

Treatment Non-Completion of a Compassion-Focused Therapy Eating Disorder

Programme: A Mixed Methods Study

Thesis submitted in partial fulfilment of the degree of

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by

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Declaration

I confirm that the research contained within this thesis is my own original work. It was completed in part fulfilment of the degree of Doctorate in Clinical Psychology and has not been submitted for any other degree or academic qualification.

**Treatment Non-Completion of a Compassion-Focused Therapy Eating Disorder
Programme: A Mixed Methods Study**

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Thesis Abstract

Literature Review

The systematic review aimed to identify factors associated with treatment non-completion for bulimia nervosa (BN). Three electronic databases (PsychINFO, Medline and Web of Science) were searched for articles published from January 2001 to August 2015. Sixteen papers met the inclusion criteria. The findings indicated a number of possible factors associated with treatment non-completion for BN, however demographic variables have consistently been found not to be associated with treatment non-completion. Given the significant methodological limitations evidenced across the reviewed studies, the conclusions remain tenuous and preclude clear recommendations for clinical practice.

Research Report

The current research aimed to explore factors associated with treatment non-completion from a Compassion-Focused Therapy for Eating Disorders (CFT-E) programme. A mixed method approach was adopted. The quantitative approach examined whether demographic variables and self-report measures predicted failure to engage in treatment. Participants were 403 patients referred to an eating disorder service who had completed the pre-programme assessment and either commenced treatment or failed to engage. Focus group interviews were used to qualitatively explore barriers and facilitators of treatment engagement among 10 participants who had completed treatment. The findings indicated that shame, eating concern and restraint concern were significant predictors of failure to engage in CFT-E. Thematic analysis of the focus group interviews indicated four main themes related to facilitators of treatment engagement: positive experiences of therapists, being in a supportive group, developing a compassionate understanding of an eating disorder and support beyond treatment; and four main themes related to barriers to treatment engagement: the demands of treatment, difficulties exploring an eating disorder, comparison with other patients, and making the transition from an eating disorder to recovery. Implications for future research and clinical practice are considered.

Critical Appraisal

Reflections and a critical appraisal of the research process are presented.

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Section A: Literature Review

Non-Completion of Treatment for Bulimia Nervosa: A Systematic Review

Abstract

Background

Bulimia Nervosa (BN) is a chronic eating disorder associated with physical health co-morbidities, psychological distress and social issues. Psychological interventions have been recommended for the treatment of BN, however treatment effectiveness remains limited by high non-completion rates. The current review aimed to critically summarise the research exploring factors associated with treatment non-completion for BN.

Method

A systematic review was conducted to extend the conclusions outlined by Bell (2001) review. Three electronic databases (PsychINFO, Medline and Web of Science) were searched for articles published from January 2001 to August 2015 were screened against *priori* inclusion/ exclusion criteria. Sixteen articles met the inclusion criteria and were critically appraised.

Results

The findings indicated a number of possible factors associated with treatment non-completion for BN. However, given the significant methodological limitations and broad range of possible factors explored in the reviewed studies definitive conclusions were precluded. The review indicated that demographic variables have been consistently found not to be associated with treatment non-completion.

Conclusions

High treatment non-completion rates have significant clinical implications however, remain a poorly understood clinical issue. The identification of reliable factors associated with treatment non-completion would inform treatment planning and provide a clear direction for clinical practice. However, the definition of treatment non-completion varied across the studies and raised important questions related to whether the current research reliably explores factors associated with withdrawing from BN treatment. Future research should address the methodological limitations to conclusively identify whether patient characteristics and demographic variables can be used to identify those more likely to leave treatment earlier than anticipated. Moreover, research would benefit from considering whether programmatic factors provide further insight into the reasons for treatment non-completion.

1 Introduction

Bulimia Nervosa (BN) is a chronic, complex eating disorder characterised by experiencing a loss of control during recurrent episodes of excessive eating (Heaner & Walsh, 2013). Binge eating episodes, defined as consuming excessive amounts of food in a relatively short period of time, then followed by inappropriate compensatory behaviours, including self-induced vomiting and the misuse of laxatives, enemas or diuretics, as well as fasting and/ or over exercising to avoid weight gain from excessive eating.

With prevalence rates estimated at up to 3% (Favaro *et al.*, 2009; Hudson *et al.*, 2007; Keski-Rahkonen *et al.*, 2009) and earlier age of onset among younger generations (Favaro *et al.*, 2009), BN has important implications for public health. Those diagnosed with BN are more likely to experience psychological and physical comorbidity, psychosocial issues and morbidity (Simon *et al.*, 2005; Hay & Mond, 2005; Johnson *et al.*, 2001; Crow *et al.*, 2009; Lasater & Mehler, 2001). In addition, the majority of individuals with BN will continue to experience significant eating disorder psychopathology five years after onset (Keski-Rahkonen *et al.*, 2009). Given the chronic course of BN and associated health services use (Striegel-Moore *et al.*, 2005; Mehler, 2011), the effective provision of eating disorder treatment remains an important priority for public health.

Even though NICE Guidelines (NICE, 2004) have recommended a range of psychological interventions for the treatment of BN, the provision of specialist services remains insufficient to meet the complex needs of the eating disordered population (Hoek & van Hoeken, 2003; Royal College of Psychiatrists' Sections of Eating Disorders, 2012). Furthermore those with eating disorders, particularly BN (Hoek, 2009), are more likely to receive treatment for comorbid physical and mental health issues (Mond *et al.*, 2007) and experience significant obstacles accessing specialist services. The inequitable distribution of specialist services, NHS efficiency savings and the implications for service provision, increased waiting times (Schmidt *et al.*, 2008; Tatham *et al.*, 2012), and stigma surrounding eating disorders (Stewart *et al.*, 2006), combined with the potential barriers related to the shame and secrecy characteristic of eating disorders (Graham & Walton, 2011) may account for the underutilisation of eating disorder services. Given the poor long-term prognosis among those unable to access early intervention (Reas *et al.*, 2010), improving the accessibility of specialist services has significant implications for the effective treatment of eating disorders.

The utilisation of services is not solely hinged on identifying treatment barriers and improving the accessibility of specialist services. Attrition rates for BN treatment range from 15% to 65% (Pingani *et*

al., 2012; Steel *et al.*, 2000; Walsh *et al.*, 1997; Fairburn *et al.*, 1993) and present another significant obstacle for the efficient delivery of eating disorder services. Treatment non-completion has implications for the provision and cost-effectiveness of services but also those who prematurely withdraw from treatment have been found to have an increased risk of relapse and rehospitalisation in the first year (Baran *et al.*, 1995), higher prevalence of mental health co-morbidity, lower social functioning (Killaspy *et al.*, 2000) and a chronic course of illness (Vandereicken & Pierloot; Baran *et al.*, 1995)

Treatment non-completion has significant clinical implications. Given the pressure of NHS efficiency savings and demand for eating disorder services (Royal College of Psychiatrists' Sections of Eating Disorders, 2012), treatment non-completion has implications for the efficient use of mental health resources. Those re-referred to services with more severe eating disorder psychopathology and/ or co-morbid physical and psychological issues may place demands on other services and require more costly treatment (Strober *et al.*, 1997). Furthermore, the allocation of patients to treatment they are unlikely to complete could create a potential barrier to accessing future treatment. Given the long-term prognosis and clinical implications associated with treatment non-completion, service development should promote the accessibility of services alongside improving treatment retention.

1.2 Previous Literature Reviews

Previous reviews have explored factors associated with non-completion from eating disorder treatment. Mahon's (2000) descriptive review concluded that demographic variables were consistently found not to be associated with non-completion. As such, Mahon (2000) questioned the clinical utility of exploring the predictive significance of pre-treatment characteristics among a heterogeneous eating disorder population. Overall, the review highlighted inconsistent findings and indicated that future research should address the methodological limitations of the reviewed studies.

Wallier *et al.* (2009) critically reviewed the literature exploring non-completion of inpatient treatment for anorexia nervosa (AN). Weight on admission, eating disorder subtype, psychiatric co-morbidity and the absence of depression were found to be associated with treatment non-completion. However, similar to the Mahon *et al.* (2000) review, Wallier *et al.* (2009) noted the methodological limitations evidenced across the reviewed studies

A review by Fassino *et al.* (2009) scoped the literature across inpatient and outpatient eating disorder treatments. The review concluded that baseline severity of eating disordered behaviours, psychiatric co-morbidity and treatment modality were not consistently associated with treatment non-completion.

On the other hand, those individuals who presented with binge-purging subtype of AN (inpatient setting) and severe BN symptomology (outpatient setting) were more likely to leave treatment prematurely. Personality dimensions low self-directedness and low cooperativeness, as well as psychological traits including high maturity and impulsivity were found to be associated with treatment non-completion. However, Fassino *et al.* (2009) noted that “*predictors of dropout were inconsistent due to methodological flaws and limited sample sizes*” (p.1).

Even though NICE Guidelines (2004) have outlined factors associated with treatment non-completion for AN, there is a lack of a similar overview for BN. To date, Bell (2001) has reviewed the literature exploring factors associated with failure to engage in or complete treatment specifically for BN. Bell (2001) concluded that comorbid borderline personality disorder was associated with the increased likelihood of failure to engage or treatment non-completion. Additionally, the discrepancy between patient and therapist expectation of treatment were highlighted as a possible explanation for why some individuals experience difficulties engaging in BN treatment. However, this descriptive review did not specify how studies had been identified and quality appraised.

Despite the prevalence and significant clinical implications of treatment non-completion, the current literature provides an ambiguous picture of factors associated with leaving treatment earlier than anticipated. Treatment non-completion is a complex clinical issue (Mahon, 2000), which has evidently been reflected in the broad range of terms used to explore the possible reasons why some individuals experience difficulties engaging in treatment. The lack of cohesion and methodological uniformity surrounding terminology including adherence, withdrawal, failure to engage and premature attrition has been highlighted as a pertinent methodological limitation across the previous literature reviews. Treatment dropout and non-completion provide a broad terminology for those who leave treatment, however the umbrella terms offers limited insight into the specific definition and criteria for being classified as a ‘*dropout*’ and has been highlighted as a barrier to the formulation of factors associated with treatment non-completion (Wallier *et al.*, 2009).

1.3 Rationale for the Current Review

The prevalence of treatment non-completion continues to be a significant clinical issue for specialist eating disorder services. More recent reviews have explored factors associated with non-completion for AN (Fassino *et al.*, 2009; Wallier *et al.*, 2009), however BN has received less attention and to date, only the Bell (2001) review has attempted to synthesis the related literature. Identifying factors associated with treatment non-completion would inform treatment planning and recommendations for service development, taking an important step towards improving treatment retention.

1.4 Aims of the Current Review

The current review aimed to extend the conclusions outlined by Bell (2001) and provide an updated synthesis of the recent literature. The related research has explored a broad range of possible variables associated with leaving treatment earlier than anticipated. The current review aimed to extend the Bell (2001) review and focused on synthesising the more recent literature, as this would allow conclusions to be drawn between the reviews and across the research exploring factors associated with treatment non-completion for BN. In addition, the current review aimed to critically appraise the literature to establish whether the methodological limitations noted in previous reviews have been taken into consideration.

2 Method

2.1 Inclusion/ Exclusion Criteria

To extend the Bell (2001) review, studies had to be articles or brief reports published by a peer review journal since 2001. Treatment had to involve at least one psychological intervention. Studies reporting an intervention to reduce treatment attrition, the number and/ or qualitative reasons for non-completion rather than factors predicting treatment non-completion were excluded. Given the evidence indicating that individuals who meet the criteria for BN except for binge eating frequency do not differ significantly from those diagnosed with BN (Thomas, Vartanian & Brownell, 2009), the current review included studies of those diagnosed with BN and bulimic type eating disorders not otherwise specified (BN-EDNOS). All studies included an adult or young adult (16years+) sample as the reason for treatment adherence, service provision and treatment modalities among younger adolescents may differ from the adult BN population. Studies from all nations published in English language were included. The review aimed to examine whether patient characteristics and demographic variables are associated with treatment non-completion and as such, qualitative studies were excluded.

2.2 Search Strategy

An initial scoping review of NHS Evidence, The Cochrane Review Library, NICE Guidelines and the electronic databases was conducted. The scoping review broadly explored the relevant literature to contextualise the focus of the current review, identify key search terms and define the inclusion/ exclusion criteria. The key search terms noted in the Bell (2001) review were considered.

A systematic review was conducted between July and August 2015. Three electronic databases (PsychINFO, Scopus and Web of Science) were searched using the key search terms bulimia, eating

disorder, dropout, attrition, withdrawal, adherence and non-completion (Appendix A). The *priori* limits English language, peer-reviewed and published from 2001-2015 were applied. Identified articles were combined in Refwork and duplicates removed.

2.3 Study Selection

Appendix B outlines the process for study selection. The title and abstract of 1123 articles identified by the initial search were screened. Articles that did not include treatment non-completion terms in the title, abstract or keywords were excluded. The remaining 54 full-text articles were then screened against the inclusion/ exclusion criteria. Single case studies, articles included in the Bell (2001) review and articles that had not reported factors associated with non-completion for each diagnosis or treatment condition were excluded. The reference list of the remaining articles and relevant literature reviews were hand searched for additional articles. 16 studies were included.

2.4 Data Extraction and Synthesis

The remaining 16 articles were systematically reviewed using a data extraction form (Appendix C) based on the Cochrane Library Guidance (Higgins & Green, 2011). Features of each article were summarised including methodology, sample characteristics, treatment condition and non-completion definition. Given the heterogeneity of the studies, meta-analysis was precluded and a narrative synthesis of the empirical findings was reported.

2.5 Quality Appraisal

The *Checklist for Measuring Quality* (Downs & Black, 1998) was used to assess the quality of the identified articles. The checklist can be used across randomised and non-randomised studies, making it appropriate to quality appraise the methodologies adopted by the included studies. Quality was assessed across five domains including reporting, external validity, internal validity and bias, internal validity and confounding variables, and power analysis; and items rated 'yes' or 'no' dependent on whether they had been evidenced. For the purpose of the current review, the checklist was modified to reflect quality issues pertaining to the aims of the review. Items more specifically related to RCT outcomes were removed and the presence of a treatment non-completion definition included.

Given the limited number of studies exploring factors associated with treatment non-completion for BN, the quality assessment was not used as an inclusion criterion. The checklist provided a descriptive measure of quality and a framework to identify the methodological limitations discussed in the current review. The quality appraisal is summarised in Appendix D.

3 Results

The literature search yielded 16 studies that met the inclusion criteria and the key features are summarised in Appendix E and the general characteristics of the included studies are initially summarised below. Following which, factors associated with treatment non-completion are outlined (Appendix F), including a brief overview of factors excluded from the current review due to the lack of related research. The current review then summarises the critical appraisal and key methodological limitations evidenced across the included studies.

The majority of participants were female and only two studies (Robinson *et al.*, 2006; Zunker *et al.*, 2011) included mixed gender samples. Participants were predominately drawn from adult populations, however four studies (Carter *et al.*, 2008; Fernández-Aranda *et al.*, 2009a; Wagner *et al.*, 2015; Dawkins *et al.*, 2013) included 16 year olds. The age of participants ranged between 16- 57 years. Three studies (Butryn *et al.*, 2006; Carter *et al.*, 2008; Wolk & Delvin, 2001) reported the ethnicity of the sample. Studies did not report comparison between the general BN and sample populations.

Selected studies considered factors associated with treatment non-completion across several psychological interventions. Four studies included internet-based self-help interventions (Carrard *et al.*, 2011; Fernández-Aranda *et al.*, 2009b; Wagner *et al.*, 2015; Zunker *et al.*, 2011), eight studies involved cognitive-behavioural therapy (CBT; Zunker *et al.*, 2011; Wolk & Devlin, 2001; Waller *et al.*, 2014; Schnicker *et al.*, 2013; Dawkins *et al.*, 2013; Butryn *et al.*, Agüera *et al.*, 2013) and two studies psychoeducation (Fernández-Aranda *et al.*, 2009a; Agüera *et al.*, 2013). Furthermore, the factors associated with treatment non-completion from an aftercare text message intervention (Robinson *et al.*, 2006), individual brief psychotherapy (IPBP) combined with fluoxetine (Fassino *et al.*, 2003), psychotherapy (Mahon *et al.*, 2001), interpersonal psychotherapy (IPT; Mitchell *et al.*, 2002) and CBT combined with either exposure (pre-binge or pre-purge cues) or relaxation training (Carter *et al.*, 2008) were all examined in one study. Interventions ranged in duration from six psychoeducation sessions (Fernández-Aranda *et al.*, 2009a) to seven months of internet-based self-help (Wagner *et al.*, 2015). The included studies all explored treatment non-completion in out-patient treatment for BN. Two studies (Fernández-Aranda *et al.*, 2009a; Agüera *et al.*, 2013) involved group and self-help sessions interventions, while the other studies explored non-completion from individual interventions.

The current review only included variables that had been reported in two or more of the studies, allowing synthesis of the research findings. The variables included in the studies but excluded from the review were educational level (Fassino *et al.*, 2003); fluoxetine efficacy (Fassino *et al.*, 2003); self-esteem (Mahon *et al.*, 2001); ethnicity (Robinson *et al.*, 2006); number of outpatient sessions (Robinson *et al.*, 2006) and time lapse between referral to assessment and treatment (Mahon *et al.*, 2001). These variables were not found to be significantly associated with treatment non-completion. However, social adjustment (Mitchell *et al.*, 2002); witnessing parental break-up (Mahon *et al.*, 2001); previous psychiatric treatment (Mahon *et al.*, 2001); childhood trauma (Mahon *et al.*, 2001); suicidal ideation (Fernández-Aranda *et al.*, 2009a); alcohol use (Fernández-Aranda *et al.*, 2009a) and state and trait anxiety (Fassino *et al.*, 2003) were found to be related to treatment non-completion.

3.1 Weight Suppression

Five studies investigated whether weight suppression, the discrepancy between an individual's highest adult weight and current body weight (Lowe 1993), was associated with treatment non-completion for BN. Butryn *et al.* (2006) explored the predictive significance of weight suppression amongst female outpatients participating in CBT-BN. Higher pre-treatment levels of weight suppression was found to be a significant predictor of treatment non-completion, with the odds of non-completion multiplied by a factor of 0.69 for each 1kg increase of weight suppression. Butryn *et al.* (2006) reported that weight suppression remained a significant predictor of non-completion when controlling for baseline BMI, duration of binge eating, Eating Disorder Examination (EDE; Fairburn & Cooper, 1993) subscales restraint, weight concern, shape concern, eating concern, objective binge eating episodes, and purging episodes.

In contrast, four studies found weight suppression was not associated with treatment non-completion (Carter *et al.*, 2008; Zunker *et al.*, 2011; Dawkins *et al.*, 2013). Interestingly, Dawkins *et al.* (2013) examined whether pre-treatment weight suppression and the likelihood of completing individual enhanced CBT was moderated by parental history of overweight, childhood body shape, pre-treatment body mass index (BMI), or the difference between the highest and lowest ever adult weight. No significant moderator effects were found.

3.1.1 Psychopathology

Nine studies investigated whether psychological distress was associated with treatment non-completion for BN.

Three studies used the Beck Depression Inventory (BDI; Beck & Steer, 1987) to establish the predictive significance of pre-treatment depressive symptoms. Schnicker *et al.* (2013) found that treatment non-completers had a significantly higher pre-treatment BDI depression scores compared to completers. Wagner *et al.* (2015) found higher pre-treatment depression scores predicted treatment non-completion from either 7-months internet-based guided-self-help (IBT-GSH) or guided bibliotherapy (BIB-GSH). However, Waller *et al.* (2014) found that baseline BDI scores were not associated with treatment non-completion.

Four studies (Carrard *et al.*, 2011; Agüera *et al.*, 2013; Mahon *et al.*, 2001; Fernández-Aranda *et al.*, 2009b) used the Symptom Checklist (SCL-90R; Derogatis, 1977) to examine whether general psychological distress was associated with treatment non-completion. Carrard *et al.* (2011) found the severity of psychological distress measured by the Global Severity Index (GSI) did not predict treatment completion from a multi-site evaluation of a guided self-help programme for BN. Agüera *et al.* (2013) found no significant difference between treatment completers and non-completers on the nine symptoms dimensions (somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism) or global indices (global severity index, positive symptoms distress index and positive symptoms total) of the SCL-90R. Furthermore, there was no significant difference in the baseline SCL-90-R mean scores between treatment non-completers across the diagnostic subtypes bulimia nervosa-purging (BN-P) and bulimia nervosa non-purging (BN-NP). Similarly, Mahon *et al.* (2001) found no significant difference in psychopathological distress between treatment completers and non-completers. However, in contrast, Fernández-Aranda *et al.* (2009b) found premature withdrawal from internet-based cognitive behavioural therapy (IBT-CBT) was associated with higher scores on the SCL90-R anxiety subscale.

Schnicker *et al.* (2013) used the Brief Symptom Inventory (BSI; Derogatis, 1993) and found no significant difference between completers and non-completers pre-treatment scores on the obsession-compulsion and anxiety subscales or the global severity index. Similarly, Wagner *et al.* (2015) found general psychopathology measured by the Structured Interview for Anorexia Nervosa and Bulimia Nervosa (SIAB-EX; Ficher & Quadflieg, 2000) did not predict treatment non-completion.

3.1.2 Eating Disorder Psychopathology

Seven studies investigated the predictive significance of core psychopathological features characteristic of BN.

Schnicker *et al.* (2013) concluded that scores on the EDI-2 subscales drive for thinness, body dissatisfaction, bulimia and perfectionism did not differ significantly between treatment completers and non-completers. Waller *et al.* (2014) combined EDI subscale scores on the drive for thinness, bulimia and body dissatisfaction to establish whether eating attitudes predicted attrition and found no significant difference between treatment completers and non-completers. Carrard *et al.* (2011) found the EDI-2 subscales did not predict non-completion and Mahon *et al.* (2001) found eating disorder psychopathology measured by the EDI did not provide any insight into patient characteristics predictive of treatment non-completion. Similarly, Wagner *et al.* (2013) used the EDI-2 subscale ineffectively, perfectionism, impulse regulation, social insecurity, body dissatisfaction and drive for thinness and reported no significant predictors of treatment non-completion.

Agüera *et al.* (2013) explored predictors of non-completion among females diagnosed with DSM-TR BN-P and BN-NP. No significant differences in the baseline EDI-2 subscales scores across the diagnostic subtypes were reported, however BN-NP patients who failed to complete treatment scored higher on the maturity fears subscale compared to non-completers. Fassino *et al.* (2003) explored whether eating disorder psychopathology predicted treatment non-completion from IPBP combined with fluoxetine. Interestingly, Fassino *et al.* (2003) found baseline scores on the impulsivity, maturity fear and ineffectiveness subscales of the EDI-2 differed significantly between treatment completers and non-completers diagnosed with BN-P. Even though the combined fluoxetine intervention could offer a possible explanation for the inconsistent findings, Agüera *et al.* (2013) did not control for concurrent psychopharmacological treatment, indicating that other variables may moderate the predictive validity of the EDI-2 subscales.

Butryn *et al.* (2006) found the EDE subscale shape concern was a significant predictor of the premature withdrawal from individual CBT and those with greater shape concerns had lower odds of completing treatment.

3.1.3 Motivation

Three studies explored whether motivation provided an explanation for treatment non-completion. Wolk and Delvin (2001) used the Stage of Change Scale (DiClemente *et al.*, 1991) to establish the predictive significance of motivation amongst 66 individuals randomly assigned to either 19 sessions of CBT or IPT. The stage of change was found to be significantly associated with treatment outcome, however did not predict treatment non-completion either following assessment or once treatment had commenced. Even though Wolk and Delvin (2001) concluded that motivation did not appear to be associated with treatment non-completion, the findings should be viewed cautiously. The sample

population comprised of individuals recruited through advertisements and as such, the convenient sample of treatment-seeking participants may not represent the BN population. Furthermore, Wolk and Delvin (2001) did not stipulate whether participants had previously accessed eating disorder services. It is therefore unclear whether motivation to engage in psychological interventions may differ among those who have previously sought treatment, and could offer a possible explanation for the findings.

Wagner *et al.* (2015) used the Bulimia Nervosa Stage of Change Questionnaire (BNSOCQ; Martinez *et al.*, 2007) and found that motivation did not predict non-completion of internet-based guided self-help intervention. Robinson *et al.* (2006) used a non-standardised rating scale to assess whether motivation was associated with treatment non-completion from a follow-up text message intervention. Even though the findings replicated other reviewed studies, the predictive significance of motivation remains tenuous. Given the use of non-standardised measures it is unclear whether the operationalisation of motivation allowed comparison.

