OR lived experience\*[TIAB] OR narrative analysis[TIAB] OR open ended[TIAB] OR participant observation[TIAB] OR phenomenolog\*[TIAB] OR purposive sample[TIAB] OR qualitative[TIAB] OR semi structured[TIAB] OR spiegelberg[TIAB] OR thematic analysis[TIAB] OR theoretical sample[TIAB] OR videotape\*[TIAB] OR “Qualitative Research”[MeSH] OR “Interviews”[MeSH] OR “Interview, Psychological”[MeSH] OR “Anthropology, Cultural”[MeSH])

AND (eating disorder\*[TIAB] OR anorexi\*[TIAB] OR binge eating[TIAB] OR bulimi\*[TIAB] OR compulsive eating[TIAB] OR dysphagia[TIAB] OR hyperphagia[TIAB] OR purging[TIAB] OR EDNOS[TIAB] OR night eating syndrome[TIAB] OR "Eating Disorders"[MeSH])

Date range: all available

**ASSIA (Applied Social Sciences Index and Abstracts) – 17/04/2007**

1. "eating disorder\*" or anorexi\* or "binge eating" or bulimi\* or "compulsive eating" or dysphagia or hyperphagia or purging or EDNOS or "night eating syndrome"
2. "action research" or "audiorecording" or "cluster sample" or "colaizzi" or "constant comparative method" or "constant comparative method" or "content analysis" or "content analysis or thematic analysis" or "data saturation" or "discourse analysis" or "discourse analysis" or "ethnography" or "ethnological research" or "ethnonursing" or "field research" or "field stud\*" or "focus groups" or "giorgi" or "grounded research" or "grounded stud\*" or "grounded theory" or "heidegger" or "hermeneutic\*" or "human science" or "husserl" or "interview\*" or "life experiences" or "lived experience\*" or "narrative analysis" or "narrative analysis" or "observational method\*" or "observational method\*" or "open ended" or "participant observation" or "phenomenolog\*" or "purposive sample" or "qualitative" or "semi structured" or "spiegelberg" or "thematic analysis" or "theoretical sample" or "videotape"
3. 1 and 2

Date range: 1987–2007

All searches were repeated in December 2009 and additional material was incorporated into the review.

## Abbreviations

AN – Anorexia nervosa  
BED – Binge eating disorder  
BN – Bulimia nervosa  
CAT – Cognitive analytic therapy  
CBT – Cognitive behavioural therapy  
ED – Eating disorder  
EDNOS – Eating disorder not otherwise specified  
GP – General practitioner  
GSH – Guided self-help  
IPA – Interpretative phenomenological analysis  
IPT – Interpersonal psychotherapy  
MET – Motivational enhancement therapy  
NHS – National Health Service  
NICE – National Institute for Health and Clinical Excellence  
RCT – Randomised controlled trial  
SEF – Significant events form  
WHO – World Health Organization