3.1.4 Eating Specific Variables

Four studies explored the association between baseline body mass index (BMI) and treatment non-completion. Robinson *et al.* (2006), Carrard *et al.* (2011) and Waller *et al.* (2014) found baseline BMI was not associated with treatment non-completion among patients diagnosed with either BN or EDNOS-BN. Similarly, Fassino *et al.* (2003) found no significant difference in BMI between BN-P patients who either completed or withdrew from a brief psychotherapy intervention combined with fluoxetine. Fernández-Aranda *et al.* (2009a) found higher maximum BMI achieved was associated with treatment non-completion; whereas in contrast, Fernández-Aranda *et al.* (2009b) found lower minimum BMI achieved was associated with treatment non-completion.

Five studies investigated whether the severity of bulimic eating disorder symptomology was indicative of treatment non-completion. Fassino *et al.* (2003) used Eating Disorder Inventory Symptom Checklist (EDI-SC; Garner, 1993) and found no significant difference in weekly laxative, binge or vomiting episodes between treatment completers and non-completers. Wagner *et al.* (2015) used the QATA (Carrard *et al.*, 2006) questionnaire developed by University Hospital of Geneva to establish whether monthly binge eating and vomiting behaviour during the 3-months preceding an internet based guided self-help intervention predicted treatment outcome. Wagner *et al.* (2015) concluded that bulimic eating disorder symptomology was not associated with treatment non-completion. Similarly, Waller *et al.* (2014) found the frequency of weekly binge eating and vomiting behaviour prior to commencing individual CBT was not predictive of treatment completion. In contrast,

Fernández-Aranda *et al.* (2009a) found lower baseline purging frequency was associated with higher probability of treatment non-completion before the fourth week of a group psychoeducational programme. Mahon *et al.* (2001) explored whether the severity of eating disorder characteristics including the frequencies of bingeing and vomiting, laxative doses and duration of eating disorder predicted treatment completion. Those with more severe symptomology were found to be more likely to complete individual psychotherapy.

Two studies explored whether hyperactivity, a compensatory behaviour characteristic of BN, was associated with treatment non-completion. Fassino *et al.* (2003) found no significant difference in weekly hyperactivity between treatment completers and non-completers. However, on the other hand, Fernández-Aranda *et al.* (2009b) found lower baseline hyperactivity was associated with treatment non-completion from IBT-CBT for BN.

3.1.5 Personality

Three studies used the Temperament and Character Inventory revised (TCI-R; Cloninger, 1999) to establish the association between personality traits and treatment completion. Fernández-Aranda *et al.* (2009a) found higher novelty seeking scores were associated with treatment non-completion from brief psychotherapy. Wagner *et al.* (2015) identified lower baseline self-directedness score predicted treatment outcome from INT-GSB; whereas Fernández-Aranda *et al.* (2009a) found treatment non-completion of IBT-CBT was associated with lower baseline reward dependence scores. On the other hand, Fassino *et al.* (2003) used the TCI (Cloninger *et al.*, 1993) to explore the predictive significance of personality dimensions and found treatment non-completion from brief psychotherapy was related to lower baseline self-directedness and cooperativeness.

3.1.6 Age of Onset and Duration of BN

Five studies (Robinson *et al.*, 2006; Agüera *et al.*, 2013; Schnicker *et al.*, 2013; Waller *et al.*, 2014; Fassino *et al.*, 2003) investigated the significance of age at the time of treatment and found no significant difference between those who completed treatment and prematurely withdrew. However, Mahon (2001) found those who did not complete individual psychotherapy were younger than treatment non-completers. Additionally, four studies (Agüera *et al.*, 2013; Fassino *et al.*, 2003; Robinson *et al.*, 2006; Carrard *et al.*, 2011) consistently concluded that the duration of the eating disorder episode was not associated with treatment non-completion.

3.1.7 Demographic Variables

Three studies explored whether employment status was associated with treatment non-completion. Agüera *et al.* (2013) and Schnicker *et al.* (2013) found employment status was not related to treatment outcome, whereas Mahon *et al.* (2001) concluded those who were unemployed, employed outside of the home or students were more likely to engage in psychotherapy. Additionally, Schnicker *et al.* (2013) and Agüera *et al.* (2013) found that civil status and living in a partnership was not associated with treatment outcome.

4.1 Methodological Issues

Previous reviews have suggested that the methodological limitations evident throughout the non-completion literature may offer a possible explanation for the lack of replicable findings (Mahon, 2000; Wallier *et al.*, 2009; Fassino *et al.*, 2009). The current review aimed to critically appraise the recent literature to establish whether these methodological limitations had been addressed. Findings from the critical appraisal (Appendix D) and the prominent methodological limitations evidenced across the reviewed studies are summarised.

4.1.1 Patient Characteristics

The reviewed studies included predominantly female samples. The research samples in two studies (Robinson *et al.*, 2006; Zunker *et al.*, 2011) comprised of both females and males, however the representation of male participants was negligible. Even though the samples may reflect the BN prevalence rate among males of 0.3% (Hudson *et al.*, 2007), the majority of studies included solely female samples. Previous research has suggested that males may experience gender-specific obstacles to treatment (Andersen & Holman, 1997; Weltzin *et al.*, 2005) and future research should consider whether gender differences may moderate factors associated with treatment non-completion. Three studies (Butryn *et al.*, 2006; Carter *et al.*, 2008; Wolk & Delvin, 2001) reported participants' ethnicity. However, given the lack of demographic characteristics provided by the majority of studies the generalisability of the findings is unclear.

Four studies included adolescent participants (Carter *et al.*, 2008; Fernández-Aranda *et al.*, 2009a; Wagner *et al.*, 2015; Dawkins *et al.*, 2013). Factors related to life stage transitions (Carter & McGoldrick, 1989), the key treatment mechanisms and therapeutic components distinctive of the psychological interventions for BN adolescents (NICE, 2004), and the role of families in the reasons for adhering to treatment (Marcosa *et al.*, 2013), may differ from adult populations and provide further explanation for treatment non-completion among adolescents. NICE guidelines (NICE, 2004) recommend specific BN treatment for adult and adolescents and as such, future research should

specifically focus on factors associated with treatment non-completion between adults and children/adolescents.

4.1.2 Recruitment and Inclusion Criteria

Several studies used convenience samples of treatment-seeking individuals. Thus, the samples may not be representative of the BN population and this may impact on the external validity of the findings.

The recruitment period varied significantly across the reviewed studies. For example, Agüera *et al.* (2013) explored predictors of treatment non-completion among individuals who accessed eating disorder treatment over an 11 year period. Given the varied and lengthy inclusion periods, it is unclear whether factors related to treatment delivery and programme development may have moderated the predictive significance of patient characteristics and could offer a possible explanation for the lack of replicable findings.

The inclusion/ exclusion criteria varied across the reviewed studies. Four studies (Mahon *et al.*, 2001; Schnicker *et al.*, 2013; Fernández-Aranda *et al.*, 2009a; Fernández-Aranda *et al.*, 2009b) did not provide an exclusion criterion. Six studies (Butryn *et al.*, 2006; Carrard *et al.*, 2011; Dawkins *et al.*, 2013; Mitchell *et al.*, 2002; Wagner *et al.*, 2015; Zunker *et al.*, 2011) excluded individuals with substance/ alcohol use. Given the prevalence of substance/ alcohol use reported among individuals with BN (Hudson *et al.*, 2007) the homogenous samples may have overlooked important features of the BN population. Individuals with complex and severe psychological disorders were generally excluded, narrowing the definition of psychopathology and scope to establish clinical features indicative of treatment non-completion.

4.1.2 Treatment Modalities and Settings

The reviewed studies all explored non-completion from outpatient treatment, however treatment modalities varied across the studies. The duration of treatment ranged from 6 to 20 individual sessions. The majority of studies included psychological interventions delivered individually, however two studies (Fernández-Aranda *et al.*, 2009a; Agüera *et al.*, 2013) explored factors associated with non-completion from a group-based psychoeducational intervention. Four studies (Carrard *et al.*, 2011; Fernández-Aranda *et al.*, 2009b; Wagner *et al.*, 2015; Zunker *et al.*, 2011) included internet or SMS interventions.

4.1.3 Outcome Measures and Statistical Analysis

The majority of studies used standardised, self-report measures. Interestingly, Mahon *et al.* (2001) found that treatment non-completers were less likely to complete self-report measures than those who engaged in treatment (58% compared with 85%: $\chi^2=9.3$, $df=1$, $p=.002$). As such, the use of self-report measures may have presented a potential selection bias and led to difficulties identifying characteristics associated with treatment non-completion among the heterogeneous BN population. Different self-report measures and subscales were used across the studies to examine the predictive significance of patient characteristics, hindering meaningful comparison across the studies.

The sample size varied from 21 (Robinson *et al.* 2006) to 367 (Agüera *et al.*, 2013). Carter *et al.* (2008) was the only study that reported power calculations and as such, it is unclear whether the statistical power of the reviewed studies allowed reliable analysis. Based on previous reviews, treatment non-completion appears to be a complex and multifaceted phenomenon. Future research should consider the feasibility of multisite research to access statically robust samples.

Three studies (Fernández-Aranda *et al.*, 2009b; Wolk & Delvin, 2001; Mitchell *et al.*, 2002) primarily aimed to explore treatment effectiveness or patient characteristics predictive of treatment outcomes for BN. Investigating predictors of treatment non-completion as a secondary research question could account for the broad range of variables and lack of replicable findings evidenced in the current research. As discussed above, non-completion has significant clinical implications and future research should address the methodological shortcomings by explicitly exploring predictive variables associated with the premature withdrawal from BN treatment.

4.1.4. Definition of Treatment Non-Completion

Six studies (Zunker *et al.*, 2011; Fernández-Aranda *et al.*, 2009a; Fernández-Aranda *et al.*, 2009b; Agüera *et al.*, 2013; Robinson *et al.*, 2006; Mitchell *et al.*, 2002) did not report a definition and as such, it is unclear whether the findings can be generalised. Across those studies that defined treatment non-completion, the criteria varied considerable. Six studies (Butryn *et al.*, 2006; Carrard *et al.*, 2011; Carter *et al.*, 2008; Wolk & Devlin *et al.*, 2013; Wagner *et al.*, 2015; Dawkins *et al.*, 2013) defined non-completion as the failure to complete a fixed number of sessions or period of treatment engagement. For example, Wolk and Delvin (2001) defined treatment non-completers as those who did not attend all 19 individual sessions, whereas Mahon *et al.* (2001) criteria stipulated attendance at 10 sessions and Carter *et al.* (2008) 5 sessions. Even though Mahon *et al.* (2001) indicated that 10 sessions was considered the minimum engagement to achieve any therapeutic benefit from psychotherapy, the other studies did not provide a clear rationale for their definitions.

Two studies (Mahon *et al.*, 2011; Fassino *et al.*, 2003) defined treatment non-completion as the premature withdrawal from treatment without agreement or recommendation from a clinician. However, the criteria clinicians used to categorise the reasons for leaving treatment as '*non-completion*' was not reported. Interestingly, Mitchell *et al.* (2002) reported that the reasons for being classified as a treatment non-completer included the patient refusing IPT treatment, no longer wanting to access treatment, had moved area or could no longer be contacted. Given the reasons cited it is unclear whether patients would have actually completed IPT had they engaged in treatment and as such, it is difficult to ascertain whether Mitchell *et al.* (2002) findings provide a clear insight into clinical indicators differentiating treatment completers and non-completers. Mitchell *et al.*'s (2002) definition, comparable with several of the reviewed studies, encompassed treatment refusal, withdrawal for personal and practical reasons and treatment non-completion.

Waller *et al.*'s (2014) definition focused on a collaborative agreement between the patient and clinician. However, it is unclear whether the absence of '*collaborative agreement*' indicated treatment failure or broadly included any mutually agreed reasons for prematurely leaving treatment. The broad definitions could obscure important factors associated with non-completion and present a methodological barrier to establishing why patients may experience obstacles to treatment completion.

Schnicker *et al.*'s (2013) definition moved beyond patients failing to attend a minimum number of sessions and acknowledged that treatment non-completion could reflect '*an early treatment success*'. Leaving treatment having achieved therapeutic targets and made changes to eating disorder behaviours should be differentiated from leaving treatment earlier than anticipated with no clinically significant improvements being made.

Across the reviewed studies, the definitions of non-completion made no reference to the timing of treatment withdrawal. However, three studies (Agüera *et al.*, 2013; Fernández-Aranda *et al.*, 2009a; Fernández-Aranda *et al.*, 2009b) reported higher rates of treatment non-completion during early stages of treatment. This raises important questions related to whether different variables account for attrition at various stages of treatment and whether the timing of treatment withdrawal should be reflected in the definition of non-completion.

5 Discussion

The current review aimed to extend the Bell (2001) review by summarising the recent literature exploring factors associated with treatment non-completion for BN. Additionally, the current review considered the methodological limitations noted in previous reviews and provided recommendations for future research.

5.1 Overview of the Findings

5.1.1 Factors Associated with Treatment Non-Completion

Attempts to synthesise the findings were made more difficult by the broad range of variables explored in the literature. Several variables had only been reported in a single study and were not discussed due to the lack of findings. The significance of variables reviewed by Bell (2001) including substance use (Coker *et al.*, 1993), weight dissatisfaction (Burket & Hodgins, 1993), Axis II disorders (Merrill *et al.*, 1987; Cooper *et al.*, 1996; Margittai, 1987; Fairburn *et al.*, 1993; Waller, 1997; Steiger *et al.*, 1993; Edelstein *et al.*, 1989), past history of AN (Agras *et al.*, 2000) and family functioning (Waller, 1997) had not been further investigated within the current literature.

Bell (2001) concluded that those with co-morbid borderline personality disorders (BPD) were more likely to prematurely withdraw from treatment, yet the association between BPD and treatment non-completion had not been further investigated. However, Fassino *et al.* (2003) suggested that higher scores on the EDI-II subscales of ineffectiveness, maturity fears and impulse regulation among non-completers indicated that personality features characteristic of BPD may provide an insight into why some individuals leave treatment earlier than anticipated. Additionally, the predictive significance of weight suppression appears to be an interesting area for future research.

Similar to the Bell (2001) review, demographic variables were not found to be robust indicators of treatment non-completion. However, conclusions remain tentative given the heterogeneity of studies included in both reviews. Treatment non-completion is not a uniform phenomenon (Mahon, 2000) and as such, it appears unlikely that demographic variables could solely account for the high non-completion rates characteristic of eating disorder treatment. Interestingly, Mahon *et al.* (2000) found that younger age moderated the predictive significance of several variables found to be associated with treatment non-completion. Future research would benefit from exploring whether demographic variables could moderate the predictive significance of patient characteristics.

Both the current and Bell (2001) review indicate that patient characteristics may provide some explanation for treatment non-completion for BN. However, the inconsistent findings may suggest that the predictive significance of patient characteristics may differ across treatment modalities and therapeutic settings. Identifying patient characteristics predictive of non-completion across different treatment modalities could inform the effective allocation of psychological interventions. As such, future research should consider whether treatment duration, type of delivery and therapeutic approach moderates factors associated with treatment non-completion across specific treatment modalities.

The recent research lacked consideration for whether patient-therapist alliance provides further insight into the reasons why some patients leave treatment prematurely. Interestingly, Mahon *et al.* (2000) concluded that difficulties forging and maintaining trusting relationships emergent from difficult childhood experiences was associated with treatment non-completion. Even though recent studies have begun to explore the role of therapeutic alliance in eating disorder treatment outcomes (for a review see Zaitsoff *et al.*, 2015), future research should consider whether patient-therapist factors present a barrier to effective engagement in eating disorder treatment.

5.1.2 Limitations and Wider Methodological Issues

Despite recommendations from the previous reviews, the quality appraisal highlighted the notable methodological limitations of the included studies which could offer a possible explanation for the inconsistent findings. However, the quality appraisal process was subjectively completed by the author and the possibility of rater bias should be taken into consideration.

Most significant for the research exploring factors associated with treatment non-completion for BN, the definition of treatment non-completion if reported at all, varied considerably across the reviewed studies. The majority of the reviewed studies used dichotomised definitions that categorised completers and non-completers based on attendance at a minimum number of sessions or fixed period of treatment engagement. These definitions predominantly neglect to consider whether individuals had achieved clinically significant progress before leaving treatment prematurely. As a consequence, the research continues to be hindered by a lack of distinction between non-completers who have successfully addressed their eating disorder and those who continue to experience problematic bulimic behaviours. Another important consideration for the definition of non-completion should be whether treatment withdrawal was initiated by the patient or clinical team. Even though several studies classified non-completion as initiated by the patient, the majority of studies did not indicate the reasons for treatment withdrawal and whether it had been initiated by the patient or

clinician. Interestingly, Sly *et al.* (2014) found that patient characteristics differed between patients who decided to leave treatment compared to those discharged by the clinical team. Homogenously grouping treatment completers and non-completers together provides questionable insight into clinical indicators associated with poor treatment outcomes.

Leaving treatment prematurely is often negatively viewed and prevalence rates considered a significant obstacle to the effective delivery of eating disorder treatment. The majority of studies did not make a distinction between leaving treatment having made positive progress, due to changes in personal circumstances and no longer being able to access treatment or referral to intensive inpatient interventions from non-completion leading to poor treatment outcomes. Consequently, non-completion rates provide a vague indicator of treatment effectiveness and the long-term outcomes of those who prematurely withdraw from treatment. Moving towards a clearer definition would support the identification of factors predicting non-completion for those likely to experience poor outcomes and clinical recommendations to improve long-term recovery.

5.3 Strengths and Limitations of the Current Review

The current review systematically reviewed and quality appraised the relevant literature. However, the systematic review was conducted by the author and could have introduced bias in the inclusion and evaluation of the reviewed studies. The articles were mainly excluded based on the title/ abstract and relevant articles may have not been included. For example, BN treatment effectiveness studies that reported variables predictive of treatment non-completion may have been excluded if the findings were not explicitly outlined in the title/ abstract.

5.4 Future Research and Implications for Clinical Practice

The current review further highlighted the notable methodological limitations and lack of replicable findings. Considerable research is still needed to comprehensively understand the high non-completion rates characteristics of eating disorder treatment and future attempts to identify robust predictors should address the methodological shortcomings. It appears unlikely that treatment non-completion can be effectively addressed by selecting 'better' patients and as such, future research should explore whether the predictive significance of patient characteristics may be moderated by therapeutic modalities and patient-therapist factors. Furthermore, the research continues to lack a standardised definition of treatment non-completion. Rather than the dichotomous categorisation of completer and non-completer irrespective of the reasons for leaving treatment, future research should adopt a definition that explores factors associated with treatment non-completion leading to poor treatment outcomes and a chronic course of BN.

Even though treatment setting was not an inclusion criteria for the current review, the reviewed studies all explored factors associated with non-completion from outpatient treatment. The NICE guidelines (2004) recommend outpatient treatment as the initial treatment for BN, however there is an evident a lack of research exploring treatment non-completion from inpatient treatment.

The identification of factors associated with treatment non-completion could provide a valuable insight into the provision of eating disorder services for the heterogeneous BN population. However, the current literature provides an ambiguous picture of factors associated with non-completion, and as yet, the lack of replicable findings has precluded the possibility for making recommendations for clinical practice.

5.5 Conclusion

The effectiveness of psychological interventions for BN remains limited by the high rate of treatment non-completion (Steel *et al.*, 2000; Agras *et al.*, 2000; Walsh *et al.*, 1997; Fairburn *et al.*, 1993). Identifying factors associated with non-completion would provide an important insight into the reasons why some individuals experience difficulties engaging in treatment and recommendations for clinical practice. The current review further highlighted the complexity of research exploring patient characteristic indicative of treatment non-completion. Patient characteristics may offer some insight into the reasons for treatment non-completion, however future research should address the methodological limitations.

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Treatment Non-Completion of a Compassion-Focused Therapy Eating Disorder Programme: A Mixed Methods Study

Abstract

Background

High treatment non-completion rates for eating disorders have been associated with poor treatment outcomes. Previous research has predominantly investigated whether patient characteristics predict non-completion and few studies have considered whether treatment mechanisms and therapeutic processes may provide further insight into the reasons for treatment withdrawal. The current research adopted a mixed method approach to explore non-completion from Compassionate-Focused Therapy for Eating Disorders (CFT-E). The research further aimed to investigate whether the high levels of shame and self-criticism associated with eating disorder psychopathology may offer further insight into the reasons for treatment non-completion.

Method

The quantitative approach examined whether demographic variables and self-report measures predicted failure to engage in treatment. Participants were 403 patients referred to an eating disorder service between 2002 and 2013 who had completed the pre-programme assessment and either commenced treatment or failed to engage. The qualitative approach used focus group interviews to explore barriers and facilitators to treatment engagement among 10 participants who had completed treatment.

Results

The findings indicated that shame, eating concern and restraint concern were significant predictors of failure to engage (FTE) in CFT-E. Thematic analysis of the focus group interviews indicated four main themes related to facilitators of treatment engagement: positive experiences of therapists, being in a supportive groups, developing a compassionate understanding of an eating disorder and support beyond treatment. Four main themes related to barriers to treatment engagement: the demands of treatment, difficulties exploring an eating disorder, comparison with other patients, and making the transition from an eating disorder to recovery.

Conclusions

The current research indicated that eating disorder psychopathology and shame may be important factors associated with FTE in CFT-E. The experience of exploring difficult and shameful eating disorder behaviours may also be an important barrier to treatment engagement and fostering a safe therapeutic setting could support retention.

1 Introduction

The effectiveness of psychological interventions for eating disorders can be limited by high treatment non-completion rates. Studies have indicated non-completion rates ranging from 29% to 73% for outpatient treatment (Wallier *et al.*, 2009) and 20.2% to 51% for patients with anorexia nervosa (AN) accessing inpatient treatment (Swan-Kremeier *et al.*, 2005). Importantly, treatment non-completion has been associated with negative treatment outcomes (Strober *et al.*, 1997; Masson *et al.*, 2007). Those patients who prematurely withdraw from treatment have an increased risk of relapse and rehospitalisation in the first year of discharge (Baran *et al.*, 1995); and a higher prevalence of medical co-morbidity and mortality (Crow *et al.*, 2009). Those who do not complete treatment are less likely to access future treatment (Mahon, 2000) and as such, improving treatment retention continues to be a significant challenge for eating disorder services.

The clinical implications of high treatment non-completion rates are multi-faceted and extend beyond negative long-term treatment outcomes. Given the chronic course of eating disorders and complex range of associated physical and psychiatric co-morbidities, eating disorders have significant implications for public health and are estimated to cost the NHS £4.6bn per annum (BEAT, 2015). Moreover, eating disorders place significant emotional and financial burden on families and careers (Haigh & Treasure, 2003; Winn *et al.*, 2007). For example, carers of patients with AN have been found to experience significant levels of psychological distress (Treasure *et al.*, 2001). The provision of specialist services and subsequent prevention of illness chronicity is an important step towards addressing the cost of eating disorders. However, high treatment non-completion rates present a significant obstacle for the effective delivery of eating disorder services. Recent estimates indicate that waiting times for outpatient appointments across some NHS Trust has increased by more than 120% over the past four year (BBC, 2016). Even though this may reflect NHS efficiency savings and the implications for service provision, treatment non-completion rates have also continued to rise (Campbell, 2009) and present a further challenge for the effective delivery of specialist services.

1.2 Factors Associated with Treatment Non-Completion: Previous Quantitative Research

The research exploring treatment non-completion has predominantly focused on establishing whether patient characteristics differentiate those more likely to prematurely withdraw from treatment. A review by Fassino *et al.* (2009) identified several factors associated with non-completion across inpatient and outpatient treatment including borderline personality disorder or personality traits (Surgenor *et al.*, 2004; Zeeck *et al.*, 2005; Woodside *et al.*, 2004; Kahn & Pike. 2001); personality dimensions including self-directedness and low cooperativeness (Bulik, 2005; Lo Sauro *et al.*, 2008),

psychological traits including high maturity fear (Swan-Kremeir *et al.*, 2005; Kahn & Pike, 2001) and impulsivity (Bulik, 2005; Bacaltchuk & Hay, 2003). Furthermore, the binge-purging subtype of AN was associated with non-completion from inpatient treatment (Swan-Kremeier *et al.*, 2005; Vandereicken & Pierloot, 1983) and more severe bulimic symptomatology from outpatient treatment. However, given the notable methodological limitations and lack of replicable findings the current research provides a limited insight into whether patient characteristics can distinguish those more likely to leave treatment earlier than anticipated (Fassino *et al.*, 2009; Wallier *et al.*, 2009; Mahon *et al.*, 2000).

Higher rates of treatment non-completion have been reported during the initial stages of treatment (Masson *et al.*, 2007; Kahn & Pike, 2001; Halmi *et al.*, 2006). Studies have indicated that failure to attend rates range from 14% to 35% (Waller, 1997; Waller *et al.*, 2009; Leavey *et al.*, 2011; Bell & Newns, 2004) and in one study, 23% of patients only attended one session (Leavey *et al.*, 2011). Huas *et al.* (2011) found factors associated with leaving treatment during the first week of an inpatient programme for AN differed from those indicative of non-completion at later stages. However, studies often define non-completion as prematurely withdrawing from treatment before the completion of a fixed number of sessions and provide no indication into the point at which individuals withdrew from treatment. Some studies have distinguished between 'early' and 'late' non-completion (Gowers *et al.*, 2004; Watson *et al.*, 2013), however it is often unclear whether the definitions reflect the number of sessions needed to achieve therapeutic benefits or junctures between different stages of treatment. Clearly differentiating 'early' and 'late' non-completion may provide an important insight into why some patients withdraw from treatment and direct clinicians to identify those likely to experience difficulties engaging in eating disorder services. However, few studies have specifically explored treatment non-completion at different treatment junctures and the broad non-completion definitions could account for the lack of replicable findings.

1.3 Factors Associated with Treatment Non-Completion: Previous Qualitative Research

Treatment non-completion is a complex clinical issue (Mahon, 2000) and it appears unlikely that patient characteristics alone will offer a comprehensive account into the reasons for leaving treatment earlier than anticipated (Kahn & Pike, 2001). However, few studies have considered whether treatment mechanisms and therapeutic processes including, therapeutic alliance, programme delivery and treatment structure can provide an insight into the reasons for non-completion.

Eivors *et al.* (2003) investigated the experience of treatment non-completion among eight women with AN. Loss of control related to the context, approach and timing of treatment emerged as a central theme associated with the unilateral decision to withdraw from treatment. Leavey *et al.* (2011)

explored barriers to engagement with an outpatient eating disorder service. Service-related and practical difficulties (for example, long waiting lists, administrative issues, difficulties arranging childcare), negative previous experiences of health services, stigma associated with eating disorders and ambivalence about making changes to eating disordered behaviours emerged as important themes associated with treatment non-completion.

Vandereycken and Devidt (2010) compared patient and staff perceptions of the reasons for non-completion from an inpatient eating disorder programme. Both patients and staff highlighted the lack of freedom, treatment being too difficult and the absence of trust as central themes associated with leaving treatment earlier than anticipated. Contrary to staff perceptions, patients highlighted being satisfied with treatment and felt they had made sufficient progress prior to withdrawal. Additionally, the inappropriateness of a hospital admission and impact on employment were cited as reasons for treatment non-completion. Masson and Sheeshka (2009) explored clinician's perceptions of the reasons for prematurely leaving inpatient eating disorder treatment. The ability to foster trusting relationships with clinicians, internal motivation, the reasons for treatment engagement and taking steps towards recovery emerged as important themes related to treatment completion. Interestingly, clinicians reflected on their experiences that some patients had achieved clinically significant progress before leaving treatment and, in some cases, had actually taken more significant steps towards recovery than those who completed treatment.

1.4 Recent Treatment Approaches: Compassion-Focused Therapy for Eating Disorders (CFT-E)

Compassion-Focused Therapy for eating disorders (CFT-E) has emerged as a psychological treatment for eating disorders. Preliminary studies have highlighted the effectiveness of CFT-E (Kelly *et al.*, 2014; Gale *et al.*, 2014), however similar to other eating disorder interventions, treatment efficacy is likely to be compromised by the high non-completion rate characteristics of eating disorder treatment.

Based on evolutionary, neuroscientific and attachment theories, CFT is a transdiagnostic psychotherapeutic approach. CFT combines the principles of cognitive-behavioural therapy and other eating disorder treatments (Goss & Allan, 2010) to address the higher levels of shame, self-criticism and self-directed hostility commonly experienced by those with eating disorders (Fenning *et al.*, 2008; Gale *et al.*, 2014; Goss & Gilbert, 2002). The CFT-E model (Figure 1) proposes that individuals with eating disorders experience the world through an activated threat-system (Goss & Gilbert, 2002). Consequently, over reliance on the threat-system for self-protection and safety-seeking leads to

difficulties accessing the soothing system to regulate negative affect. Restricting or binge/ purge eating behaviours activate reward and pleasure within the drive-system (Goss & Allan, 2014) and function to regulate threat. Pride associated with eating disordered behaviours may also regulate threat-based and shame-based emotions and play an important role in alleviating the negative affect associated with the threat-system. However, dependence on the pride and/ or drive-system to regulate or avoid emotional distress in turn, leads to a vicious maintenance cycle of eating disordered behaviours and difficulties effectively accessing the self-soothing system (Goss & Allan, 2012).

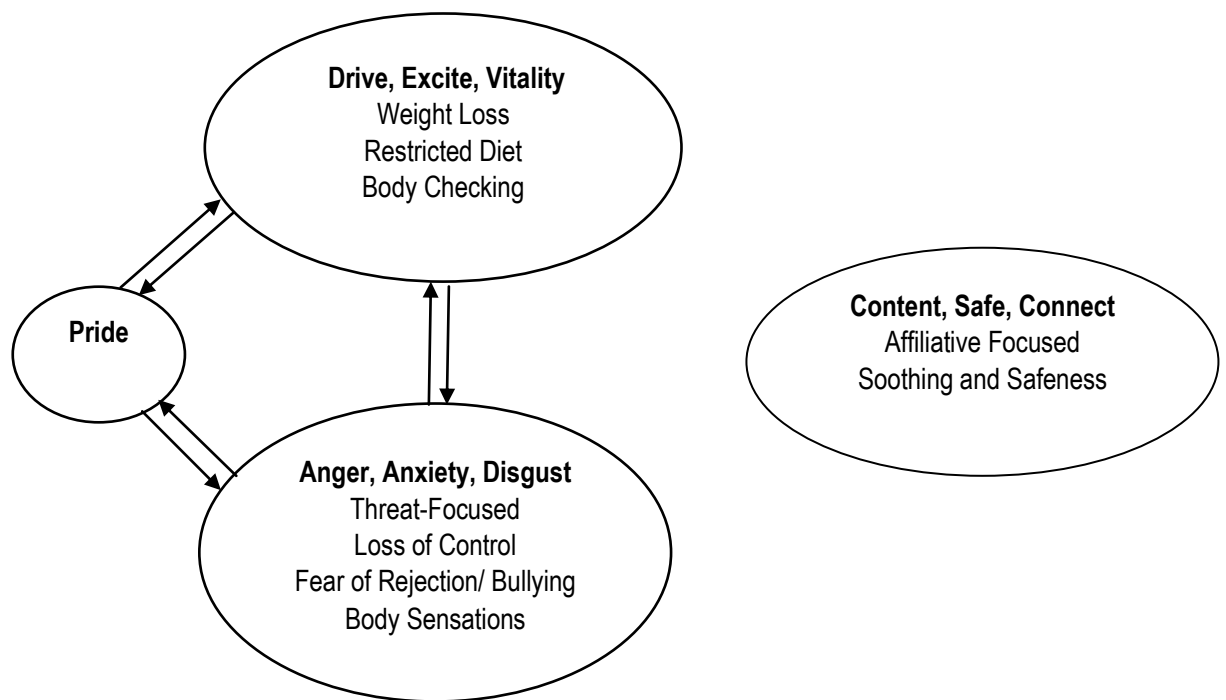


Figure 1: Compassion-Focused Model for Eating Disorders. Based on Goss and Gilbert (2002) Eating Disorder Affect Regulation Model

1.5 Treatment Engagement and Shame

Shame, negative self-evaluation centred around being weak, worthless, flawed, inferior and the external fear of hostility and criticism from others (Goss & Allan, 2009), has been linked to the psychopathology and maintenance of eating disorders (Kelly & Carter, 2012; Troop & Redshaw, 2012; Troop *et al.*, 2008; Swan & Andrews, 2003; for a review see Goss & Allan, 2009). However, there has been little consideration into whether the high levels of shame associated with eating disorders may offer a possible explanation for the underutilisation of specialist services.

The shameful and stigmatising experience of disclosing an eating disorder has been found to be a barrier to accessing services. Seeking support and the stigma associated with a mental health illness diagnoses (Becker *et al.*, 2010; Hepworth & Paxton, 2007), the embarrassment and guilt surrounding eating disordered behaviours, alongside the fear of disclosure (Meyer, 2001) and shame stemming from the being negatively evaluated by others (Goodwin & Fitzgibbon, 2002) may cause individuals to avoid treatment (Becker *et al.*, 2010). In addition, negative experiences of treatment have been identified as possible factors associated with treatment non-completion (Leavey *et al.*, 2011). These negative treatment episodes centred on the lack of compassionate and nurturing experienced by therapist could subsequently be internalised within the threat system and feelings of shame, anger and anxiety create a barrier to accessing future treatment.

Few studies have explored whether shame may impact on the therapeutic process. Swan and Andrews (2003) found shame was associated with non-disclosure in women with eating disorders. The emotional distress elicited through disclosure or reflection on the shameful experience of eating disordered behaviours may activate the threat system and subsequently, create a barrier to treatment engagement. Interestingly, Lindsay-Hartz and colleagues (1995) suggested that individuals may be more likely to withdraw from treatment if shameful disclosures are not compassionately explored by therapists.

Even though it has been suggested that the shame experienced by those with eating disorders could account for the underutilisation of specialist services, to date, there has been no research exploring whether shame and self-criticism may be associated with treatment non-completion.

1.6 Rationale for the Current Research

Treatment non-completion has significant economic, social and clinical implications. The identification of factors associated with non-completion may support clinicians to identify those more likely to withdraw from treatment and guide service development. The Fassino *et al.* (2009) review highlighted the lack of replicable factors associated with treatment non-completion, suggesting that treatment mechanisms and therapeutic components characteristic of different treatment modalities may moderate the validity of patient characteristics. However, there is currently no research exploring treatment non-completion from CFT-E. The proposed research aims to extend the current literature and explore whether shame and self-criticism offer further insight into the reasons for treatment non-completion.

As noted above, previous research has indicated that different clinical factors may be indicative of treatment non-completion at different stages of treatment (Masson *et al.*, 2007; Kahn & Pike, 2001). The current research will focus on the initial CFT-E treatment phase, exploring whether patient characteristics and demographic variables account for treatment non-completion between the pre-programme assessment and psycho-educational programme.

The previous research has mainly focused on establishing the predictive significance of patient characteristics including demographic and clinical features. Even though there is growing recognition of the value of developing services to reflect the needs of service users (Department of Health, 2004), few studies have adopted qualitative approaches to explore patient experiences and the reasons for treatment non-completion. The proposed research will adopt a mixed methods approach, adding depth to the quantitative findings by exploring the experiences of those who have completed the CFT-E programme to identify potential barriers to engagement, and importantly, what supported patients to overcome these obstacles and successfully remain in treatment.

1.7 Aims and Objectives

In addition to exploring whether patient characteristics and demographic variables predict failure to engage (FTE) in treatment, the current mixed methods research will elicit patient experiences of the CFT-E programme, why at times they may have struggled to attend sessions, and what supported them to complete the CFT-E programme.

- Examine whether patient characteristics and demographic variables predict FTE in CFT-E. More specifically, whether levels of shame and self-criticism play a significant role in predicting those more likely to withdraw from treatment.
- Explore patient experiences of CFT-E to identify what components of the programme for eating disorders and/ or the process of accessing treatment create potential barriers to engagement.
- Identify factors that support patients to overcome barriers to treatment engagement and complete the CFT-E programme.

2 Method

2.1 Research Design: Mixed Methods

The current research adopted a convergent mixed methods approach (Creswell *et al.*, 2011). Quantitative methods exploring whether patient characteristics and demographic variables predicted FTE in treatment were completed in parallel with qualitative methods that focused on the experience of CFT-E treatment and obstacles to treatment completion. The quantitative and qualitative data was independently analysed, and then integrated (Creswell & Plano Clark, 2011) to provide a rich account into treatment non-completion for CFT-E. Appendix G presents the research process chronology.

2.2 Ethical Approval

The research received approval from the Local Research Ethics Committee (Appendix H) and relevant NHS Trust Research and Development Committee (Appendix I).

2.3 CFT-E Treatment Programme

CFT-E is a group-based treatment for adult outpatients delivered by a multi-disciplinary team including Specialist Nurses, Clinical Psychologists and Psychological Assistants. CFT-E consists of four treatment phases: psycho-education, developing compassionate skills, recovery and maintenance. The four-day didactic psycho-education sessions provides an overview of the physical, psychological and social consequences of an eating disorder. The sessions focus on developing an understanding of the causes and maintenance of eating disorders, alongside exploring motivation to change. The compassionate skills phase, comprises of twice weekly, 2.5 hour sessions, for 4-weeks and involves developing compassionate skills, meal-planning, and identifying goals for recovery. The recovery phase focuses on developing a compassionate understanding of the beliefs and behaviours maintaining the eating disordered behaviors and comprises 12 weekly, 2.5 hour sessions. The final stage of the CFT-E programme involves 3 monthly maintenance sessions.

2.4 Quantitative Research

2.4.1 Research Design

The quantitative research adopted a retrospective design, drawing on archival data collated by an eating disorder service. The independent variable was treatment group and consisted of two levels, commenced treatment and FTE. The commenced treatment group consisted of those who had completed the two CFT-E assessment sessions and then attended at least one psychoeducation session. On the other hand, the FTE consisted of those who completed the two initial CFT-E

assessment sessions and then disengaged from the Eating Disorder Service without attendance any of the group-based treatment sessions irrespective of the reason for non-attendance.

The dependent variables were:

- Eating disorder diagnosis
- Age
- Gender
- Ethnicity
- Clinical Outcome in Routine Evaluation Measure (CORE-OM)
- The Eating Disorder Examination Questionnaire (EDE-Q)
- Internalised Shame Scale (ISS)
- Others as Shamer Scale (OAS)
- Self-Compassion Scale (SCS)
- Functions of Self Criticism Scale (FSCS)
- Forms of Self Criticism Scale/ Attacking and Self-Reassurance Scale (FSCRS)

2.4.2 Inclusion/ Exclusion Criteria

Inclusion Criteria: Included participants were aged between 18-65 years old and had a diagnosed eating disorder including AN, BN or EDNOS. Participant were those who had completed the pre-programme assessment and assessed as suitable for CFT-E, and then either FTE or attended at least one group session.

Exclusion Criteria: Based on the Eating Disorder Services eligibility criteria, individuals with a body mass index of 15 or less kg/m², aged under 18 years, recent history of self-harm; suicidal ideation, planning or intent; illegal drug use; alcohol misuse; diagnosis of psychosis; history of aggressive behavior were excluded. Additionally, individuals who had been referred to the eating disorder service and assessed as unsuitable to commence CFT-E; had been invited to a pre-programme assessment and failed to attend were excluded. Those individuals who had not completed the pre-programme assessment and/ or had incomplete assessment measures were excluded.

2.4.3 Participants

Participants were 1140 patients consecutively referred to an outpatient Eating Disorder Service between April 2002 and January 2013. As outlined in Figure 2, the final quantitative sample comprised 403 patients who had completed the pre-programme assessment and had available pre-programme assessment measure outcomes.

Characteristics of the final quantitative sample are presented in Table 1. The final sample comprised of 285 participants who had commenced treatment and 118 participants who had completed the pre-programme assessment and subsequently FTE in treatment. Participants were predominately white British females and were aged between 18 and 54 years old (commenced treatment $n=285$, mean= 27.65yrs; FTE $n=118$, mean= 27.41yrs). Across both the commenced treatment and FTE groups, participants predominantly met the diagnostic criteria for EDNOS.

Figure 2: Flowchart of the Quantitative Data Sample

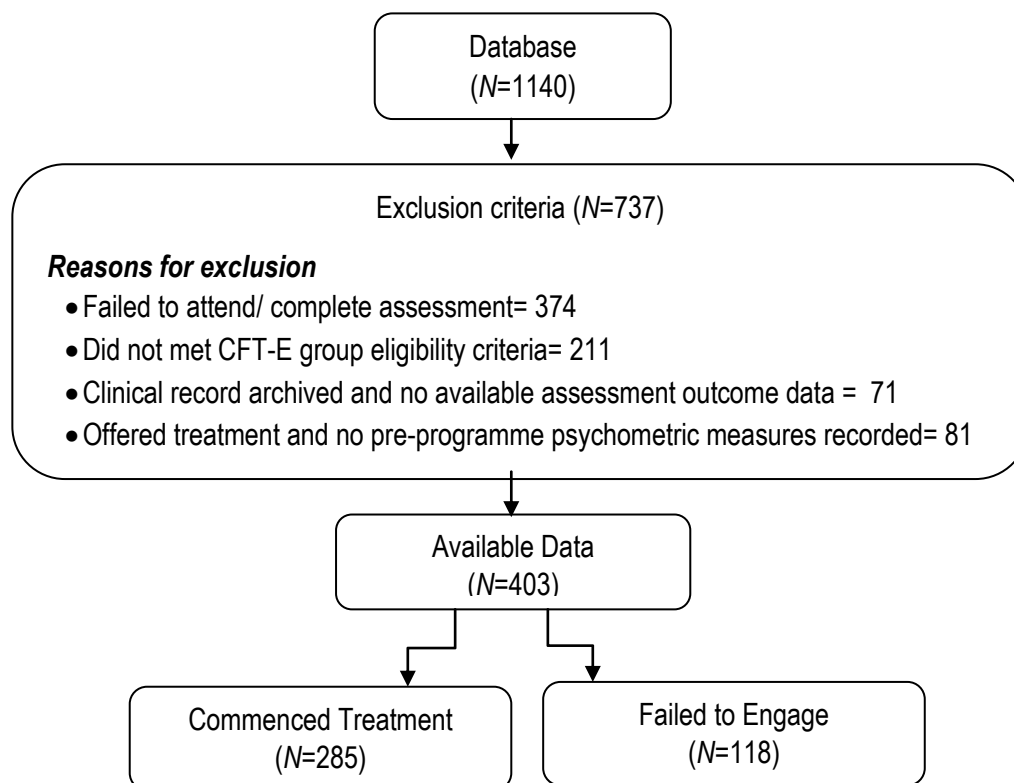


Table 1: Participant Characteristics for the Commenced Treatment and FTE Groups

	Commenced Treatment (N=285)	Failed to Engage (N=118)
Age, M (SD)	27.65 (8.97)	27.41 (9.36)
Female, <i>n</i> (%)	274 (96.1)	111 (94.1)
Male, <i>n</i> (%)	11 (3.9)	7 (5.9)
AN diagnosis, <i>n</i> (%)	41 (14.5)	11 (9.3)
BN diagnosis, <i>n</i> (%)	84 (29.5)	36 (30.5)
EDNOS diagnosis, <i>n</i> (%)	155 (54.4)	67 (58.8)
Diagnosis Unknown	5 (1.6)	4 (3.4)
White British, <i>n</i> (%)	254 (89.1)	103 (87.3)
Black Caribbean, <i>n</i> (%)	1 (0.4)	1 (0.8)
Black Other, <i>n</i> (%)	1 (0.4)	0
Indian, <i>n</i> (%)	10 (3.5)	5 (4.2)
Pakistani, <i>n</i> (%)	4 (1.4)	1 (0.8)
Chinese, <i>n</i> (%)	0	1 (0.8)
Ethnicity Unknown (%)	2 (0.7)	4 (3.4)

2.4.4 Materials and Resources

During the pre-programme assessment, participants completed the self-report measures listed below.

CORE-OM (Evans *et al.*, 2000): The CORE-OM is a 34-item self-report measure assessing psychological distress over the past week. Psychological distress is measured on four subscales; subjective wellbeing, social/life functioning, commonly experienced problems or symptoms and risk to self and others. High scores on the CORE-OM indicate psychological distress. The CORE-OM has demonstrated good internal consistency ($\alpha = 0.75-0.95$; Evans *et al.*, 2002)

EDE-Q (Fairburn & Beglin, 1994): The EDE-Q is a self-report questionnaire version of the Eating Disorder Examination semi-structured interview (Fairburn & Cooper, 1993). The 36 item questionnaire examines the frequency and severity eating disorder psychopathology over the past 28 days. The measure is comprised of a global scale and four subscales including dietary restraint, eating concerns, shape concerns and weight concerns. High scores on the EDE-Q indicate severe eating disorder psychopathology. The EDE-Q has demonstrated high internal consistency ($\alpha = .93$; Mond *et al.*, 2004).

ISS (Cook, 1994, 1996): The ISS is a 30 item self-report questionnaire measuring negative self-evaluation. The scale is comprised of two subscales, the self-esteem and internalised shame subscales. Each item is rated on a five-point Likert scale ranging from never to almost always. Cook (1994) reported that the ISS has high internal consistency ($\alpha = .95$) and reasonable test-retest reliability ($r = .69$).

OAS (Allan, Gilbert & Goss, 1994): The OAS is adapted from Cook's (1993) Internalised Shame Scale. The scale is comprised of 18 items measuring external shame and the frequency with which others judge the self. Each item is rated on a four point scale from never to almost always. Allan *et al.* (1994) reported high internal consistency ($\alpha = .92$).

SCS (Neff, 2003). The SCS is a 26-item self-report questionnaire. The scale contains items measuring the three components of self-compassion defined by Neff (2003) as self-kindness, common humanity and mindfulness. Items are rated on a five-point Likert scale ranging from almost never to almost always. High scores on the SCS indicate greater self-compassion with a range of 26-130. Neff (2003) reported that the SCS demonstrated good internal consistency ($\alpha = .92$) and test-retest reliability ($r = .93$) among a sample of undergraduate students.

FSCS (Gilbert, Clarke, Hempel, Miles & Irons, 2004). The FSCS is a 21-item questionnaire designed to measure the function and reason for self-criticism. The scale contains items assessing two functions of self-criticism; self-persecution and self-correction to motivate improvement. The items are rated on a five point scale from 'not at all like me' to 'extremely like me'. Gilbert *et al.* (2004) reported a Cronbach alpha of .92.

FSCRS (Gilbert, Clark, Hempel, Miles & Irons, 2004). The FSCRS Scale is a 22-item scale designed to measure self-criticism and the ability to reassure oneself. The measure comprises of three sub-scales. Two self-criticalness subscales measure the inadequate self and hated self, and the other subscale measures self-reassurance. The items are rated on a five point scale. Gilbert *et al.* (2004) noted a Cronbach alpha of 0.90 for inadequate self and 0.86 for hated self and self-reassurance subscales.

2.4.5 Procedure

All referrals between April 2002 and January 2013 were initially screened against the service's eligibility criteria. Eligible participants were invited to attend two assessment sessions with a clinician

working in the eating disorder service. During the assessment, participants completed a clinical interview and self-report measures. Data was collated by the clinicians to monitor patient's progress and for clinical audit. The researcher was provided with anonymized assessment data.

2.4.6 Data Analysis

Data analysis was completed using SPSS Version 20. Preliminary data screening and normality testing was completed, and categorical variables with limited data collapsed. Descriptive statistics across the demographic and self-report measures were reported. Chi-squared tests of independence and independent samples t-tests were used to investigate whether the treatment groups differed significantly across the independent variables. Logistic regression analysis were used to establish whether the dependent variables predicted treatment non-completion. Separate logistic regression analyses were completed to establish the predictive significance of the demographic variables and self-report measures.

2.4.7 Power Analysis

An *a priori* power analysis was conducted. G* Power 3.1 indicated that the independent sample t-test analysis would need a sample size of 51 to achieve a medium effect size, 0.80 power and a significance value of 0.05.

As outlined above, logistics regression analyses were used to explore whether demographic variables and self-report measures predicted FTE in treatment. The logistic regression for the demographic variables included the largest number of dependent variables and as such, the power analysis was based on the regression for the 8 variables. According to the Peduzzi, *et al.* (1996) equation, a sample size of 80 participants would be needed for both the commenced and FTE groups.

2.5 Qualitative Research

2.5.1 Research Design

Focus groups were used to explore participants' experiences of CFT-E treatment. In contrast to interviews, it has been suggested that focus groups facilitate the exploration of critical comments and provide a valuable methodological approach for service related research (Watts & Ebbutt, 1987; Kitzinger, 1995). The focus group approach aimed to facilitate discussion related to treatment obstacles and patient negative treatment experiences. To promote discussion and interaction among participants (Morgan, 1998; Stewart & Shamdasari, 1990), each focus group consisted of individuals

previously acquainted and shared the common experience of completing the same CFT-E programme.

2.5.3 Epistemological Position

The researcher's epistemological position is outlined in Appendix J.

2.5.2 Recruitment

A purposive sample was identified by the eating disorder service clinicians. Clinicians initially discussed the research with potential participants. Individuals who expressed an interest to participate and met the inclusion criteria were invited to attend an information session with the researcher. The session outlined the aims of the research and what participation would involve. Participants were informed that participation was voluntary and the treatment received would not be affected by the decision to participate or withdraw from the research. Participants reviewed the information sheet and consent form, and were given a week to decide if they wished to participate. Participants were then invited to attend a focus group held at the eating disorder service.

2.5.3 Inclusion/ Exclusion Criteria

Inclusions Criteria: Included participants were aged between 18-65 years old and had a diagnosed eating disorder including AN, BN or EDNOS. Participants were those who had been assessed as eligible for the CFT-E programme and had completed the final group session.

Exclusion Criteria: Participants were excluded according to the eating disorder service eligibility criteria (see Section 2.3.2). Participants whose first language was not English were excluded. The researcher recognized the importance of research exploring whether cultural issues could be associated with treatment non-completion however, the use of interpreters in focus groups can be a complex and problematic issue and was outside the scope of the current research.

2.5.4 Participants

Ten participants were recruited, nine females and one male. The mean age of the sample was 26.2 years (range 19-54 years). One participant was diagnosed with AN, 4 BN and 5 EDNOS. Ethnic background included white British ($n=5$), other white background ($n=2$), mixed white and Caribbean ($n=1$) and did not specify ($n=2$). Two participants had previously undertaken CFT-E, one had completed treatment and the other withdrawn prior to completion.

2.5.5 Materials and Resources

The research materials are included in Appendix K-N, including the participant information sheet and consent form.

The researcher devised a semi-structured interview schedule (Appendix O) alongside the Head of the Eating Disorder Service and Research Supervisor. The interview schedule explored thematic areas including programme content, and engagement and completion. However, the schedule remained flexible and evolved throughout the data collection process to incorporate interesting and novel themes that emerged from the focus groups.

2.5.6 Procedure

Prior to each focus group, the researcher met participants to review the information sheet, answer any questions, and obtain written informed consent. The researcher facilitated the focus group using a semi-structured interview schedule and open-ended questions to prompt interesting and important areas. Three focus groups were completed and involved 2-5 participants. Each focus group was audio recorded. Following the focus group, the researcher completed a debrief to establish whether participants had experienced any distress. The focus group interviews were translated verbatim by the researcher and anonymised.

2.5.7 Analysis

Thematic analysis (TA; Braun & Clarke, 2006) was used to analyse the focus group transcripts. TA seeks to identify salient themes across the entire data set and capture a rich description of participant's experiences. Few studies have used qualitative methods to explore barriers to the completion of eating disorder treatment and as such, an inductive approach was used to identify diverse themes related to the research question rather than pre-existing coding frames or theoretical area of interest (Braun & Clarke, 2006). Appendix P provides an outline of the TA analysis process and Appendix Q and R presents example of coding and identifying the themes within the focus group transcripts.

2.5.8 Quality Issues

Given the diversity of qualitative approaches, assessing reliability and validity presents a challenge for qualitative research (Yardley *et al.*, 2000). The coherence, credibility, and transparency (Elliot *et al.*, 1999; Yardley, 2000) of the current research was safeguarded by implementing the following quality assurance checks.

The researcher attended a teaching session and a peer supervision group to develop competencies in interviewing and TA. Rigor, the thoroughness of data collection and analysis, was supported through discussions with the Research Supervisor and peer support group. Considering alternative perspectives allowed the researcher to reflect on their closeness to the data and challenge the bias/assumptions made during the data analysis process (Shenton, 2004; Patton, 1994). This was further supported by maintaining a reflective diary that allowed the researcher to reflect on the process of data analysis and identification of the key themes embedded within the interview transcripts.

The sampling trustworthiness was safeguarded by employing a purposeful and criterion-based sampling procedure (Marrow, 2005). The purposeful sample consisted of individuals who could offer a rich insight into the research question. In addition, the sample was criterion-based and specifically consisted of those who had completed the CFT-E programme and could offer an insight into their experiences of the facilitators and barriers to treatment completion. Potential participants were informed that involvement in the research was voluntary and could refuse to participate, ensuring that the focus groups involved those who were prepared to openly reflect on their experiences (Shenton, 2004). The aim of the focus groups, confidentiality and the independent role of the researcher was clearly outlined in the Information Sheet (Appendix L) and introduction to the focus group sessions, encouraging participants to provide a rich, in depth account into their experiences of the CFT-E programme (Shenton, 2004).

Reflexivity, the role of the researcher's biases, values and experiences in collection and interpretation of the qualitative data (Robson, 2002) is an important consideration for the transparency and validity of qualitative research. The following quality checks were employed to support the researcher to reflect on their role in decision making and the interpretation of the focus group interviews. The researcher kept a reflective diary and reviewed the data interpretation with the Research Supervisor. An audit trail detailing the process of data analysis and coding the interview transcripts was maintained (Robson, 2002). Additionally, the researcher completed a focus group debrief to facilitate reflections, note any observations and attended regular debrief sessions with the Research/Field Supervisor (Shenton, 2004).

3 Results

3.1 Quantitative Analysis

3.1.1 Reliability of the Scales

Table 2 presents the Cronbach's alpha measure of internal reliability for the psychometric measures. As outlined by DeVellis (2002) a coefficient of 0.7 was used as the criterion for adequate internal consistency. The measures demonstrated adequate internal reliability.

Table 2: Internal Reliability of the Self Report measures

	Cronbach Alpha
CORE	.959
EDE-Q	.899
ISS	.893
OAS	.948
SCS	.948
FSCS	.920
FSCRS	.701

3.1.1 Missing Data

Inspection of the dataset indicated substantial missing data for the SCS, FSCS and FSCRS measures and as such, the measures were not included in the logistic regression analysis to avoid missing data impacting on the sample size. Across the CORE, EDE, OAS and ISS 22 questionnaires had randomly incomplete data items. Given that more than 20% of the values were missing the questionnaires were excluded rather than the data replaced. Cases with missing data were excluded for specific analyses (cases excluded pairwise).

3.1.2 Outliers and Normality

Inspection of the Boxplots indicated several outliers that were examined to establish whether the data had been entered correctly. Since the outliers were within the clinical range for the specific measure and the 5% Trimmed Mean (Appendix S) indicated that the values had only a modest influence on the mean, the values were not removed (Pallant, 2007).

The data was assessed for normality, one of the key assumptions for parametric tests (Pallant, 2010). The Kolmogorov-Smirnov test, Histograms, Kurtosis and Skewness, Normal Q-Q Plot and Detrended Normal Q-Q plots, and 5% Trimmed Means were examined and indicated that the assumption of normality had been violated for several of the subscale measures. Kurtosis and skewness were examined and values ranging between above -1 and below +1 (Dancey & Reidy, 2003) indicated that some of the subscale data was both skewed and kurtotic. The subscales that did not meet the normality, and kurtosis and skewness assumptions were age, CORE risk, EDE shape concern, FSCS self-persecution and FSCRS inadequate self/ hated self. Attempts to transform the positively skewed CORE risk subscale and age involved 'logarithm transformations', and the negatively skewed EDE shape concerns, FSCS self-persecution, FSCRS inadequate self/ hated self subscales 'reflect and logarithm' (Appendix T). The transformations did not notably improve the distribution of the data. Therefore, given the relatively large sample size original values rather than the transformed data were used for the parametric tests (Elliott, 2007, Clark-Carter, 2009).

3.1.3 Demographics and Preliminary Analysis

Participant characteristics are shown in Tables 3 and 4. The mean ages were similar across the commenced treatment ($M= 27.65$ yrs, $SD= 8.97$) and FTE ($M= 27.41$ yrs, $SD= 9.36$) groups, and an independent samples t-test revealed no significant difference between the group ($t(368) = .459$, $p>.05$)

The sample was predominately white British (commenced treatment= 89.1%; FTE= 87.1%) and female (commenced treatment= 96.1%; FTE= 94.1%). EDNOs was the most frequently reported diagnosis across the treatment groups (commenced treatment= 54.4%; FTE= 58.8%).

A chi-squared analysis of independence was used to establish whether there was a significant association between ethnicity, gender and diagnosis and treatment group. A key assumption of chi-squared analysis is that the lowest expected cell frequency should be 5 or greater or at least 80% of the cells should have a minimum expected frequency of 5 (Pallant, 2010) and as such, the ethnicity categories were collapsed. As outlined in Table 3, the chi-squared analysis revealed no significant associations between treatment group and gender ($X^2(1, N= 370)= .57$, $p>.05$), ethnicity ($X^2(2, N= 380)= .04$, $p>.05$) and diagnosis ($X^2(2, N= 394)= 1.76$, $p>.05$)

Table 3: Frequencies and Chi-Squared Analysis across Gender, Ethnicity and Diagnosis

		Commenced Treatment		FTE		Chi-Squared		
		<i>N</i>	%	<i>N</i>	%	<i>N</i>	<i>X</i> ²	<i>p</i>
Gender	Male	11	3.9	7	5.9	370	.491	.571
	Female	274	96.1	111	94.1			
Ethnicity	Black/ Black British	2	.7	1	.8	380	.040	.980
	Asian/ Asian British	14	4.9	6	5.1			
	White	254	89.1	103	87.3			
	Other	15	5.3	8	6.8			
Diagnosis	AN	41	14.5	11	9.3	394	1.765	.414
	BN	84	29.5	36	30.5			
	EDNOS	155	54.4	67	56.8			
	Not Known	5	1.8	4	3.4			

Table 4 presents the mean scores and standard deviations across the self-report measures. The CORE subscale mean scores indicated that the commenced treatment and FTE groups experienced clinical levels of psychological distress. The CORE risk subscale scores were within the non-clinical range, however the eating disorder service exclude those with current risk to self/ others and the mean scores reflect the service exclusion criteria. The EDE-Q subscales scores for the commenced treatment and FTE groups were above the clinical range for BN and AN, indicating clinical levels of eating disorder psychopathology. The mean scores for the CORE and EDE-Q were comparable to other clinical samples of eating disordered patients (Gale *et al.*, 2014)

The ISS shame subscale mean scores for the commenced treatment and FTE groups were above the clinical cut off of 50 (Cook, 1994), indicating that both groups experienced clinically problematic levels of internalised shame and painful feelings of inferiority, worthless and inadequacy. The ISS self-esteem subscale mean scores for both groups were below the clinical cut off of 12 (Cook, 1994), indicating low or negative self-esteem. For the OAS scores above 36 indicate problematic levels of externalised shame and a vulnerability to feeling negatively evaluated by others, however both the commenced and FTE did not report clinically problematic levels.

Table 4: Mean, Standard Deviations and T-Tests across the Self-Report Measures and Age

	Commenced Treatment			FTE			T-Test	
	Mean	N	SD	Mean	N	SD	<i>t value</i>	<i>p</i>
Age	27.65	285	8.97	27.41	118	9.36	.46	.65
CORE Wellbeing	2.49	285	.89	2.55	118	.88	-.69	.49
CORE Problem	2.11	285	.83	2.18	118	.92	-.74	.46
CORE Functioning	1.81	285	1.89	1.89	118	.811	-.96	.34
CORE Risk	.55	285	.67	.69	117	.81	-1.93	.05
CORE Global Score	1.77	285	.70	1.86	118	.76	-1.15	.25
EDE-Q Restraint	3.82	284	1.64	4.11	118	1.71	-1.87	.06
EDE-Q Eating Concern	3.61	285	1.38	3.52	117	1.52	.53	.59
EDE-Q Shape Concern	4.74	285	1.33	4.77	118	1.36	-.55	.58
EDE-Q Weight Concern	4.34	285	1.39	4.41	116	1.42	-.83	.41
Total OAS	32.28	279	17.01	33.33	111	17.08	-.10	.92
ISS Self-Esteem	8.50	282	4.47	9.01	114	4.66	-1.02	.31
ISS Shame	57.73	284	21.94	59.03	116	22.60	-.97	.33
Total SCS	57.19	126	16.97	57.34	50	15.57	.13	.89
FSCS Self-Correction	22.28	161	8.61	12.83	57	9.26	-.69	.49
FSCS Self-Persecution	13.77	161	8.61	12.83	57	9.27	.31	.76
FSCRS Self-Criticalness	25.41	163	8.27	25.21	60	6.70	-.09	.92
FSCRS Self-Reassurance	9.86	161	6.05	10.35	60	7.68	-.57	.57
FSCRS Inadequate Self/	10.07	163	5.65	10.38	60	5.70	-.57	.56

The mean OAS score suggested that both groups experienced high levels of externalised shame. Both groups reported externalised shame below the clinical range, however the mean scores were comparable to other clinical samples of eating disordered patients (Ferreira *et al.*, 2013)

The commenced treatment and FTE groups reported higher means scores on the SCS scale indicating greater levels of self-compassion towards themselves during difficult experiences. In contrast to a previous studies by Ferreira *et al.* (2013), the mean SCS score was higher than the non-clinical sample (M= 40.51; SD= 7.46) and eating disorders sample (M=30.31; SD= 8.78).

In terms of the FSCRS, both treatment groups reported high levels of inadequate self and feelings of inferiority and being flawed compared to the mean scores for the inadequate-self/ hated-self and the self-reassurance subscales. The means for the FSCRS subscales were comparable to other clinical populations (Baiao *et al.*, 2015). Both treatment groups reported comparable scores on the FSCS self-persecution subscale. However, those who commenced treatment reported higher levels of self-criticalness compared to the FTE group.

3.1.4 Independent Sample T-Test: Analysis of Significant Difference between the Commenced Treatment and FTE Groups for the Self-Report Measures

Independent samples t-tests were used to establish whether the commenced treatment and FTE differed significantly across the self-report measures. Given the number of planned comparisons between the groups, a Bonferroni adjustment to the alpha level was applied. The alpha level of 0.003 was used. The independent samples t-tests revealed there were no significant differences between the commenced treatment and FTE across the self-report measures (Table 4).

3.1.5 Logistic Regression

Logistic regression analysis was used to determine whether the dependent variables predicted FTE in the CFE-E programme. Prior to data analysis, preliminary assumption test were conducted to establish sample size, multicollinearity and outliers were met.

3.1.5.1 Logistic Regression Assumptions

Pallant (2010) indicates that the logistic regression analysis may be affected by a small number of cases for categorical variables. As noted above, the ethnicity categories were collapsed. Furthermore, the diagnosis unknown and ethnicity unknown/ ethnicity other categories were not included as the variables would not provide any insight into patient characteristics distinguishing those more likely to fail to engage in treatment.

Logistic regression analysis assumes that the relationship between the dependent variables is not highly correlated and as such, the CORE subscales were excluded as the measure demonstrated significant multicollinearity. Outliers were examined by inspecting the Mahalanobis distances, revealing that three cases exceeded the critical values. However, since the scores were slightly outside the critical value they were retained within the data set (Pallant, 2007).

3.1.5.2 Logistic Regression: Demographic and Psychometric Variables

The current exploratory research aimed to establish predictors of FTE in CFT-E. A logistic regression was performed to establish the predictive significance of the demographic variables. The model was not significant $X^2(6, N=370) = .82, p > .05$ and indicated that the demographic variables did not predict FTE in treatment.

A further logistic regression analysis was conducted to explore the predictive significance of the self-report measures including the EDE-Q, OAS, and ISS. The model was significant $X^2(7, N=370) = 16.04, p < 0.05$ and indicated that the model was able to distinguish between those who commenced treatment and FTE. The Hosmer and Lemeshow test indicated a significant goodness-of-fit between the predicted and observed data $\chi^2(8, n=370) = 10.15, p > .05$, indicating that the model was able to distinguish between treatment commenced and FTE. The model explained between 4.4% (Cox and Snell R^2) and 6.4% (Nagelkerke R^2) of the variance in programme engagement. As shown in Table 5, the ISS shame (Wald $\chi^2(1) = 5.99, p < .05$), EDE-Q restraint (Wald $\chi^2(1) = 6.13, p < .05$), EDE-Q eating concerns subscales (Wald $\chi^2(1) = 4.74, p < .05$) significantly contributed to the predictive ability of the model and ISS self-esteem subscale approached significance. The odds ratio indicated that an increase in the EDE-restraint (odds ratio 1.30; 95% CI 1.06-1.60) and ISS shame (odds ratio 1.03; 95% CI 1.000-1.144) subscales increased the likelihood of FTE. In contrast, the odds ratio for the EDE-Q eating concerns subscale (odds ratio .74; 95% CI .58-.97) indicated that increased eating concern increased the likelihood of commencing treatment.

Table 5: Logistic Regression Analysis of Self Report Measures that Predict of FTE in CFT-E

	B	S.E	Wald	df	p	Odds	95.0% C.I for	
							Lower	Upper
EDE-Q Restraint	.26	.11	6.13	1	.01	1.30	1.06	1.60
EDE-Q Eating	-.30	.14	4.74	1	.03	.74	.58	.97
ÊDE-Q Shape	.05	.19	.06	1	.80	1.05	.73	1.51
ÊDE-Q Weight	.02	.18	.01	1	.93	1.02	.71	1.46
ÊTotal OAS	-.02	0.1	2.75	1	.09	.98	.96	1.00
ISS Self-Esteem	.07	.03	3.83	1	.05	1.07	1.00	1.14
ISS Shame	.03	.01	5.99	1	.01	1.07	1.00	1.05

3.2: Qualitative Results

The thematic analysis focused on identifying themes related to participant's experiences of barriers and facilitators to treatment engagement. Table 6 summarises the main themes and Figures 3 and 4 present thematic maps outlining interactions between the main themes and subthemes.

3.2.1 Treatment Barriers Themes and Subthemes

As detailed in Table 6, four themes and eight subthemes were identified that summarised participant's experiences of CFT-E and barriers to treatment engagement.

3.2.1.1 Demands of Treatment

The theme summarised the challenges of managing the demands of treatment alongside other personal commitments. Participants experienced conflict between the importance of treatment and at the same time, difficulties accepting that they would not be able to achieve the same self-imposed high standards in their other roles and responsibilities while engaged in treatment. Participants felt overwhelmed by the demands of treatment and resented how focusing their time and resources on recovery had impacted on others. As such, some participants expressed concern that their competency and commitment to their other roles and responsibilities would be negatively viewed by others.

Table 6: Summary of Thematic Themes

	Theme	Subthemes
Treatment Barriers	Demands of treatment	Competing commitments: Spinning too many plates Life on hold: Recovery dominating the day-to-day
	Difficulties exploring an eating disorder	Emotional Distress: Storm before the calm Expectations about being open with others
	Comparison to other patients	Comparing shape, weight and eating disordered behaviours Comparing treatment progress with others
	Transition from an eating disorder to recovery	Ambivalence about leaving an eating disorder behind Putting CFT-E into practice
Treatment Facilitators	Positive experiences of therapists	Collaborative therapeutic relationship: Not us and them Therapist skills and qualities Treatment focused towards the individual not the eating disorder
	Being in a supportive group	Understanding what others don't: Everyone in the same boat Safe place to explore shameful and difficult experiences
	Compassionate understanding of an eating disorder	Compassionate skills to manage emotional distress Formulation clearly linked to the CFT-E treatment approach
	Support beyond treatment	External support Support to use compassionate skills

Figure 3: Thematic Map of the Treatment Facilitators Themes and Subthemes

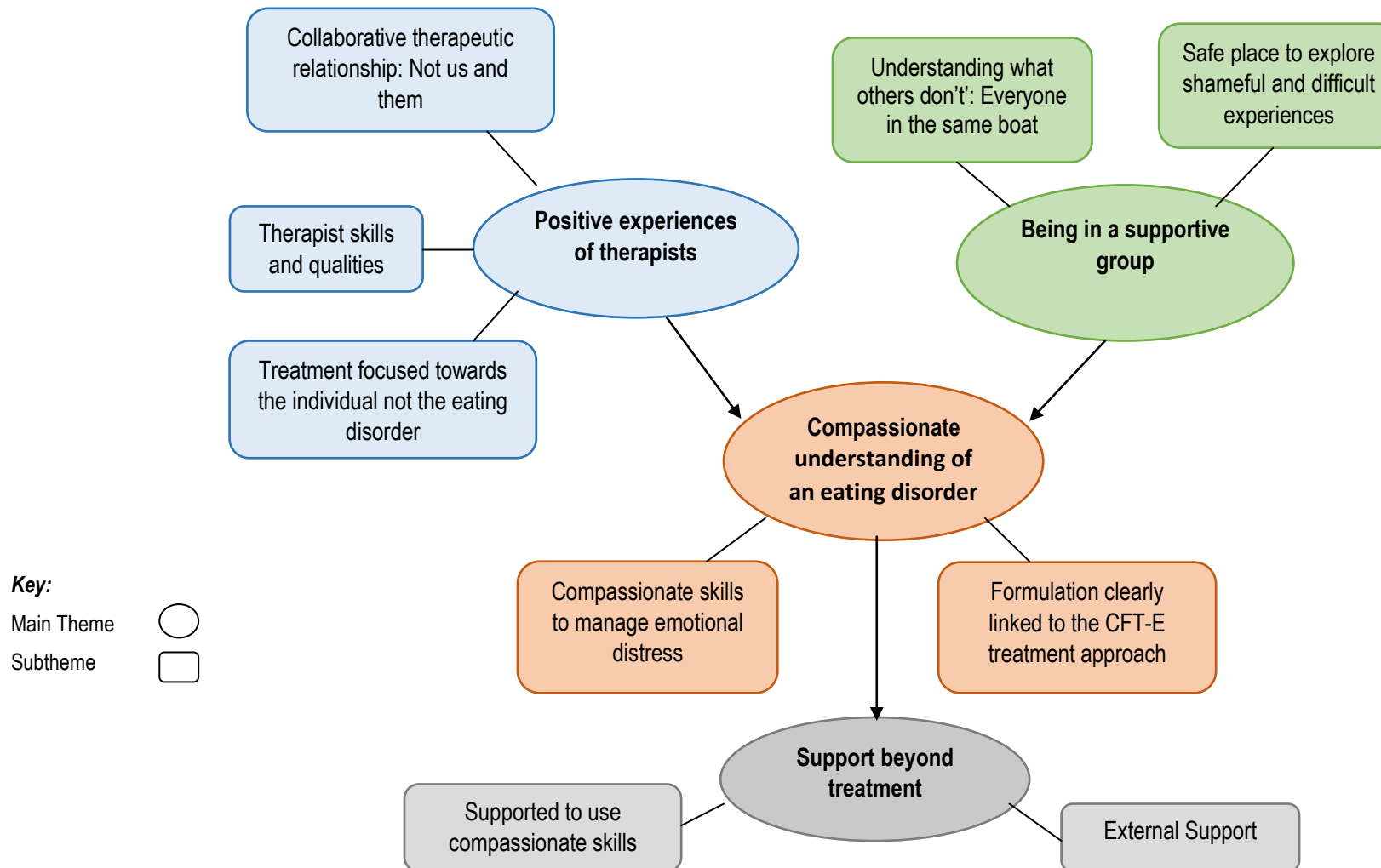
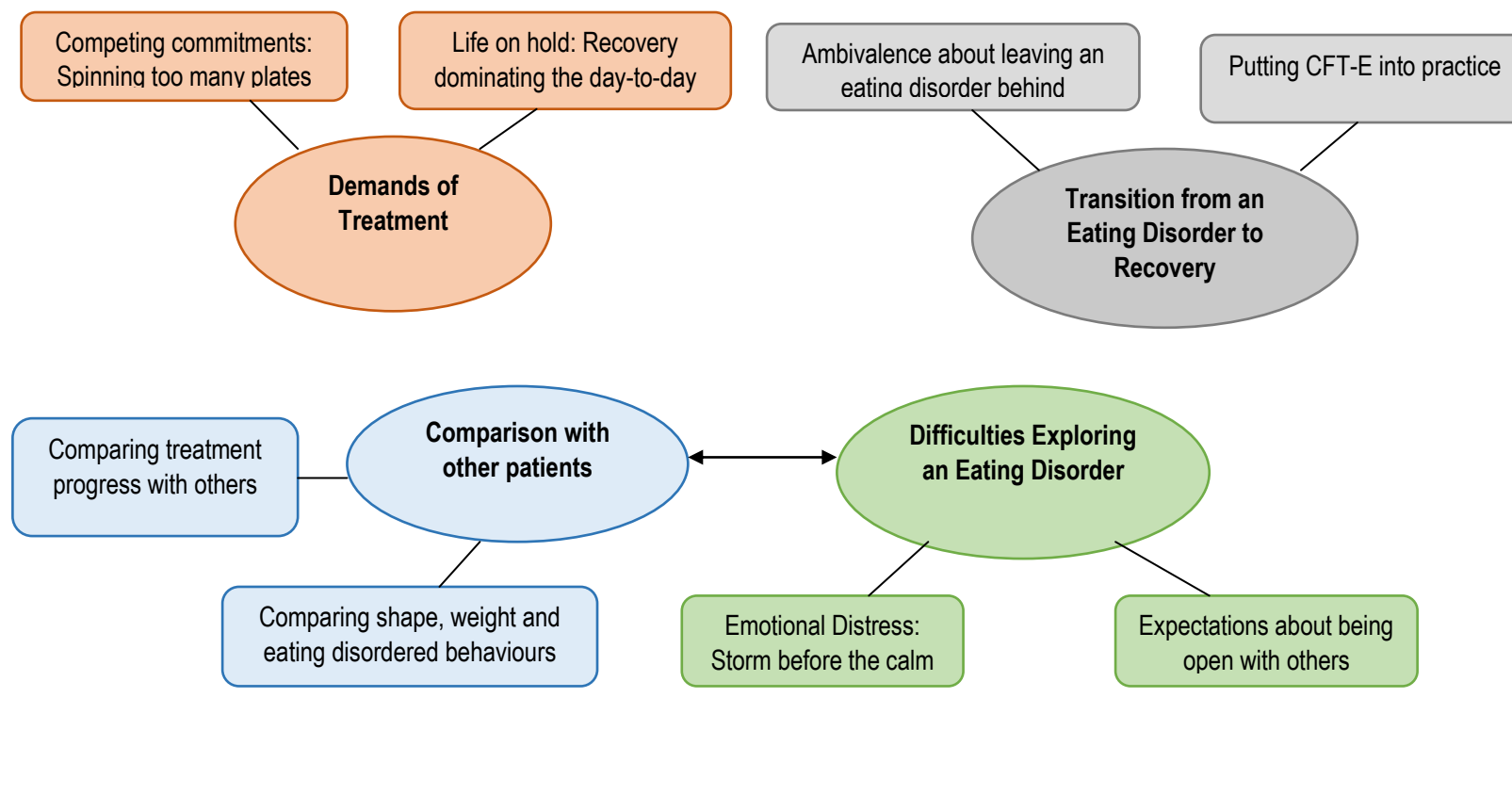


Figure 4: Thematic Map of the Treatment Barrier Themes and Subthemes



Participants' often felt every aspect of their lives had been engulfed by the treatment expectations of how recovery should be integrated into the day-to-day. The control of an eating disorder had been replaced by the demands of recovery, and one participant explained that they felt *'in a siege'* (5) and treatment had *'created a monster'* (5).

'I got very angry because I got the impression that [therapists] just literally wanted us to abandon all other aspects of our lives to just focus on therapy.....we don't want eating to rule our lives anymore, so why should I give up literally every other aspect of my life'. (5)

Eating disordered behaviours had previously provided control, and some participants described struggling with the perceived loss of control over their decisions and routines. Treatment was considered an important step towards recovery, however participants felt isolated, lonely and *'ostracised'* (2) that *'life couldn't happen'* (3).

Several participants described the challenge of reintroducing mealtimes into daily routines, and the expectation to consume six meals a day was *'awkward'* (2) and *'confining'* (2). Even though participants recognised the reasons for addressing their eating disordered behaviours, the demand of planning mealtimes was *'daunting'* (10).

3.2.1.2 Difficulties Exploring an Eating Disorder

The theme summarised difficulties linked to the experience of exploring *'secret(ive)'* (9) and *'shameful'* (9) eating disordered behaviours with others. Participants expectations of treatment were preoccupied by anxieties about personal disclosure and the assumption that they would be *'judge(d)'* (6) by others. Consequently, fears related to building trusting relationships and exploring difficult experiences with others were described as important obstacles to treatment engagement.

Several participants discussed feeling overwhelmed by the *'constant emotional whirlwind'* (2) experienced during treatment. Difficult emotions would have previously been avoided or masked by eating disordered behaviours, however the process of treatment had left them feeling overwhelmed and vulnerable. Anticipating the emotional distress related to exploring difficult experiences had caused some to feel apprehensive about attending treatment.

The emotional distress experienced by two participants had felt so intense and overwhelming they became preoccupied by suicidal ideation. One participant described being *'so unsure'* (3) of

themselves, at times they felt unable to cope with the emotional distress created by reflecting on their eating disordered behaviours.

'Just every week I just didn't want to come....every week I would come to group it just brought up so many painful things and I was just so unsure of myself....I became suicidal basically....knowing that I would go home and have had everything stirred up but not had a focus or an outlet or a way to deal with it that was just the worst thing so there were' (3)

3.2.1.3 Comparing Self to Other Group Members

The theme summarised the anxieties linked to participant's negative self-evaluation and being overly concerned about others expectations of their weight, shape and eating disordered behaviours. Having not previously attended treatment with eating disordered patients, several participants described feeling anxious about involvement in a specialist group-based treatment and comparing themselves to others with an eating disorders.

'I had never been in a position where there would be other people who were ill and umm, has always just me or a Doctor, or me and a Nurse who weren't ill umm, so I was really sort of apprehensive about that....you're going to be the fattest one there and I arrived thinking, yeah I just want to hide everything' (3)

One participant indicated that the comparison with others had led them to question whether their eating disordered behaviours were problematic and their suitability to access an intensive treatment programme.

'I mean the first time I came here I was like I felt so fat in comparison to everyone else and I was like I'm not supposed to be here because I'm too fat, I'm not, I don't have a problem' (5)

Additionally, one participant described the shame of binge eating and expressed concerns that 'stuffing myself with food' (3) would be negatively viewed compared to others eating disordered behaviours.

Some participants suggested that comparing their treatment progress with others had created an obstacle to treatment engagement. In particular, weight targets and meal plans had provided a benchmark for comparison and difficulties achieving the same treatment goals had led to self-critical evaluation of being a 'failure' (10).

'I felt a bit overwhelmed with it and as the weeks went on they were trying to increase (the meal plan)....I wasn't like kind of keeping up.....and as much as I enjoy seeing everyone getting on well, I felt a bit of a failure because I was still stuck on the first one' (10)

One participant highlighted the difficulties of comparing their meal plan targets and increasing concern that they were eating more than other group members.

'Then it moved up the meal plan, and I was like 'ow now that means I'm eating more than everyone else' and I felt really bad about that... I don't want to be up higher than everybody else' (9)

3.2.1.4 Transition from Eating Disorder to Recovery

Ambivalence associated with leaving an eating disorder behind and taking steps towards recovery had caused some participants to question their reasons for engaging in treatment. One participant expressed concerns that recovery meant losing an important '*friend*' (3). Even though participants clearly recognised the negative consequences and missed opportunities associated with their eating disorder, the loss of a functional way to control and manage emotional distress created tension surrounding treatment engagement.

'Really, really sad because weird as it sounds it had been a sort of friend, like it was sort of always there and you could blot out so many painful thoughts... ensuring certain factors in my life remained constant' (3)

'Letting go of my hope of being super skinny is very much like mourning, like I feel someone has died, like going through the wardrobe and getting the clothes that you used to fit into its like someone has died' (5)

Some participants described how their identities had been constructed around an eating disorder and the ambivalence surrounding recovery was related to the anxieties about accepting a new self. Difficulties accepting a new physical appearance and body image issues were highlighted as an unmet treatment need and participants expressed fears about exploring a new way to relate to their body.

'I don't want to feel I have lost a big part of me that I, there is nothing else beyond my ability to restrict for example... (it) was a big, big chunk of my identity and every week I was kind of afraid that it would be taken away from me' (2)

The shift from understanding the causes of an eating disorder and exploring compassionate skills to taking steps towards recovery had been a demanding treatment juncture. Participants described feeling apprehensive about the challenges of the recovery phrase and no longer having the security of their eating disordered behaviours to cope with difficulties.

'We started to focus on having to make a change rather than turning up each day.....I was still coping in a way that I knew how to cope' (10)

In particular, participants' described the challenging transition from exploring the reasons for change to meal planning and gaining weight. Weighing scales had often been avoided and consequently, anxieties about being weighed and others seeing their weight gain was highlighted as an important treatment obstacle.

'The first time I got weighed umm, I shouted at [therapist name], I was heartbroken because I hadn't weighed myself in years and that was horrible for me as well getting on the weighing scales' (4)

'The biggest issue for me is getting on the scales and knowing that I'm going to define myself by what I see' (3)

3.2.2 Treatment Facilitators Themes and Subthemes

As detailed in Table 4, four themes and nine subthemes were identified that summarised participants experiences of support to overcome barriers to treatment engagement.

3.2.2.1 Positive Experiences of Therapists

The theme summarised the core therapist's skills and qualities that had supported participants' to overcome barriers to treatment engagement. Rather than '*us and them*' (9), therapists willingness to actively engage in skills practice and share their reflections had fostered a collaborative therapeutic approach. Building a collaborative therapeutic alliance had led to participants feeling comfortable and confident to approach therapists when they experienced difficulties and may have considered leaving treatment.

'I did struggle during the group with other things...[therapist name] always offered the opportunity to speak to them...and talk individually about things and that offered support, helped me to kind of comeback' (6)

Professional knowledge and understanding of specific eating disorder issues were also highlighted as a key feature of the therapeutic relationship. The professional knowledge demonstrated by therapists was 'reassuring' (2) and had created a safe space to explore emotionally distressing experiences.

'They somehow managed to get this magical string and piece things together..... it was really helpful for them to say things that joined my completely disordered thoughts that were here, there and there and bring it all together' (2)

The importance of the compassion experienced from therapists was articulated throughout participant's accounts of overcoming difficult treatment junctures. Therapists had provided a space to explore the challenges of implementing the CFT-E skills, validating and supporting participants to recognise the positive steps they had taken towards recovery rather than focusing on setbacks and reinforcing self-critical narratives. Therapists were experienced as non-judgemental, 'understand(ing)' (10) and 'supportive' (10).

'We've all had our little blips....but it's not been made a huge issue of, it's not like 'ow my God, what have you done', it's just like 'let's figure out why and lets move forward' (10)

Participants highlighted the value of therapists recognising the difficulties and problems specific to the group rather than rigidly delivering the CFT-E framework. Therapists had been flexible in tailoring the programme to reflect idiosyncratic experiences of an eating disorder and difficulties implementing the CFT-E skills. Participants felt their experiences had been validated and in turn, this had fostered a sense of trust and safeness in the therapeutic process. Additionally, recognising the individual and allowing space to explore personal difficulties outside of treatment that could have impacted on engagement had demonstrated the therapist's compassion beyond treatment.

'I was having problems at home and I was finding it difficult, I couldn't focus on anything at the time....rather than talking in a whole group, talking to them individually it helped' (6)

3.2.2.2 Being in a Supportive Group

The importance placed on being in a supportive group was articulated throughout the accounts of overcoming barriers to treatment engagement. Participant's highlighted concerns about being a 'burden' (9) and how the lack of understanding surrounding eating disorders had been a barrier to approaching others for support. In contrast, CFT-E had provided a forum to explore difficult

experiences with others who *'were in the same boat'* (6) and compassionately explore eating disordered behaviours.

'All our friends because they haven't got what we have they don't have a clue, they just judge kind of thing,,,,,because we all kind of have the same thing in common we all understand each other' (2)

'I deserve to feel good about myself and this is probably one of the best places for me to do that, in an environment that I feel safe and be able to talk about how I really feel rather than keep it bottled up' (8)

The *'respect'* (2) and *'understand(ing)'* (2) demonstrated by the other group members had created emotional safety to explore shameful experiences and develop a compassionate understanding of an eating disorder. Being in a supportive group was experienced as *'not judge(ing)'* (8) and *'feeling safe'* (10), supporting participants to invest in the therapeutic process and explore any barriers to treatment engagement. During difficult points in treatment, being in a mutually supportive group had encouraged participants to overcome any obstacles because *'(we are) all sort of there for each other'* (10).

3.2.2.3 Compassionate Understanding of an Eating Disorder

The theme summarised how developing a compassionate understanding of an eating disorder had supported participants to overcome difficulties encountered in the therapeutic process. Participants described the emotional distress emerging from exploring past experiences. However, developing a compassionate understanding of an eating disorder and the ability to use the soothing system to regulate threat and drive had allowed participants to move beyond the shame and self-criticism related to their eating disorder. The compassionate approach had created a safe space to develop an idiosyncratic formulation and engage in the therapeutic process rather than avoiding the emotional distress associated with their difficult past experiences

'When you struggle instead of pushing yourself and pushing, pushing to acknowledge its hard and its ok for it to be hard....before it would be like 'you're a failure, you're weak, you have to be strong' (5)

Central to developing a compassionate understanding of an eating disorder was the importance of introducing the CFT-E model in an accessible way and specifying how it related to the individualised

formulations. One participant explained that they had initially found the CFT-E model and compassionate skills ‘ridiculous’ (2) and ‘childish’ (2). However clearly linking the rationale for the model to the individualised formulations supported participants to understand the reasons for their eating disorder and complete the often challenging skills practices.

3.2.2.4 Support beyond Treatment

Participants frequently reported that the support from their family, friends and professional had played an important role in overcoming barriers to treatment engagement. Understanding the impact their eating disorder had on significant others enabled them to remain focused on change and the importance, even though very difficult at times, of remaining in treatment and taking steps towards recovery.

‘I am mostly doing this for myself but also for the ones I love as well, for those who care about me because I wouldn’t want to let them down by not persevering through’ (2)

Participants described the difficulties implementing CFT-E beyond therapy, however having developed a compassionate understanding of their eating disorder they felt more confident to approach others for support.

‘Having to eat 6 times a dayI was not doing it and I felt myself slowly slipping back and it was worrying me, but they [employers] were really supportive’ (10)

At times, participants described feeling overwhelmed by expectations of recovery. However, participants acknowledged that recovery would continue beyond treatment completion and felt the support from others, in particular those who had also experienced an eating disorder, would remain invaluable.

4 Discussion

The current research aimed to identify whether patient characteristics and demographic variables predict failure to engage in a CFT-E programme. This exploratory research aimed to establish whether levels of shame and self-criticism offer a possible explanation for the high rates of treatment non-completion characteristic of eating disorder treatment. In addition, the current research explored the experience of CFT-E to consider whether treatment mechanisms and therapeutic processes provide a more comprehensive account into the reasons for non-completion.

4.1 Summary of the Findings

4.1.1 Demographic Variables

Previous research has suggested that demographic variables are not reliable predictors of treatment non-completion (for review see Fassino *et al.*, 2009; Wallier *et al.*, 2009; Bell, 2001; DeJong *et al.*, 2012), irrespective of the stage of treatment non-completion. Interestingly, the current research further indicated that demographic variables do not also appear to be associated with FTE in treatment. Even though the previous research has predominantly focused on the predictive significance of patient characteristics including demographic variables, the growing literatures suggests that demographic variables are not reliably associated with non-completion across different treatment modalities, therapeutic settings and the point of treatment non-completion.

The current sample was predominantly white female, mirroring a methodological limitation evident across studies exploring treatment non-completion for eating disorders (Wallier *et al.*, 2009). Eating disorders span gender and ethnicity (Becker *et al.*, 2003) however, given the small sample size of males and those from ethnic minority backgrounds it is unclear whether the current findings provide a clear indication into the predictive significance of these demographic variables. Similar to the previous research, the current sample appeared to further highlight the underutilisation of eating services among ethnic minorities and males (Becker *et al.*, 2003; Striegel-Moore *et al.*, 2000) and the challenges associated with the delivery of specialist services. Alongside future research exploring barriers that account for the underutilisation of eating disorder treatment, the effective delivery of eating disorder services would be further supported by consideration into whether demographic variables are associated with treatment non-completion across the heterogeneous eating disorder population.

4.1.2 Eating Disorder Psychopathology

The findings indicated that the EDE-Q restraint subscale was a significant predictor of FTE in CFT-E, and those with higher levels of restraint over eating, avoidance of food and dietary rules were more likely not to commence treatment. One possible explanation for the decision not to commence treatment could reflect ambivalence surrounding recovery. Individuals may recognise that their eating disordered behaviours have become problematic, or have been encouraged to access treatment by others. Furthermore, individuals could experience ambivalence about relinquishing the positive feelings of control, achievement and self-confidence associated with dietary restraint (Serpell *et al.*, 1999) and this could present a further barrier to treatment.

In addition, the EDE-Q eating concern subscale was found to be a significant predictor of FTE in treatment and those with higher levels of preoccupation with food, anxiety and guilt associated with eating were more likely to commence treatment and take a step towards recovery.

4.1.3 Internal and External Shame

The findings indicated that internal shame maybe an important factor associated with treatment non-completion. Internal shame was found to be a significant predictor of FTE, and indicated that those with higher levels of internalised shame were less likely to commence treatment.

Internal shame, the tendency to view the self as inadequate, flawed and inferior (Gilbert, 1998; Tangney & Dearing, 2002) may manifest as a consequence of not achieving self-defined standards (Tangney, 1995). Furthermore, negative self-perception and the expectation of being viewed negatively by others (Gilbert, 1992; Goss and Allan, 2009) have also been related to hostile internal emotions including self-hatred, anger and disgust (Whelton & Greenberg, 2005).

The qualitative findings further supported the possible role of shame in treatment engagement and completion. Participants initially described being overly concerned about others expectations of their weight and shape, and anxious that they would be the '*fattest*' group member. These self-defined standards relating to how their weight compared with others may manifest in feelings of being inadequate, inferior and disgusting. Participants articulated the negative emotions associated with their '*shameful*' and '*secret*' eating disorders, and one participant described unfavourable comparison with others and how they felt dietary restriction was less shameful than their binge/ purging eating disordered behaviours. The experience of accessing treatment and the experience of disclosing an eating disorder could evoke shameful feelings that the flawed and inadequate self has been revealed, creating a possible barrier to treatment engagement.

In addition, the qualitative findings indicated that those who commenced treatment and FTE reported clinically elevated levels of external shame. Participants' outlined how their expectations of treatment had been preoccupied by anxieties about personal disclosure and the assumption that they would be 'judged' by others. Feelings of external shame stemming from perceptions of being negatively viewed by others (Gilbert, 1998, 2003, 2007) were highlighted as potential obstacles to the therapeutic process and willingness to contribute to group discussions. Swan and Andrews (2003) found higher levels of shame were associated with non-disclosure in women with eating disorders, and Lindsay-Hart *et al.* (1995) reported that individuals may be more likely to withdraw from treatment when shameful disclosures are not explored with empathy and compassion. However, participants described how the 'respect' and 'understanding' demonstrated by the other group members and therapists had created a safe space to explore shameful experiences and alleviated their experiences of external shame.

The current findings suggested that the experience of shame may be an important factor associated with treatment engagement and retention. Shame is the key emotional experience associated with stigma (Lunoma & Platt, 2015). Stigma has been found to be a barrier to accessing mental health services (Evans *et al.*, 2011; Wang, 2006) and is associated with treatment-seeking delays (Kushner & Sher, 1991). The shameful and stigmatising experience of disclosing eating disordered behaviours and being labelled with a mental health issue (Becker *et al.*, 2009; Hepworth & Paxton, 2007) has been found to be an obstacle to treatment engagement, most notably among males and ethnic minorities (Griffiths *et al.*, 2015; Marques *et al.*, 2011). Even though patients may access services, the shame and stigma associated with accepting support and commencing treatment (Masson *et al.*, 2007; Kahn & Pike, 2001; Halmi *et al.*, 2006) could offer a possible explanation for the higher rates of non-completion during the initial stages of treatment. As such, treatment settings and therapeutic alliances that nurture compassion and mutual trust could support patients to overcome these potential obstacles and support treatment retention.

4.1.4 Self-Criticism

Those who commenced treatment and FTE reported high levels of self-critical thoughts and feelings related to self-loathing and self-directed hostility (Gilbert, 2000; Whelton & Greenberg, 2005), and lower levels of self-reassurance. Individuals with high levels of self-criticism are unable to access self-reassurance (Gilbert & Proctor, 2006) and subsequently, may be more vulnerable to experiencing shame stemming from self-critical thoughts (Gilbert & Miles, 2000). Self-reassurance may lessen the

experience of shame (Gilbert & Proctor, 2006) and the lower level of self-reassurance reported by those who FTE might have contributed to the predictive significance of internal shame.

In terms of the function of self-criticism, individuals who commenced treatment reported higher levels of self-critical correction for self-improvement and motivation. High levels of self-criticism have been found among those with eating disorders (Fenning *et al.*, 2008; Speranza *et al.*, 2003), however the function of self-critical thoughts and feelings may provide an indication into those more likely to prematurely withdraw from treatment. Those accessing services may recognise the negative experiences associated with a loss of control (Serpell *et al.*, 1999; Williams & Reid, 2010) over their eating disorder behaviours and, having made the decision to seek treatment, self-critical thoughts of self-improvement and motivation may support patients to overcome difficulties experienced in treatment.

The qualitative findings highlighted the role of self-criticism as a potential barrier to treatment engagement. One participant described how meal plans had provided a benchmark for comparison and not achieving the same treatment goals as others had led to self-critical thoughts and feeling associated with being a '*failure*'. Therapists' acknowledgement of the positive steps participants had taken towards recovery rather than focusing on setbacks and reinforcing self-critical narratives, had provided important support to overcome difficult treatment junctures. Interestingly, participants outlined that prematurely withdrawing from treatment would have meant '*failure*' to achieve their own and others expected recovery. As such, the current findings may tentatively suggest that self-criticism may also be associated with motivation and self-improvement among those who complete treatment.

Self-criticism has been conceptualised as the absence of self-compassion (Gilbert & Irons, 2005). Interestingly, participants explained that the programme's focus on building self-compassion had supported them to overcome difficulties encountered during treatment. Rather than becoming preoccupied by self-critical thoughts related to being weak, a failure and inadequate, developing self-compassion had supported them to acknowledge the challenges of recovery. Kelly *et al.* (2014) found that building self-compassion and alleviating the experience of shame facilitated positive treatment responses. As such, self-compassion may be an important component of eating disorder treatment that facilitates recovery and also supports patients to view treatment obstacles with more empathy.

4.1.5 Therapeutic Alliance

The qualitative findings indicated that the therapeutic alliance had been an important feature of treatment. Previous research has suggested that difficulties building trusting relationships with

clinicians may offer a possible insight into the reasons for treatment non-completion (Masson & Sheeshka, 2009; Vandereycken & Devidt 2010). Participants articulated how the experience of validation, respect, trust and compassion from therapists had created a safe therapeutic setting to explore their difficult experiences. The current research appears to indicate the importance of building trusting therapeutic relationships to support treatment engagement and retention and subsequently, could account for the association between the therapeutic alliance and positive treatment outcomes (Brown *et al.*, 2013; Tierney, 2008; Elvins & Green, 2008; Sly *et al.*, 2013; for a review see Zaitsoff *et al.*, 2015), and

Consistent with the previous research, therapists' knowledge of eating disorders was an important component of the therapeutic alliance (Clinton *et al.*, 2004; Pettersen & Rosenvinge, 2002; Rosenvinge & Klusmeier, 2000). Therapists' expertise had nurtured participant's confidence to invest in the therapeutic process and collaboratively explore their eating disordered behaviours. Even though expertise was evidently valued, the 'expert role' experienced as 'us and them' was associated with a barrier to treatment engagement. In addition, participants emphasised the importance of therapists collaboratively participating in the programme, modelling the skills practices and sharing their reflections.

The current findings indicated that the therapeutic alliance may extend beyond the relationship with therapists. Establishing supportive and trusting relationships with other patients was highlighted as an important facilitator of treatment engagement and retention. Participants described the emotional distress experienced when reflecting on difficult past experiences, and at times becoming overwhelmed by negative emotions that would have been masked by an eating disorder. The validation, support and non-judgemental understanding demonstrated by both the therapists and the other patients was associated with positive treatment experiences. Even though comparison with others had led to self-critical thoughts and feelings, the experience of a group-based intervention had normalised eating disordered behaviours and fostered a sense of belonging that promoted treatment attendance at difficult treatment junctures. Following treatment completion, patients felt that continued contact with others who understood the difficulties associated with recovery from an eating disorder would be invaluable support.

4.1.6. Programme Structure and Delivery

Participants expressed ambivalence about the control associated with treatment expectations surrounding weight gain, meal planning and how the CFT-E model should be applied to recovery. Feeling a sense of control has been linked to the function and maintenance of an eating disorder

(Serpell *et al.*, 1999; Williams & Reid, 2010), however the loss of control over entrenched restricting and/ or purging eating disordered behaviours has been associated with treatment-seeking (Reid *et al.*, 2008). Interestingly, Eivors *et al.* (2003) found the perceived loss of control related to the timing and experience of treatment was associated with treatment non-completion. Even though the sense of being controlled by an eating disorder may lead to treatment-seeking, if treatment is experienced as controlling and prescriptive this may create an obstacle to treatment engagement and retention.

Participants' initial ambivalence surrounding the CFT-E model and compassionate skills practices were outlined in the qualitative findings. The novel treatment approach felt abstract, uncomfortable and, at times, participants described their difficulties relating the concepts to the experience of an eating disorder and the process for recovery. Central to understanding the CFT-E model was the importance of an idiosyncratic formulation of the causes and maintenance of an eating disordered behaviours. Clearly linking the rationale for the model to individualised formulations had facilitated engagement in the challenging skills practices and in turn, this had supported retention in treatment. Formulation and building a collaborative understanding of psychological distress has also been found to be a key component of the therapeutic alliance (Bieling & Kuyken, 2003; Kuyken, Padesky & Dudley, 2008, Nattrass *et al.*, 2015) and as highlighted by the current findings, may be an important factor associated with treatment engagement and retention.

4.2 Strengths and Limitations of the Research

The current research has extended the previous literature, identifying factors associated with non-completion in the initial stages of CFT-E treatment and, more specifically explored the role of shame and self-criticism in the high non-completion rates characteristic of eating disorder services. The mixed method approach was a notable strength of the current research, providing a context for the quantitative findings and insight into how factors associated with the experience of CFT-E might offer further explanation for treatment non-completion.

In terms of the quantitative research limitations, the reasons for non-completion were not reported. As such, it was unclear whether treatment non-completion was related to personal and practical issues and patients would have completed the programme had they commenced treatment. The quantitative data collection spanned 11 years and factors related to treatment delivery and programme development may have moderated the predictive significance of the pre-treatment patient characteristics.

Given the ethical issues associated with recruiting patients who had previously withdrawn from services, the qualitative research explored the barriers and facilitators to engagement among those who had completed CFT-E. These patients were more likely to have had positive treatment experiences and even though the current research identified several themes related to barriers to treatment engagement, the experiences of those who had completed CFT-E may differ from patients who leave treatment earlier than anticipated. Future research would benefit from exploring the experience of treatment non-completion at different junctures of the CFT-E programme however, the feasibility of the approach would need to be considered. The validity of the qualitative findings could have been further supported by respondent validation, inviting participants to comment on the analysis (Silverman, 1993) to clarify whether the identified themes accurately reflected their experiences of the CFT-E programme. However, this was not feasible within the research timescale.

The current findings indicated the high levels of shame and self-criticism experienced by those with eating disorders and as such, focus groups and comparison with others may have impacted on participant's willingness to openly explore their negative treatment experiences. The focus groups were held at the eating disorder service prior to the final group session and as such, participants may have been reluctant to openly reflect on their negative experiences of treatment. However, current engagement within treatment may have supported the reliability of participant's accounts of a CFT-E programme. Rather than becoming merged with previous experiences of psychological interventions, participants accounts may have more reliability reflected the facilitators and barriers to engagement in CFT-E treatment. The qualitative research explored the experience of CFT-E within one eating disorder service limiting the generalisability of the findings.

The current findings provide some insight into factors associated with treatment non-completion from the CFT-E programme however, the conclusions drawn across the qualitative and quantitative approaches should be interpreted cautiously. Treatment non-completion is a broadly defined clinical issue, and across the literature often does not take into consideration the possibility that factors indicative of leaving treatment earlier than anticipated may vary at different treatment junctures. For example, it appears unlikely that factors contributing to the decision FTE and leaving treatment at the pre-programme assessment will reflect the barriers to engagement experienced by those who completed treatment. The current exploratory research provides some insight into factors associated with treatment non-completion from a CFT-E programme, however the findings reflect different aspects of treatment non-completion.

4.3 Clinical Implications and Future Research

The current findings indicated that demographic variables do not appear to be reliable, robust factors associated with treatment non-completion. Consistent with the previous literature, the current findings appear to question the utility of further research exploring the predictive significance of demographic variables. However, as noted above, the current literature exploring factors associated with treatment non-completion amongst the heterogeneous eating disorder population has predominantly comprised of white female samples. Future research should explore whether the underrepresented demographic variables could be associated with FTE.

Previous research exploring the predictive significance of eating disorder psychopathology has been inconsistent (for a review see Fassino *et al.*, 2009; Wallier *et al.*, 2009; Bell, 2001; DeJong *et al.*, 2012) and, to date, there has been no previous research related to FTE in treatment. The preliminary findings presented here suggested that eating disorder psychopathology, and more specifically dietary restraint and eating concern may be important factors associated with FTE and warrants future research. However, future research should take into consideration the methodological limitations inherent of the literature to identify reliable factors associated with treatment non-completion (Wallier *et al.*, 2009).

The exploratory findings indicated that internalised shame and the negative perception of being flawed, inadequate and inferior may be a significant predictor of FTE in treatment. Shame has been found to be an important factor associated with treatment engagement across other mental health difficulties (Wang, 2006; Schomerus *et al.*, 2009; Jagdeo *et al.*, 2009), and based on the preliminary findings the role of shame in eating disorder treatment may warrant further research. In terms of clinical implications, the experience of shame and self-criticism was highlighted as a possible barrier to treatment engagement. Negative experiences of treatment have been associated with poor treatment outcomes (Leavey *et al.*, 2011) and supporting the delivery of eating disorder services in a compassionate and empowering therapeutic setting may be an important facilitator of treatment engagement and recovery. In particular, therapist competencies, building a collaborative therapeutic alliance with both therapists and other patients, and formulation were highlighted as key features of a safe therapeutic space that facilitated exploration of difficult and shameful eating disordered behaviours.

In addition, participants highlighted the importance of external support to overcome difficult treatment junctures. Recovery from an eating disorder is a challenging process that extends beyond the completion of eating disorder treatment. However, the stigma and lack of understanding surrounding

eating disorders was cited as a barrier to accessing support from others. Services should support significant others to understand the reasons and maintenance of an eating disorder, the treatment approach, and process of recovery. External support could support treatment completion and also individuals to take steps towards recovery and, subsequently, to reduce the likelihood of accessing future treatment. Interestingly the CFT-E model provides psycho-educational sessions to family and significant others and the current findings suggest that services should consider how to build links with external support to promote treatment engagement and retention

Eating disorder services should consider the value of exploring barriers to treatment during the assessment. For example, the Barriers to Treatment Instrument (ABTI; Allen & Dixon 1994) has been used with substance misuse populations and similar tools might provide an insight into barriers during the initial challenging stages of treatment. The identification of treatment barriers would inform treatment planning and facilitate referrals to other services that could support patients' engagement and retention in eating disorder services.

The current findings indicated that supportive and trusting relationships with other patients have an important role in treatment engagement and retention. Future qualitative research should explore how the therapeutic relationships with other patients support treatment completion among eating disordered patients. Future research should take into consideration what aspects of the CFT-E programme structure, delivery and role of therapist nurture positive therapeutic relationships with other patients.

4.4 Conclusions

The current research indicated that eating disorder psychopathology and shame may be important factors associated with FTE in CFT-E. Shame has been linked to the psychopathology and maintenance of eating disorders (for a review see Goss & Allan, 2009), and future research is needed to establish whether shame is a robust predictors of treatment non-completion at different treatment junctures. Additionally, the experience of shame may be an important barrier to treatment engagement and fostering a safe therapeutic setting to explore difficult and shameful eating disorder experiences may support treatment retention. Treatment non-completion is a complex clinical issue. The current research suggests that patient the features of an eating disorder may provide an insight into why some individuals leave treatment, however the experience of the therapeutic context and programmatic features offers context to understand the reasons for treatment non-completion at different treatment junctures.

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Section C: Critical Appraisal

Based on the research journal, the following section provides a reflective account and critical appraisal of the decision-making processes that shaped the current research. Initially, the critical appraisal will summarise the research process including, the decision to explore treatment non-completion, experience of a mixed method approach and the process of undertaking quantitative and qualitative methods. Following which, the personal and professional development attained through the research process, and the influence on clinical practice will be outlined.

1 Research Process

1.1 Decision to Explore Treatment Non-Completion

Before commencing clinical training I completed MSc research exploring factors associated with treatment non-completion from a prison-based drug treatment programme. The research interest had been sparked by my clinical experience of facilitating the treatment programme and curiosity surrounding the reasons why individuals' experienced difficulties completing treatment.

Even though the focus on exploring predictors of treatment non-completion has valuable clinical implications, previous clinical experience and review of the relevant literature indicated the relative lack of research exploring service users' experiences of the reasons for treatment non-completion. Despite growing acknowledgement of the value of developing services to reflect the needs of service users (Department of Health, 2004), the lack of research into the reasons for leaving treatment earlier than anticipated was striking. I became increasingly interested in qualitative approaches and felt that listening to service users experiences would provide a valuable insight into how services could be developed to support engagement and retention, rather than simply identifying those more likely to prematurely withdraw from treatment.

Previous clinical experience had also emphasised the negative discourse surrounding treatment non-completion, and how the responsibility for leaving treatment is predominantly placed on the individual with a lack of consideration for the possible role of programmatic factors or organisational barriers. Reflecting on my own practice, I became aware that my previous role in service management had become defined by performance targets and audit requirements rather than understanding individuals experiences of the treatment 'conveyor belt'. Alongside building on my previous research, I was keen to use the research process as an opportunity to step back from the demands of clinical practice to listen to the difficulties service users may encountered during treatment.

My particular interest in eating disorders was sparked by attending a teaching session and exploring the literature describing the high treatment non-completion rates characteristic of eating disorder treatment. Through discussion with my research and academic supervisor, I was fortunate to establish links with a local eating disorder service that nurtured and supported clinical research. Since there was no previous research exploring factors associated with treatment non-completion for CFT-E, the research provided an exciting opportunity to contribute to the evidence-base and establish whether shame and self-criticism account for the high rates of non-completion among those with eating disorders. Being a novice to CFT, I attended two training courses to develop a sound understanding of the model that informed the research process.

1.2 Experience of a Mixed Methods Approach

The decision to adopt a mixed methods approach stemmed from my clinical experience and insight into the challenges and difficulties patients may encounter when accessing treatment. Even though the literature has predominantly focused on exploring whether patient characteristics can predict those more likely to leave treatment earlier than anticipated, the influence of therapeutic context and programmatic features has received less attention. As such, a mixed methods approach allowed me to move beyond focusing on patient characteristics to consider how the experience of treatment could offer a richer explanation into the factors associated with non-completion.

Even though at times I felt overwhelmed by the demands of a mixed methods approach, the current research has provided an opportunity to broaden my research skills and contribute to the evidence-base. The support provided by the eating disorder service and participants' willingness to openly reflect on their difficult experiences has been remarkable and as such, the constraints of the thesis word count have often felt an obstacle to providing a comprehensive account of the rich data. However, on reflection, the research process has developed my ability to concisely and clearly report research findings, a valuable skill for clinical practice and future research.

1.2.1 Quantitative Approach

Based on previous research experience I initially felt more confident about completing the quantitative research. However, since the database had been collated for clinical audit and reasons other than the current research ethical approval stipulated that I could not access patient files to complete missing data. I was initially concerned that this would present an unmovable obstacle, however the eating disorder service was very supportive and planned for an Honorary Psychological Assistant to update the database. Not only did this facilitate completion of the quantitative analysis but also provided the opportunity to develop professional skills supervising other colleagues.

Data Analysis

The current research has highlighted some of the opportunities and challenges of using secondary clinical data. In terms of opportunities, clinical services are well placed to routinely collect large volumes of data for audit, research and service development. Given the organisational demands of delivering clinical services the completeness and accuracy of routinely collected data maybe not always be a priority for clinicians (de Lusignan & van Weel, 2005) and as such, data quality may present a challenge for researchers. Initially I felt frustrated by the missing data and the additional time spent exploring ways to approach the data analysis. However, through the research process I have gained an appreciation for the tensions between the challenges of delivering clinical services alongside undertaking research, and the importance of researchers understanding the clinical context.

1.2.2 Qualitative Approach

My initial research interest was to explore the experiences of those who had withdrawn from CFT-E and gain an insight into the reasons for treatment non-completion. However, given the potential difficulties recruiting an adequate sample size within the time constraints of DClinpsy research, alongside ethical issues associated with approaching patients who had withdrawn from treatment, this was not feasible. Consequently, I decided to focus the qualitative research on the experiences of patients who had completed CFT-E. This provided an opportunity to explore what aspects of the programme patients had found difficult and had created potential barriers to engagement, alongside what had supported patients to overcome these obstacles and successfully remain in treatment.

Data Collection and Experience of Focus Groups

Having spent considerable time finalising research proposals and navigating the ethics process, I looked forward to the focus groups and the opportunity to listen to participants experiences.

Based on previous experience of facilitating treatment groups I felt confident about moderating the focus groups which in turn, alleviated some of the anxieties associated with using a novel methodology to explore a treatment programme and clinical presentation that I had no previous experience with. The moderator skills to facilitate and promote interaction between participants allowed me to elicit different viewpoints and debate. Nevertheless, I was faced with the challenge of some participants dominating the discussions. This raised important questions about whether the dominant 'voice' represented the opinions and experiences of the focus group, or merely reflected the individuals' viewpoints (Smithson, 2000). Quieter participants were directly encouraged to express

their opinions to clarify whether the dominant 'voices' echoed the mutual viewpoints about the potential obstacles to treatment engagement. The tendency for participants to provide socially desirable responses has been highlighted as an important limitation of individual interviews. Focus groups involve exploring views and experiences among participants and as such, the methodological limitation may be even more pertinent in focus group research (Smithson, 2000). Interestingly, the focus group discussions highlighted participants' anxieties related to concerns about being negatively evaluated or judged by others. The awareness of others negative perceptions may have hindered participants' willingness to express negative and controversial views about their experiences of CFT and how the group itself may have been an obstacle to treatment engagement. On reflection, further research should consider whether conducting individual interviews would support participants to explore how, if at all, their experiences of being in a group and dynamics with other group members may offer further insight into factors associated with treatment non-completion.

During the data collection process, I was mindful of the importance of building a rapport with participants (Kvale, 2003). Even though holding 'information sessions' prior to the focus groups had been an opportunity to take steps towards establishing a rapport, it often felt difficult to foster a meaningful connection given the number of participants and the time constraints for conducting the focus groups. This may have not only undermined participants' confidence to disclose personal experiences, but clouded the distinction between my role as a trainee 'researcher' psychologist from other psychologists and trainees within the service.

Reflection on the negative experiences associated with an eating disorder and the challenges of taking steps towards recovery clearly caused some participants to feel emotionally overwhelmed. At these times, I found myself becoming confined by the security of the interview schedule rather than probing novel and interesting areas. I had not anticipated the emotional distress that would be conveyed though the focus group discussions, however I was equally struck by participants accounts of their positive treatment experiences and how the eating disorder service had supported them to overcome possible obstacles to treatment engagement. Furthermore, I was drawn to the therapeutic content of participants experiences and personal discourses and at times, the boundaries between the researcher and therapist had become merged (Birch & Miller, 2000). Given the therapeutic nature of qualitative interviews, researchers could be drawn to asking sensitive questions and participants guided to disclose personal experiences they had not expected when consenting to research (Richards & Schwartz, 2002). As such, I was mindful to revisit the distinction between my role as a researcher and therapist, and reflect on the focus groups to consider why I had been drawn to explore particular experiences. Furthermore, the research process highlighted the importance of

allowing time to complete a debrief and planning for clinicians to be available to offer participants additional support if needed.

With looming deadlines, mounting anxieties to 'get it right' and the time constraint of the focus group interviews, the initial group discussions were governed by the interview schedule and again, this led me to steer away from asking explorative questions. On reflection, conducting a pilot focus group would have provided an opportunity to build my confidence in using a novel methodology and establish whether the interview schedule effectively explored areas pertinent to the research question. However, given the length of the CFT-E programme and limited opportunities to complete focus groups during the research period this was not feasible. The focus group debrief and reflective journal were a valuable tool during the data collection process, specifically promoting reflections on the practicalities of facilitating the focus groups, how the interview schedule had been interpreted by participants, whether it had facilitated discussions related to the research question and identifying interesting and novel areas that had emerged in the discussions and should be integrated into future focus groups.

Given the practicalities and time commitment associated with participating in the research, the focus groups were held prior to the final CFT-E. Even though the focus groups had been scheduled to support recruitment this may have impacted on how comfortable participants felt to openly reflect on their experiences of treatment. The research process has highlighted the challenges of juggling the importance of robust research designs alongside supporting participant engagement and undertaking research in a busy clinical service.

Data Analysis

Despite the demands of using a mixed methods approach, I decided to transcribe the focus group interviews rather than use a third party. The '*powerful act of representation*' (Oliver *et al.*, 2005) gained through the transcription process was echoed in my own experiences. The interviews were transcribed following each focus group, allowing me to reflect on my moderator role and collate process notes to inform the facilitation of future focus groups and the data analysis process. Even though transcription was time consuming and frustrating, becoming immersed in the data allowed me to formulate initial impressions and identify potential themes embedded in the data.

Throughout the research process, I was concerned that my response to the emotional distress expressed in the focus groups may have influenced my interpretation of the data. My initial assumptions about the role as a qualitative researchers were centred on the need to take a

'distanced, objective' (Malacrida, 2007) stance, providing a pragmatic account of participants experiences. However, the data collection and analysis process has highlighted the importance of acknowledging my own bias, experiences and motivations. Rather than avoiding my role in the research process, the research journal and conversations with other trainees and supervisors provided an invaluable forum to acknowledge my responses and reasons for being drawn to particular excerpts in the interview transcripts. The analysis process has highlighted the subjectivity inherent to qualitative data analysis and the importance of continuous reflection to explore my role in decision making and interpretation of the interview transcripts.

Thematic Analysis

During the initial stages of the research proposal I tussled with the suitability of using Interpretative Phenomenological Approach (IPA) and Thematic Analysis (TA). IPA captures the subjective lived experience and an individual's perceptions of a particular situation (Smith & Osborn, 2007). On the other hand, TA focuses on identifying important patterns of themes predominant within the data set (Braun & Clarke, 2006). Since the qualitative approach aimed to identify obstacles to treatment completion and the use of focus groups has been advocate as a methodology to facilitate the exploration of critical comments to provide a valuable insight into service development (Watts & Ebbutt, 1987; Kitzinger, 1995), TA was adopted. Furthermore, TA offered the epistemological flexibility (Braun & Clarke, 2006) to take a critical realist position congruent with the mixed methods approach.

The TA adopted an inductive approach, identifying 'bottom-up' themes strongly linked to the data. Given my previous research experience and the literature review completed to inform the research proposal this could have potentially influenced my openness to the data and narrowed my analytical perspective (Tuckett, 2005). Rather than objectively identifying themes I often felt led by previous research and my clinical experience of barriers/ facilitators of treatment engagement. Revisiting the codes and discussions within a qualitative peer group allowed me to reflect on whether the themes had captured the 'essence' (Braun & Clarke, 2006) of the data. Interestingly, Strauss & Corbin (1998) suggested that previous knowledge of the literature could enhance the researchers' sensitivity to the subtle nuances embedded in the data and the quality of data analysis.

The TA was far more time consuming than initially anticipated and at times, I felt overwhelmed by the volume of data. Focusing the TA on the specific research question rather than the entire data set often left me feeling I had discounted some of the personal and difficult experiences shared by the participants. I became preoccupied with attempts to make the entire data set 'fit' the research

question rather than remaining focused on the clinical value of understanding barriers/ facilitators of treatment engagement. Furthermore, having had no previous experience of delivering CFT-E my interpretations of the focus group discussions may not have reflected participants understanding of their experiences.

2 Reflections on Professional and Personal Development

Navigating the research process has been a challenging and at times, difficult journey. As the finishing line approaches and I reflect on the value of completing the research, I am struck by both the personal and professional development. The research process has helped me to feel more confident in my role as a 'scientist-practitioner'. Even though clinical placements have emphasised the organisational challenges associated with undertaking applied research in clinical roles, clinical training has highlighted the research skills offered by psychologists and the importance of promoting these within the health service.

The current research has enriched my interest in qualitative research, and appreciation for the value of exploring service users experiences to inform service development. At times, I have felt the patients 'voice' has become lost among the demands of busy clinical settings, however patients experiences clearly have an important role in service delivery and also reflections on my own clinical practice. Furthermore, the research has informed my clinical work by highlighting the obstacles service users may experience and what support, both as a service and a clinician, would enable individuals to engage in treatment and achieve their own goals for recovery.

The research process has also provided the opportunity to explore the CFT model and apply the approach in my clinical practice, particularly during a CAMHS eating disorder placement. I have also contributed to team and service development by facilitating CFT teaching. Alongside the professional development associated with broadening my understanding of different therapeutic approaches, CFT has highlighted the importance of demonstrating compassion towards myself in both professional and personal roles.

In terms of personal development I feel more confident to juggle the demands of personal and professional roles. The importance of using supervision to reflect on my workload and revisit my own and others' expectations of my role has been a valuable learning point. Rather than 'soldiering on' and becoming overwhelmed by mounting pressures, the importance of self-care and effectively managing workloads to support my clinical practice and the ability to facilitate meaningful therapeutic encounters has been an important learning point to take into qualified roles.

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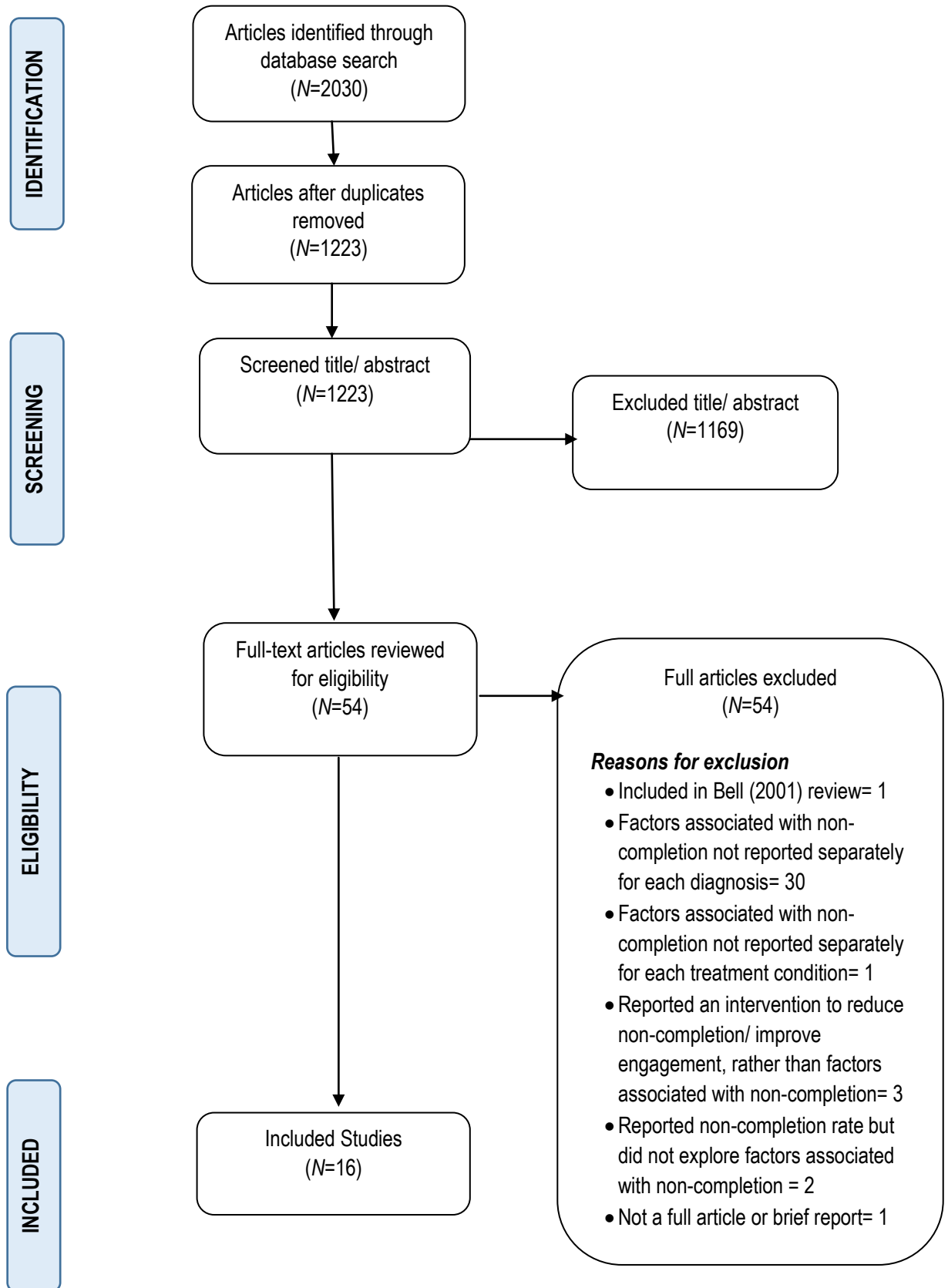
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Section D: Appendices

Appendix A: Search Terms

Database	Search Terms	Number of Articles
PsycInfo	dropout OR drop-out OR attrition OR terminat* OR withdraw* OR adherence OR non-completion bulimia OR eating disorder* Combined AND with limits <ul style="list-style-type: none"> • 2001-2015 • English Language • Peer Reviewed • Empirical Studies • Exclude dissertations 	359
Scopus	dropout OR drop-out OR attrition OR terminat* OR withdraw* OR adherence OR non-completion bulimia OR eating disorder* Combined AND with limits <ul style="list-style-type: none"> • 2001-2015 • English Language • Article 	875
Web of Science	dropout OR drop-out OR attrition OR terminat* OR withdraw* OR adherence OR non-completion bulimia OR eating disorder* Combined AND with limits <ul style="list-style-type: none"> • 2001-2015 • English Language • Article 	796
Total number of articles		2030
Total number of articles excluding duplicates		1223

Appendix B: Flowchart of Selection for Included Studies



Appendix C: Data Extraction Form

General	Reference
	Year of publication
	Journal title
	Country
Design	Study design
	Recruitment strategy
Sample	BN size sample
	Gender
	Ethnicity
	Mean age (range/ standard deviation)
	Sampling method
	Inclusion criteria
	Exclusion criteria
Intervention	Intervention
	Duration and frequency
	Individual/ group intervention
Non-Completion	Definition of treatment non-completion
	% non-completion
	Timing of non-completion
Findings	Significant variables of non-completion
	Non-significant variables of non-completion
Results	Statistical analysis
	Power analysis

Appendix D: Quality Appraisal based on the Checklist for Measuring Quality (Down & Black, 1998)

		Agüera et al. (2013)	Butryn et al. (2006)	Carrard et al. (2011)	Carter et al. (2008)	Dawkins et al. (2013)	Fassino et al. (2003)	Fernández-Aranda et al. (2009a)	Fernández-Aranda et al. (2009b)	Mahon et al. (2001)	Mitchell et al. (2002)	Robinson et al. (2006)	Schnicker et al. (2013)	Wagner et al. (2015)	Waller et al. (2014)	Wolk & Devlin (2001)	Zunker et al. (2011)
Reporting	Is the hypothesis/aim of the study clearly described?	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	Are the main outcomes to be measured clearly described in the Introduction or Methods section?	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	Are the characteristics of the participants clearly described?	1	1	1	1	1	1	0	0	0	1	1	0	1	1	0	1
	Are the interventions clearly described?	1	1	1	0	0	1	1	1	0	1	1	0	1	1	1	0
	Is treatment non-completion clearly defined?	0	1	1	1	1	1	0	0	1	0	0	1	1	1	1	0
	Are the principal confounders described? (2-0)	1	0	0	0	0	1	1	1	0	1	1	1	1	0	0	0
	Are the main findings of the study clearly described?	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1
	Does the study provide estimates of the random variability in the data for the main outcomes?	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	Have all important adverse events that may be a consequence of the intervention been reported?	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Have actual probability values been reported (e.g., 0.035 rather than <0.05) for the main outcomes except where the probability value is less than 0.001?	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1
External Validity	Were the participants asked to participate in the study representative of the entire population from which they were recruited?	1	0	0	0	1	0	1	1	1	1	1	0	1	1	1	0
	Were those participants who were prepared to participate representative of the entire population they were recruited?	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
	Were the staff, places, and facilities where patients were treated, representative of the treatment the majority of patients receive?	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

		Agüera et al. (2013)	Butryn et al. (2006)	Carrard et al. (2011)	Carter et al. (2008)	Dawkins et al. (2013)	Fassino et al. (2003)	Fernández-Aranda et al. (2009a)	Fernández-Aranda et al. (2009b)	Mahon et al. (2001)	Mitchell et al. (2002)	Robinson et al. (2006)	Schnicker et al. (2013)	Wagner et al. (2015)	Waller et al. (2014)	Wolk & Devlin (2001)	Zunker et al. (2011)
Internal Validity: Confounding Variables	If any of the results of the study were based on 'data dredging' was this made clear?	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	Were the statistical tests used to assess outcomes appropriate?	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1
	Was compliance with the intervention/s reliable?	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Were the main outcome measures used accurate (valid and reliable)?	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1
	Were the participants recruited from the same population?	NA	NA	NA	NA	NA	NA	NA	1	NA	1	NA	NA	1	NA	1	1
	Were study participants recruited over the same period of time?	NA	NA	NA	NA	NA	NA	NA	1	NA	1	NA	NA	1	NA	1	1
	Was there adequate adjustment for confounding in the analyses from which the main findings were drawn?	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Power	Did the study have sufficient power to detect a clinically important effect where the probability value for a difference being due to chance is less than 5%?	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Total Quality Score*		13	12	12	12	13	13	12	14	10	15	11	11	16	12	14	12

**Total quality scores in bold indicate that the study included a comparison group and as such, additional quality assessment criteria were applied. Higher scores indicate higher quality research.*

Appendix E: Sample Characteristics and Methodology

Author(s)	Design	Sample Selection	Sample/ Participants	Format of Treatment(s)	Definition of Non-Completion
Agüera <i>et al.</i> (2013)	Cross-sectional	Consecutive patients admitted to an outpatient ED Unit over 11yrs	<p>N= 367 All female outpatients Mean age BN-P= 26.2yrs, BN-NP= 19.8yrs DSM-IV-TR BN diagnosis. BN-P= 327, BN-NP= 40 Duration of illness BN-P= 7.5yrs, BN-NP= 7.0yrs Mean BMI BN-P= 24.3 kg/m², BN-NP= 26.4kg/m²</p> <p><i>Exclusion criteria</i> Severe co-morbid psychopathological symptoms e.g. suicidal attempts requiring inpatient/ individual therapy</p>	<p>Outpatient Manualised Group intervention 22 weekly 90-minutre sessions comprised of 6 psychoeducation sessions and 16 CBT sessions.</p>	No definition provided
Butryn <i>et al.</i> (2006)	Cross-sectional	Recruited through local media advertisements and from three ED clinics	<p>N=188 All female outpatients Mean age= 28.1yrs DSM-III-R BN diagnosis Mean BMI= 23.5kg/m² Ethnicity =88% white, 5% African American, 3% Hispanic, 3% Asian</p> <p><i>Exclusion criteria</i> Current anorexia nervosa Current alcohol or drug abuse Severe physical or psychiatric illness Use of any medication known to affect</p>	<p>Outpatient Manualised 18 individual weekly sessions CBT-BN Multi-site</p>	Did not complete all 18 sessions.

<i>Author(s)</i>	<i>Design</i>	<i>Sample Selection</i>	<i>Sample/ Participants</i>	<i>Format of Treatment(s)</i>	<i>Definition of Non-Completion</i>
			weight Current psychiatric or psychotherapeutic treatment		
Carrard <i>et al.</i> (2011)	Cross-sectional	Recruitment varied across the research sites and included local advertisements and internet; consecutive patients referred for assessment and treatment at an outpatient ED Unit; patients on a waiting list. Recruited over 2yrs	<i>N</i> = 127 Age= 18-43yrs, <i>M</i> = 24.7yrs DSM-IV diagnosis BN-P (76.4%), BN-NP (2.3%) or EDNOS-BN (21.3%) Mean illness duration= 8.4yrs Mean BMI= 21.5 kg/m ² <i>Exclusion criteria</i> Current CBT Alcohol and substance misuse Severe depression Recent suicide attempt BMI lower than 17.5kg/m ² or higher than 40kg/m ²	Outpatient Manualised 4-month CBT based internet self-help programme including weekly email with a coach. Three individual evaluation sessions completed before and after the self-treatment programme Multi-site	No longer engaged after 4 weeks of commencing treatment without any connection or email contact.
Carter <i>et al.</i> (2008)	Cross-sectional	Recruited through local media, direct mailing to GPs and mental health providers, advertisements at local Universities/ Polytechnic institutes.	<i>N</i> = 132 females All female outpatients Age= 17-45yrs, <i>M</i> = 26.1yrs Ethnicity= 91% Caucasian, 6% Maori, 3% other 73% had previously received ED/ psychiatric treatment Mean duration of illness= 6.7yrs Mean BMI= 25.0kg/m ² DSM-III-R BN diagnosis	Outpatient Manualised Completed 8 individual sessions of CBT and then randomised to either: Exposure to pre-binge cues Exposure to pre-purge cues Relaxation training	Did not complete at least five of the eight behavioural therapy sessions.

<i>Author(s)</i>	<i>Design</i>	<i>Sample Selection</i>	<i>Sample/ Participants</i>	<i>Format of Treatment(s)</i>	<i>Definition of Non-Completion</i>
			<i>Exclusion criteria</i> Current AN Current obesity (BMI>30kg/m ²) Current severe major depression with severe suicidal ideation or requiring immediate treatment with antidepressants Current severe mental illness or severe medical complications of BN Current use of psychoactive medication and unwillingness to undergo a supervised drug wash out period.		
Dawkins <i>et al.</i> (2013)	Cross-sectional	Consecutive patients referred to an outpatient ED Unit over 8yrs	N= 117 All female outpatients Age= 16-54yrs, M= 25.5yrs DSM-IV-TR BN or EDNOS-BN diagnosis BMI<14kg/m ² <i>Exclusion criteria</i> Alcohol/ substance abuse or current dependence Current acute schizophrenia, psychosis or schizoaffective disorder Suicidality BMI<14kg/m ²	Outpatient Manualised 20 individual sessions CBT-E Average number of sessions attended completers= 19, non-completers= 6	Patient-initiated withdrawal from treatment and did not complete the 20 CBT sessions.
Fassino <i>et al.</i> (2003)	Cross-Sectional	Patients attending an outpatient ED Unit over 2yrs	N= 86 All female outpatients Age=18-30yrs, Mean completers=	Outpatient Manualised 12-15 individual sessions	Discontinued treatment before the therapist's recommendation,

<i>Author(s)</i>	<i>Design</i>	<i>Sample Selection</i>	<i>Sample/ Participants</i>	<i>Format of Treatment(s)</i>	<i>Definition of Non-Completion</i>
			<p>25.90yrs, non-completers= 24.92yrs DSM-IV BN-P diagnosis Mean duration of illness completers= 85.01 months non-completers= 78.57months Mean BMI completers= 20.93kg/m², non-completers=21.15kg/m²</p> <p><i>Exclusion criteria</i> Axis 1 co-morbidity Eating disorder severity and referral to inpatient treatment. Male participants Age below 18yrs and above 30yrs.</p>	<p>IPBP combined with fluoxetine 45 min sessions completed over 16 weeks</p>	<p>independently of motivation.</p>
Fernández-Aranda <i>et al.</i> (2009a)	Cross-sectional	Consecutive patients admitted to an outpatient ED Unit over 20 months	<p>N= 241 All female outpatients Age= 17-57yrs, M= 26.4yrs DSM-IV BN diagnosis 87.1% BN-P Mean BMI= 24.4kg/ m² Mean duration of illness= 6.7yrs</p>	<p>Outpatient Group intervention 6 weekly 90-min psychoeducation sessions.</p>	No definition provided
Fernández-Aranda <i>et al.</i> (2009b)	Cross-sectional with comparison group	Consecutive patients referral to an outpatient ED Unit	<p>N= 62 All female outpatients Mean age= 23.7yrs Mean duration of illness= 6.0yrs Number of previous treatments range= 0-4 DSM-IV BN diagnosis</p>	<p>Outpatient IBT-CBT Self-help manual completed over 4 months Weekly contact with coach including two face-to-face evaluation sessions</p>	No definition provided

Author(s)	Design	Sample Selection	Sample/ Participants	Format of Treatment(s)	Definition of Non-Completion
Mahon <i>et al.</i> (2001)	Cross-sectional	Consecutive patients who attended an assessment session in an outpatient ED Unit	N= 111 All female outpatients Mean age= 24.47yrs ICD-10 BN or atypical BN diagnosis	Outpatient Individual psychotherapy	Withdrew from the ED service against the advice of the therapist before session 10. Attended at any point of the assessment but decline treatment.
Mitchell <i>et al.</i> (2002)	Cross-sectional with comparison group	Unsuccessful completion of CBT and consecutive referral to IPT or medical management	N= 31 All female outpatients Mean age= 28.0yrs DSM-III BN diagnosis and purging by self-induced vomiting at least 2 times a week for 3months Mean BMI= 23.2kg/m ² <i>Exclusion criteria</i> Substance dependence in the last 6months History of psychosis	Outpatient Completed 20 sessions of CBT-BN and those with bulimic symptoms at the end of treatment (purging) were offered 20 individual IPT sessions or medical management Multi-site	No definition provided
Robinson <i>et al.</i> (2006)	Cross-sectional	Completion of 10-20 session of guided self-help, CBT, CAT and consecutive referral to aftercare intervention	N= 21 Female= 95.3% Age= 19-48yrs, M=26yrs DSM-IV diagnosis BN or EDNOS-BN BMI range= 17.8kg/m ² to 43.1kg/m ² Duration illness range <2yrs to >20yrs <i>Exclusion criteria</i>	Outpatient Completed 10-20 session of guided self-help, CBT, CAT and then received a 6-month SMS aftercare intervention Participants received monthly written feedback on their progress	No definition provided

Author(s)	Design	Sample Selection	Sample/ Participants	Format of Treatment(s)	Definition of Non-Completion
Schnicker <i>et al.</i> (2013)	Cross-sectional	Professional or self-referral to a University outpatient ED clinic over 5 years	<p>Lack of a mobile phone Acute suicidality Psychosis Needing further intense treatment for their ED</p> <p>N= 69 All female outpatients Mean age completers= 24.3 yrs, non-completers= 21.8yrs Mean BMI completers= 21.5 kg/m², non-completers= 21.8 kg/m² DSM-IV diagnosis. 51 BN, 18 EDNOS-BN</p>	Outpatient Manualised CBT-BN Mean number of therapeutic sessions completers= 46.5, non-completers= 26.1	Prematurely terminated treatment having completed at least 6 therapy sessions and the psychotherapist did not consider that the therapeutic targets had been achieved Prematurely ended treatment but the therapeutic targets (remission of symptoms) had been achieved were categorised as a planned ending.
Wagner <i>et al.</i> (2015)	Cross-sectional with comparison group	Consecutive patients referral to ED Unit over 17months	<p>N=126 All female outpatients Age=16-35yrs, M= 24.17yrs DSM-IV diagnosis. BN-P (90%), EDNOS-BN (10%) with bingeing or purging behaviours between once or twice a week for less than 3 months BMI above 18 kg/m²</p>	Outpatient 7-months INT-GSH (N=70) or BIB-GSH (N=56). Both included weekly email support	Participated in therapy for two months or more, or completing at least 3 modules in the INT-GSH and six chapters in the bibliotherapy

<i>Author(s)</i>	<i>Design</i>	<i>Sample Selection</i>	<i>Sample/ Participants</i>	<i>Format of Treatment(s)</i>	<i>Definition of Non-Completion</i>
			Mean duration of illness= 8.82yrs <i>Exclusion criteria</i> Acute suicidality Severe depression and other mental disorders affecting cognitions Current drug abuse Current participation in CBT		
Waller <i>et al.</i> (2014)	Cross-sectional	Consecutive patients assessed at an outpatient ED Unit and referred for CBT	N=78 All female outpatients Mean age=27.8yrs DSM-IV diagnosis. 52 BN-P, 3 BN-NP, 23 EDNOS-BN Mean BMI= 22.1 kg/m ² <i>Exclusion criteria</i> Psychosis Learning disabilities Inability to work in the UK	Outpatient Manualised 20 1-hour individual CBT sessions. The number of sessions offered was reduced/ increased dependent on severity of symptomology Mean number of sessions= 19.2	Patient ended treatment before the agreed termination point (defined by patient and clinician), regardless of whether the patient withdrew early or late in treatment.
Wolk & Devlin (2001)	Cross-sectional with comparison group	Recruited through advertisements and consecutive patients seeking treatment at an outpatient ED Unit.	N= 110 All outpatient females Mean age IPT= 25.1yrs (SD=5.4), CBT= 28.2yrs (SD=6.6) DSM-III-R BN diagnosis Ethnicity = 79 White, 15 Hispanic, 9 African American, 7 Asian Mean BMI IPT= 23.4 kg/m ² , CBT= 23.0kg/m ²	Outpatient Manualised Randomly assigned to 19 individual sessions CBT (n=54) or IPT (n=56)	Did not complete the full course of treatment (19 sessions) or failed to remain in treatment throughout the study period and did not complete a termination EDE interview

<i>Author(s)</i>	<i>Design</i>	<i>Sample Selection</i>	<i>Sample/ Participants</i>	<i>Format of Treatment(s)</i>	<i>Definition of Non-Completion</i>
			<p>Exclusion criteria</p> <p>Severe physical or psychiatric conditions (e.g. psychosis)</p> <p>Current AN</p> <p>Current psychotherapeutic treatment</p> <p>Psychotropic medication</p> <p>Pregnancy</p>		
Zunker <i>et al.</i> (2011)	Cross-sectional with comparison group	Recruited through advertisements and referral from clinics. Included participants were telephone screened.	<p><i>N</i>=128</p> <p>98.4% female</p> <p>Age= 18-60yrs, <i>M</i>=29.0yrs</p> <p>DSM-IV criteria for BN-P or BN-NP or EDNOS with either DSM-IV criteria for BN except binge eating/ purging at a minimum of once a week, or DSM-IV criteria for BN with only subjective binge eating episodes</p> <p><i>Exclusion criteria</i></p> <p>Body weight below 85% ideal weight</p> <p>Change in prescribed psychotropic medication within the past 6 months or dependent in the past month</p> <p>Even received 8 or more CBT sessions</p> <p>Substance misuse within the past 6 months or were dependent in the past month</p> <p>Other significant condition e.g. high risk of suicide, actively psychotic</p>	<p>Outpatient</p> <p>Received either 20 individuals sessions FTF-CBT or 20 telemedicine sessions TV-CBT</p>	No definition provided

Abbreviations: *BN*, bulimia nervosa, *BN-P* bulimia nervosa purging; *BN-NP*, bulimia nervosa non-purging; *CBT*, cognitive-behavioural therapy; *DSM*, diagnostic and statistical manual for mental health; *FTF-CBT*, face-to-face-cognitive behavioural therapy; *TV-CBT*, telemedicine cognitive behavioural therapy; *BMI*, body mass index; *INT-GSH*, internet-based guided self-help; *BIB-GSH*, guided bibliotherapy; *BDI*, Beck Depression Inventory; *IPT*, interpersonal therapy; *IBPP*, individual brief psychotherapy; *CBT-E*, enhanced CBT; *EDE*, Eating Disorder Examination interview; *ED*, eating disorder; *IBT-CBT*, internet based therapy-cognitive behavioural therapy; *IPT*, interpersonal psychotherapy; *FTF-CBT*, face-to-face cognitive behavioural therapy; *TV-CBT*, telemedicine cognitive behavioural therapy; *ICD-10*, international classification of diseases.

Appendix F: Results Table: Significant and Non-Significant Factors Associated with Treatment Non-Completion

Author(s)	Non-Completion Rate	Significant Variables for Non-Completion	Non-Significant Variables for Non-Completion
Agüera <i>et al.</i> (2013)	BN-P= 12.8% BN-NP= 15.4% 8% sample withdrew during the first 2 sessions.	BN-NP treatment non-completers scored significantly higher mean scores on the maturity fears subscale of the EDI compared to completers.	No significant difference between completers and non-completers: Civil status Employment status Age Onset of the ED Length of ED <i>EDI subscales</i> Drive for thinness Body dissatisfaction Interceptive awareness Bulimia Interpersonal distrust Perfectionism Impulse regulation Ascetism Social insecurity Total score <i>SCL-90-R subscales</i> Global Severity Checklist Positive Symptoms Distress Index Positive Symptom Total
Butryn <i>et al.</i> (2006)	n= 26% (48)	Weight suppression found to be a significant predictor of treatment non-completion. Increased weight suppression of 1kg associated with a 0.69 increase in the odds of treatment non-completion.	Non-significant predictors of non-completion Baseline BMI Duration of binge eating

Author(s)	Non-Completion Rate	Significant Variables for Non-Completion	Non-Significant Variables for Non-Completion
		Weight suppression remained a significant predictor of non-completion when controlling for baseline BMI, duration of binge eating, EDE subscales restraint, weight concern, shape concern, eating concern, objective binge eating episodes, purging episodes. EDE subscale shape concern found to be a significant predictor of treatment non-completion. Those with greater shape concerns had lower odds of completing treatment.	<i>EDE subscales</i> Restraint Weight concern Eating concern Objective binge eating episodes Purging episodes.
Carrard et al. (2011)	N= 25.2% (27) Average duration of treatment engagement= 1.5months	No predictors identified	BMI Illness duration EDI-2 subscales SCL-90R GSI
Carter et al. (2008)	N= 20.4% (27)	No predictors identified	Weight suppression not found to be a significant predictor of treatment non-completion
Dawkins et al. (2013)	N= 34% (40)	No predictors identified	Higher pretreatment weight suppression not found to a significant predictor of treatment non-completion No significant moderator effects between parental overweight history, mother/ father overweight history, childhood body shape, pretreatment BMI and difference between highest and lowest ever adult body weight and weight suppression
Fassino et al. (2003)	N= 32.5% (28) None of the patients withdrew from treatment before the third IPBP	Significant difference between treatment completers and non-completers:	No significant difference between treatment completers and non-completers: Age Age of ED onset

Author(s)	Non-Completion Rate	Significant Variables for Non-Completion	Non-Significant Variables for Non-Completion
	session or following the twelfth session.	<p><i>STAXI subscales</i></p> <p>Intensity of anger as an emotional state.</p> <p>General predisposition to feel or express anger without a specific reason</p> <p>General index of the expression of anger.</p> <p><i>TCI subscales</i></p> <p>Self-directedness</p> <p>Cooperativeness</p> <p><i>EDI-II subscales</i></p> <p>Ineffectiveness</p> <p>Maturity fears</p> <p>Impulse regulation</p>	<p>Duration of illness</p> <p>BMI</p> <p>Laxative episodes/ week</p> <p>Vomiting episodes/ week</p> <p>Binge episodes/ week</p> <p>Hyperactivity/ week</p> <p>Educational level</p> <p>Fluoxetine efficacy</p> <p>Educational level</p> <p><i>STAXI subscales</i></p> <p>Angry temperament</p> <p>Suppressed anger</p> <p>Anger expressed towards other people or objects in the environmental</p> <p>Anger control</p> <p><i>TCI Subscales</i></p> <p>Drive for thinness</p> <p>Bulimia</p> <p>Body dissatisfaction</p> <p>Perfectionism</p> <p>Interpersonal distrust</p> <p>Interoceptive awareness</p> <p>Asceticism</p> <p>Social insecurity</p>
Fernández-Aranda <i>et al.</i> (2009a)	27.4% before week 4 34.0% during the whole treatment	During the initial 4weeks of treatment suicidal ideation, alcohol abuse and lower baseline purging frequency found to be associated with a higher probability of treatment non-	No non-significant predictors identified

Author(s)	Non-Completion Rate	Significant Variables for Non-Completion	Non-Significant Variables for Non-Completion
		completion During the whole treatment the presence of suicidal ideation, higher maximum BMI achieved and higher TCI-R novelty seeking scores found to be associated with a higher probability of treatment non-completion	
Fernández-Aranda <i>et al.</i> (2009b)	25% initial month 7% second month 3% third month 10% after week 12	Variable predictive of treatment non-completion Higher SCL90-R-anxiety scale Lower hyperactivity Lower minimum BMI <i>TCI-R subscales</i> Lower TCI-R reward dependence Higher TCI-R novelty seeking	No non-significant predictors identified
Mahon <i>et al.</i> (2001)	N= 48% (53)	Witnessing parental breakup, being younger, being employed outside the home, having previous experience of psychiatric treatment found to predict treatment non-completion Childhood trauma had a dose effect. Patients who had experienced two of the four trauma discontinued treatment before session 10 Patients with more severe ED symptoms were found to be more likely to engage in treatment	Frequency of vomiting, childhood physical abuse, domestic circumstances, childhood sexual abuse and distance travelled were not found to predict treatment non-completion No significant difference between treatment completers and non-completers for the time elapsed from referral to assessment and from assessment to the beginning of treatment No significant different between treatment completers and non-completers on the EDI, SCL-90 and Rosenberg self-esteem questionnaire
Mitchell <i>et al.</i> (2002)	N= 32.2% (10)	Treatment non-completion associated with younger age and better social adjustment measured by the Inventory of Interpersonal problems	No non-significant predictors identified

Author(s)	Non-Completion Rate	Significant Variables for Non-Completion	Non-Significant Variables for Non-Completion
Robinson <i>et al.</i> (2006)	N= 57.1% (12) 28.5% within the first month	No significant predictors identified	No significant difference between treatment completers and non-completers found for Age Ethnicity BMI Duration of illness Number of outpatient sessions Motivation to engage in treatment
Schnicker <i>et al.</i> (2013)	N= 40.5% (28)	Non-completers found to have significant higher pre-treatment difference BDI score than completers Odds ratio of having a comorbid psychiatric condition 1.69 times higher among completers compared to non-completers	No significant difference between completers and non-completers Age BMI Number of co-morbid disorders Living in partnership <i>BSI subscales</i> Obsession-Compulsion Anxiety Global severity index <i>EDI-2 Subscales</i> Bulimia Body dissatisfaction Perfectionism Drive for Thinness
Wagner <i>et al.</i> (2015)	N= 34% (44) INT-GSH= 37% (26) BIB-GSH= 32% (18)	Higher BDI score and lower TCI-R self-directedness found to predict non-completion.	Non-significant predictors of non-completion Frequency of monthly binge eating and vomiting prior to treatment

Author(s)	Non-Completion Rate	Significant Variables for Non-Completion	Non-Significant Variables for Non-Completion
	Mean treatment duration until treatment non-completion= 23.5 weeks		SIAB-EX BNSOCQ <i>TCI-R subscales</i> Novelty seeking Reward dependence Persistence Cooperativeness Self-transcendence Harm avoidance <i>EDI-II subscales</i> Ineffectively Perfectionism Impulse regulation Social insecurity Drive for thinness Body dissatisfaction
Waller <i>et al.</i> (2014)	N= 10% (8)	No significant predictors identified	Non-significant variables of treatment non-completion Age BMI Frequency of bingeing or vomiting EDI scores BDI scores
Wolk & Devlin (2001)	N= 40% (44)	No significant predictors identified	Pre-treatment stage of change not found to be significantly associated with treatment non-completion

Author(s)	Non-Completion Rate	Significant Variables for Non-Completion	Non-Significant Variables for Non-Completion
Zunker <i>et al.</i> (2011)	N= 37% (48) .	No significant predictors identified	Pre-treatment weight suppression not found to predict treatment non-completion

Abbreviations: *BN*, bulimia nervosa; *BMI*, body mass index; *SIAB-EX*, Structured interview for anorexia nervosa and bulimia nervosa; *EDI-II*, Eating Disorder Inventory; *BNSOCQ*, bulimia nervosa stages of change questionnaire; *STAXI* state-trait anger expression inventory; *TCI*, temperament and character inventory; *BN-P* bulimia nervosa purging; *BN-NP*, bulimia nervosa non-purging; *SCL-90-R*, symptom checklist- 90 revised; *EDE*, eating disorder examination interview; *BDI*, beck depression Inventory; *BSI*, brief symptom inventory.

Appendix G: Chronology of the Research Process

Proposal submitted for peer review	December 2014
Ethic and Research and Development approval granted	July 2015
Participant recruitment and qualitative data collection	September 2015-February 2015
Transcribe and analysis qualitative data	February 2015
Quantitative data analysis	March 2016
Write-up and submit draft thesis	March- April 2016
Thesis Submitted	24 th April 2016
Research Viva	Week Commencing 6 th and 13 th July 2016
Preparation of publication manuscript, dissemination of research and trainee research conference	July– September 2016

Appendix H Ethics Approval



02 June 2015

[Redacted]
[Redacted]
[Redacted]
[Redacted]
[Redacted]

Dear [Redacted]

Study title: Factors Associated with Treatment Non-Completion of a
Compassion-Focused Therapy Eating Disorder
Programme: A Mixed Methods Study

REC reference: 15/WM/0151
Protocol number: EDIS0699
IRAS project ID: 169844

Thank you for your letter of 29th May 2015. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 21 May 2015

Documents received

The documents received were as follows:

Document	Version	Date
Participant information sheet (PIS)	Version 3	29 May 2015

Approved documents

The final list of approved documentation for the study is therefore as follows:

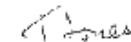
Document	Version	Date
Covering letter on headed paper		27 March 2015
Covering letter on headed paper	Version 2	13 May 2015
GP/consultant information sheets or letters	Version 1	27 March 2015
Interview schedules or topic guides for participants	Version 1	27 March 2015

IRAS Checklist XML [Checklist_08042015]		08 April 2015
IRAS Checklist XML [Checklist_15052015]		15 May 2015
IRAS Checklist XML [Checklist_29052015]		29 May 2015
Letter from sponsor		27 March 2015
Letter from statistician	Version 1	27 March 2015
Letters of invitation to participant	Version 1	27 March 2015
Other [Service User Reference Group Feedback]		
Other [Service User Reference Group Information Sheet]		
Other [Statistician Comments]		
Participant consent form	Version 2	13 May 2015
Participant information sheet (PIS)	Version 3	29 May 2015
REC Application Form [REC_Form_08042015]		08 April 2015
Research protocol or project proposal	Version 2	13 May 2015
Summary CV for Chief Investigator (CI) [Chief Investigator CV]		27 March 2015
Summary CV for student [Researcher CV]		27 March 2015
Summary CV for supervisor (student research)	Version 1	02 April 2015
Validated questionnaire		
Validated questionnaire [EDE-Q]	Version 1	02 April 2015
Validated questionnaire [SCS]		
Validated questionnaire [OSS Scale]		
Validated questionnaire [FSCRS]		
Validated questionnaire [FSCS]		
Validated questionnaire [ISS Scale]		

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

15/WM/0151 **Please quote this number on all correspondence**

Yours sincerely



REC Assistant

E-mail: [redacted]

Copy to: [redacted] NIHR CRN: West Midlands

Appendix I: NHS Research and Development Approval

Coventry and Warwickshire Partnership Trust

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

10 July 2015

Mrs Danielle Grey
Trainee Clinical Psychologist
Coventry and Warwickshire Partnership NHS Trust
c/o University of Leicester
104 Regent Road
Leicester LE1 7UR

Dear Danielle

Project Title: Factors associated with non-completion of compassion-focused therapy
R&D Ref: CWPT0004/RS
REC Ref: 15/WM/0151

I am pleased to inform you that the R&D review of the above project is complete, and NHS permission has been granted for the study at Coventry and Warwickshire Partnership NHS Trust. Your research activity is now covered by NHS indemnity as set out in HSG (96) 48, and your trial has been entered onto the Trust's database.

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

Document	Version	Date
REC Favourable Opinion Letter		21/05/2015
Protocol	2	13/05/2015
Participant Information Sheet	2	13/05/2015
Consent Form	2	13/05/2015
GP Letter	1	27/03/2015
Participant Invitation Letter	1	27/03/2015
Interview Schedule	1	27/03/2015
CV Dr Ken Goss		27/03/2015
CV Danielle Grey		27/03/2015
CV Steven Allan		02/04/2015
Letter from Sponsor		27/03/2015
Letter from CWPT Service		13/05/2015

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

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

It is your responsibility to keep the R&D Office and Sponsor informed of all Serious Adverse Events and to ensure that they are reported according to the Trust Clinical Incident policy, where required. All SAEs must be reported within the timeframes detailed within ICH-GCP statutory instruments and EU directives.

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

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

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

Yours sincerely



Senior Research Support Facilitator
CRN: West Midlands

cc:  *Chief Investigator/Clinical Supervisor*
 *Sponsor rep.*
 *Academic Supervisor*
 *R&D Manager*

Appendix J: Epistemological Position

The current research adopted a critical realist position. Unlike direct realism that conceptualises reality as embedded within objective, quantifiable constructs (Guba, 1990) critical realism postulates that reality is not explicitly observable and our understanding of the world is shaped by theories, conceptual frameworks and lived experience (McEvoy & Richards, 2006). On the other hand, in contrast to constructionism that assumes reality is socially constructed and meaning created through lived experiences (Gergen, 1999), critical realism understands social disclosure in the context of mechanisms that mediate a phenomenon (Williams, 2003). Bridging realism and constructionism, critical realism argues that reality is observable, contextual, multi-layered (Benton & Craib, 2001) and emerges from the interaction between causal mechanisms and social context (McEvoy & Richards, 2006).

Previous research exploring treatment non-completion has predominantly focused on exploring the predictive significance of patient characteristics and provided little contextual insight into the meaning and experience of eating disorder treatment. The current research utilised a mixed methods approach, triangulating qualitative and quantitative methods to gain a broader understanding into why some individuals leave treatment earlier than anticipated. Critical realism offers a framework for mixed methods research, merging qualitative and quantitative data to explore the multi-dimensional facets of reality (McEvoy & Richards, 2006). The current research recognised the salience of contextual factors to understand why and how treatment non-completion occurs within different treatment modalities and therapeutic settings. As such, the current research combined quantitative data exploring patient characteristics predictive of treatment non-completion with qualitative focus groups to identify themes that would not have been captured by standardised quantitative measures (McEvoy & Richards, 2006). By adopting a critical realist position and mixed methods approach, the researcher aimed to gain a comprehensive insight into the research question and understanding into factors associated with treatment non-completion from CFT-E.

The current research utilised focus groups to explore what aspects of a CFT-E programme create potential barriers to treatment completion. Consistent with critical realism, it has been suggested that focus groups provided a forum to explore the social structures that occur through social interaction (Christensen & Dwyer, 2004).

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**University of
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Coventry and Warwickshire

Partnership Trust



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Dear (participant name)

***Research Title: Treatment Non-Completion of a Compassion-Focused Therapy
Eating Disorder Programme: A Mixed Methods Study***

As part of my Clinical Psychology Training at the University of Leicester I will be conducting research exploring treatment non-completion from a Compassion-Focused Therapy Eating Disorder programme. The research will explore factors associated with treatment non-completion of a Compassion-Focused Therapy Eating Disorder programme.

Your involvement, should you agree to participate in the research, will involve completing a focus group lasting approximately 2 hours. The focus group will explore your experiences of Compassion Focused-Therapy. I'm really interested to understand what the group was like for you, what you found helpful and what aspects of the programme may have been more difficult. If there were points of the programme that you found more challenging, I would like to spend some time thinking about why it was difficult and if at any time you struggled to attend sessions. The research will provide a valuable insight into your experiences of the programme and thoughts about how it can be improved to support service users to overcome obstacles that may make the programme difficult at times.

Please read the enclosed Information Sheet which provides further information about the research and what participation would involve. I will be in contact with you to discuss your decision about whether to participate and can answer any questions.

Participation is entirely voluntary, and you can decide not to take part without providing any explanation. If you decide to participate, you will be invited to a focus group at the Coventry Eating Disorder Service.

Thank you.



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Participant Information Sheet

Research Title: Treatment Non-Completion of a Compassion-Focused Therapy Eating Disorder Programme: A Mixed Methods Study

Researcher: Danielle Grey, Clinical Psychologist Trainee, University of Leicester

Contact: email: dh133@le.ac.uk

tel: 07709 577879

I would like to invite you to take part in the above study. The following information will explain the study and what it will involve. Please take time to read the information sheet before deciding whether to participate. If you have any further questions please contact the researcher.

104. *What is the reason for the study?*

Compassion Focused Therapy can be an important part of supporting individuals towards recovery from their eating disorder. However, some people start this treatment and do not complete. Service users who have accessed the Compassion-Focused Therapy Eating Disorder (CFT-E) programme can provide an important insight into the experience of eating disorder treatment, what aspects of the programme they found helpful, if there were any difficult points and if so, why they may have struggled to attend sessions and what supported them to continue the programme. Listening to service user experiences will allow eating disorder services to understand what works and what doesn't, and explore what they can do differently

to support individuals to overcome the obstacles that makes treatment difficult at times.

2. Why have I been invited to participate?

Everyone who attends the Coventry Eating Disorder Service (CEDS) and has finished the CFT-E programme in the time that the study is being completed, will be invited to take part in the study. You will have received the information sheet from CEDS and asked to decide whether you would be keen to participate. The study is part of a Clinical Psychology Doctorate programme with the University of Leicester.

3. What will I be asked to do?

You will be asked to participate in a focus group. The focus group will involve 6-8 service users who have currently completed treatment with CEDS. The session will be facilitated by the researcher and will involve exploring your experiences of CFT-E, if at any points you found the programme difficult, why it was challenging and what supported you to overcome any obstacles.

4. Do I have to take part?

It's up to you, participation is voluntary. I will contact you to discuss the information sheet and answer any questions. If you decide to participate I will ask you to sign a consent form to show that you have agreed to take part. You are free to withdraw from the study at any point. You can contact the researcher on the above details and will not be expected to provide a reason for not participating in the study. The treatment received from CEDS will not be affected by your decision to participate or withdraw from the study.

5. What will happen if I agree to take part?

You will be invited to attend a focus group at CEDS. Before starting the focus group, you will have the opportunity to ask any questions and review the consent form. The focus group will be facilitated by the researcher and will last approximately 2 hours. You will be asked about your experiences of treatment, what you found helpful and what aspects of the programme you may have found difficult. There are no right or wrong answers, you can say as little or as much as you like, I'm just really interested in your experiences. You can decide not to answer the researcher's questions and will be able to withdraw from the focus group at any point without providing a reason. The

interview will be audio-recorded. Following the interview, the researcher will discuss your views about participating in the research and you will be able to ask any further questions.

6. Confidentiality and Anonymity

The researcher, CED therapists and your GP will be aware that you are taking part in the research.

The audio recording of the focus group will be stored securely. To keep your information confidential, you will be assigned an identification number and a tracking sheet containing your personal details will be stored separately to the audio recording. The information will be stored in a locked cupboard at CEDS.

The recording will be transcribed by the researcher or a professional transcriber who will have signed a confidentiality agreement. The recording will be deleted once it has been transcribed. The interview transcript will be anonymized, removing any information that could identify you. Anonymised quotes from your interview will be used for a Doctoral Thesis and published in an academic journal. Transcripts will be stored by the University of Leicester for six years following completion of the study. You can withdraw your information from the study at any point up until the focus groups have been anonymously transcribed at which point, quotes may be used in any publications.

If at any point, the discussion raises concerns about your safety or the safety of others, I will discuss this with the CEDS clinicians and research supervisors to make sure that you are signposted to the most appropriate support.

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

You can choose not to answer any of the questions. However, there is a possibility that it could be difficult to talk about your experiences. If so, the researcher will contact the CEDS clinicians to make sure you can access any further support. Additionally, you will need to give up approximately 2 hours of your time to complete the interview.

8. What are the potential benefits in taking part?

Participating in the study will be an opportunity to express your views and experiences of the CFT-E programme. The study aims to identify ways the CFT-E programme can be further developed to effectively support individuals to complete treatment.

9. How will the findings of the study be used?

The research findings will be used for a Doctorate Thesis. The results will also be distributed to participants, CEDS, presented at conferences and published in academic journals. You can contact the researcher to request a copy of the final report which will be available in autumn 2016.

10. Who is funding the research?

The research being funded by the University of Leicester and is sponsored by Leicestershire Partnership Trust.

11. Who has reviewed the study?

The research has been reviewed by the University of Leicester and the West Midlands – Coventry and Warwickshire Research Ethics Committee and has received ethical approval.

12. Can I offer feedback or complain?

If you would like to provide any feedback or have concerns regarding any aspect of your involvement in the research please contact:

Patient Advice and Liaison Service
Coventry and Warwickshire Partnership NHS Trust
Wayside House
Wilsons Lane
Coventry
CV6 6NY
Tel: 0800 212 445 Email: pals@covwarkptnhs.uk

13. Further Information

If you require any further information or would like to take part in the study please contact the researcher: Danielle Grey el: 07709 577879 E-mail: dh133@le.ac.uk

**THANK YOU FOR TAKING THE TIME TO CONSIDER TAKING PART IN THIS
STUDY**



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Consent Form

Research Title: Treatment Non-Completion of a Compassion-Focused Therapy Eating Disorder Programme: A Mixed Methods Study

Researcher: Danielle Grey, Clinical Psychologist Trainee, University of Leicester

Contact: email: dh133@le.ac.uk

tel: 07709 577879

Thank you for agreeing to take part in the research project. Please read the consent form and ask any further questions.

***Please initial
the box***

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information and ask any questions I have about the study. ☐
2. I understand that my participation is voluntary, I am free to withdraw at any point before my interview. My interview is anonymously transcribed, without providing a reason, and without any services I currently receive or may receive in the future being affected. ☐
3. I agree to being interviewed. I understand that the interview will be audio recorded and transcribed. ☐
4. I understand that anonymous quotes from my interview will be used for a Doctoral thesis. The results will also be distributed to participants, presented at conferences and published in academic journals. ☐

5. I understand that the anonymized interview transcripts will be securely stored at the University of Leicester for six years following completion of the research. ☐
6. I understand that the interviewer has a duty to breach confidentiality if they have any concerns about my safety or the safety of others. ☐
7. I understand that my GP will be made aware that I have agreed to participate in the study. ☐
8. I can receive a summary of the results by contacting the researcher at dh133@le.ac.uk ☐
9. I agree to take part in the study. ☐

Your Name

Date

Your Signature

Researchers Name

Date

Researchers Signature



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Dear (GP Name)

Re: Participant Details

(Insert Participant Name) is currently completing treatment with the Coventry Eating Disorder Service and has consented to participate in a research study exploring treatment non-completion from a Compassion-Focused Therapy Eating Disorder (CFT-E) programme. The research is being completed as part of a Doctoral training course at The University of Leicester.

Participation will involve completing a focus group lasting approximately 2 hours at the Coventry Eating Disorder Service. The focus group will provide an important insight into the experiences of eating disorder treatment and how it can be improved to support service users to overcome obstacles that may make the programme difficult at times. Participation within the focus group will not affect the treatment received by the Coventry Eating Disorder Service, and participants will be able to withdraw from the research at any point.

If you have any further questions please do not hesitate to contact me.

Danielle Grey
Trainee Clinical Psychologist

Appendix O: Interview Schedule



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Coventry and Warwickshire **NHS**
Partnership Trust

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Interview Schedule

**Research Title: Treatment Non-Completion of a Compassion-Focused Therapy Eating
Disorder Programme: A Mixed Methods Study**

Researcher: Danielle Grey, Clinical Psychologist Trainee, University of Leicester

Contact: email: dh133@le.ac.uk

tel: 07709 577879

Introduction

Thank you for attending today's focus group. My name is Danielle Grey, I'm a Trainee Clinical Psychologist at the University of Leicester. As part of the training course, I am currently undertaking research with CEDS to explore service users experiences of Compassion-Focused Therapy and how the service can be improved to support those accessing treatment.

Aims and Structure: Thank you for agreeing to take part in the focus group, which should last about 2 hours. The focus group will explore your experiences of Compassion-Focused Therapy. I'm really interested to understand what the group was like for you, what you found helpful and what aspects of the programme may have been difficult. If there were points of the programme that you found more challenging, I would like to spend some time thinking about why it was difficult and if at times this meant you struggled to attend sessions. There are no right or wrong answers, I'm would really like to listen to your experiences of the programme and thoughts about how it can be improved to support service users to overcome obstacles that may make the programme difficult at times.

Consent: As you may recall, you were sent an Information Sheet and Consent Form before attending today. I would like to read through the Consent Form and check whether anyone has any further questions before we start.

Confidentiality: It is important that everyone feels comfortable to discuss their experiences. As a 'ground rule', similar to the CFT-E group sessions, it is important that the content of the interview remains confidential and is not discussed outside of the focus group. Our discussion will be confidential. The audio recording of the session will be securely stored and once transcribed, will be deleted. Personal details will be separate from the audiotape and kept in a locked cabinet at CEDs. Quotations from the interview will be used in the research report however, any information that could identify you will be changed. If at any point, the discussion raises concerns about your safety or the safety of others, I will discuss this with the clinicians to make sure that you are signposted to the most appropriate support.

So just before we start, if at any point, you would like to leave the focus group, please let me know. Do you have any questions you would like to ask me before we start?

Interview Schedule

I'd be really interested to hear about your experiences of the different stages of Compassion-Focused Therapy programme, what you found helpful and if there were any aspects of the programme that you found more difficult and if you experienced any difficulties whether ever struggled to attend sessions or considered leaving treatment

Let's take one of these at a time, thinking about think the psycho-education programme, compassionate skills Programme, and then the recovery programme.

A: Programme Content

Psycho-education

Thinking back to when you initially discussed attending the psycho-education program, what were your thoughts about attending the group?

If you had any concerns/ anxieties about attending psycho-education, could you tell me what you thought might be difficult? Prompt: discussing experiences in a group

How did this compare to your experience of attending psycho-education?

What, if anything, did you find helpful about this psycho-education?

Was there anything that you found difficult? If so, what did you find difficult?

If you experienced any difficulties, did you ever struggle to attend sessions or consider leaving treatment? If so, why?

If yes, what motivated your decision to continue the in the programme? Prompt: friend, family or other professional support; programme structure and delivery

Compassionate Skills Programme

Thinking back to when you initially discussed attending the Skills program, what were your thoughts about attending the group?

If you had any concerns/ anxieties about attending Skills program, could you tell me what you thought might be difficult?

How did this compare to your experience of attending Skills program?

How did you find the Skills program? Prompts: distraction, practical soothing; breathing exercises; soothing imagery; compassion imagery ('you at your best' and 'compassionate companion'); letter writing

Was there anything that you found difficult? If so, what did you find difficult?

If you experienced any difficulties, did you ever struggle to attend sessions or considered leaving treatment? If so, why?

If yes, what motivated your decision to continue the in the skills programme? Prompt: friend, family or other professional support; programme structure and delivery

Recovery Programme

Thinking back to when you initially discussed attending the recovery program, what were your thoughts about attending the group?

If you had any concerns/ anxieties about attending the recovery programme, could you tell me what you thought might be difficult?

How did this compare to your experience of attending the recovery program?

Was there anything that you found difficult? If so, what did you find difficult?

If you experienced any difficulties, did you ever struggle to attend sessions or considered leaving treatment? If so, why?

If yes, what motivated your decision to continue the recovery programme? Prompt: friend, family or other professional support; programme structure and delivery

As you know, the Recovery Programme focused on challenges. Let's take one of these at a time.....

Challenge: Eating

What was it like being on the meal plans and managing your energy balance?

How did you find the transition from meal plan 1, 2 and 3?

If there was any point when you found it really difficult managing this challenge, did you ever struggle to attend sessions or consider leaving treatment because of this challenge? If so, why?

If yes, what meant that you decided to continue the CFT-E programme? Prompt:
friend, family or other professional support; programme structure and delivery

Challenge: Weight

What were your thoughts about being weighed weekly?

How did it feel being weighed at the beginning of each session?

How did you feel discussing on or off weight targets in the group?

If there was any point when you found it really difficult managing this challenge, did you ever struggle to attend sessions or considered leaving treatment because of this challenge? If so, why?

If yes, what meant that you decided to continue the CFT-E programme? Prompt:
friend, family or other professional support; programme structure and delivery

Challenge: Eating Disorder Behaviour

How did you feel about using the skills and 'letting go' of your eating disorder behaviour?

If there was any point when you found it really difficult managing this challenge, did you ever struggle to attend sessions or considered leaving the group? If so, why?

If yes, what meant that you decided to continue the CFT-E programme? Prompt:
friend, family or other professional support; programme structure and delivery

Challenge: Compassion

Can you describe your experience of becoming more self-compassionate? Prompts: receiving compassion; giving compassion; being self-compassionate.

If there was any point when you found it really difficult managing this challenge, did you ever struggle to attend sessions or considered leaving the group? If so, why?

If yes, what meant that you decided to continue the CFT-E programme? Prompt:
friend, family or other professional support; programme structure and delivery

B: Engagement and Completion

If anyone in the group has had previous treatment for their eating disorder, would you mind discussing your experiences during this interview? If yes,

Did you complete the program? If yes, was there anything different in your experience of the program this time?

If you didn't complete, what meant that you completed the programme?

Thinking back, what other support may have made the programme feel less challenging?

Can you describe what it would have meant not to complete the CFT-E programme? Prompts:
recovery, self-identify, others views

Is there anything you would like to add about your experience of CFT-E and why at times you may have struggled to attend the group?

Debrief

Thank you for taking the time to participate in the focus group. How do you feel after talking about your experiences of CFT-E and aspects of the programme you found difficult? Prompt: explore thoughts, feelings, distress.

If the participant has experienced distress, the researcher will do or arrange for a risk assessment to be completed with a CEDS clinician. The participant will be informed that the CED clinician will be informed to provide support and the content of the focus group will not be disclosed unless it breaches the boundaries of confidentiality. At the end of the interview, review the Information Sheet highlighting contact details and how a copy of the final report can be obtained.

Thank you again for participating and taking the time to share your thoughts about CFT.

Appendix P: Braun and Clarke (2006) Phases of Thematic Analysis

Familiarisation with the Data

The researcher conducted and transcribed the focus group interviews to become immersed in the data. During the process of transcribing the interview, the researcher noted initial thoughts and meaning embedded in the focus group discussions. The transcripts were then checked against the audio recording for accuracy. Following which, the researcher re-read the transcripts to become immersed in the data.



Generating Initial Codes

The entire data set was systematically reviewed to identify codes and patterns of meaning. Codes were identified at the semantic level, reflecting the content of the data rather than inferring meaning or interpretation from the interviews. Transcripts were manually coded to identify potential patterns (Appendix Q) across the entire data set. Key quotes from each transcript were tabulated.



Searching for Themes

As recommended by Braun and Clarke (2006), the initial codes were placed on post-it notes and then reviewed and collated into patterns of meaning and emerging relationships between the codes explored. The codes were then combined into overarching themes and subthemes (Appendix R)..



Reviewing Themes

The themes were reviewed and refined. The tabulated codes were revisited and the researcher considered whether the theme provide a coherent description of the entire data set. The transcripts were then re-read and the validity of the themes and subthemes considered. A thematic map of analysis was outlined.



Defining and Naming Themes

The themes were reviewed and the researcher considered how the 'story' of each theme related to the research question and whether it encapsulated the meaning expressed in the focus group interviews. The themes were compared to check for overlap and to identify whether further sub-themes may have been concealed within the themes. Themes were then discussed in supervision to further refine and generate clear definitions that accurately described the data.

Appendix Q: Coded Transcript Example

74 only when I felt more comfortable accepting that I'm ill and that everyone's acceptance others CO
75 illness is different and it manifests itself in different ways and yeah. different.

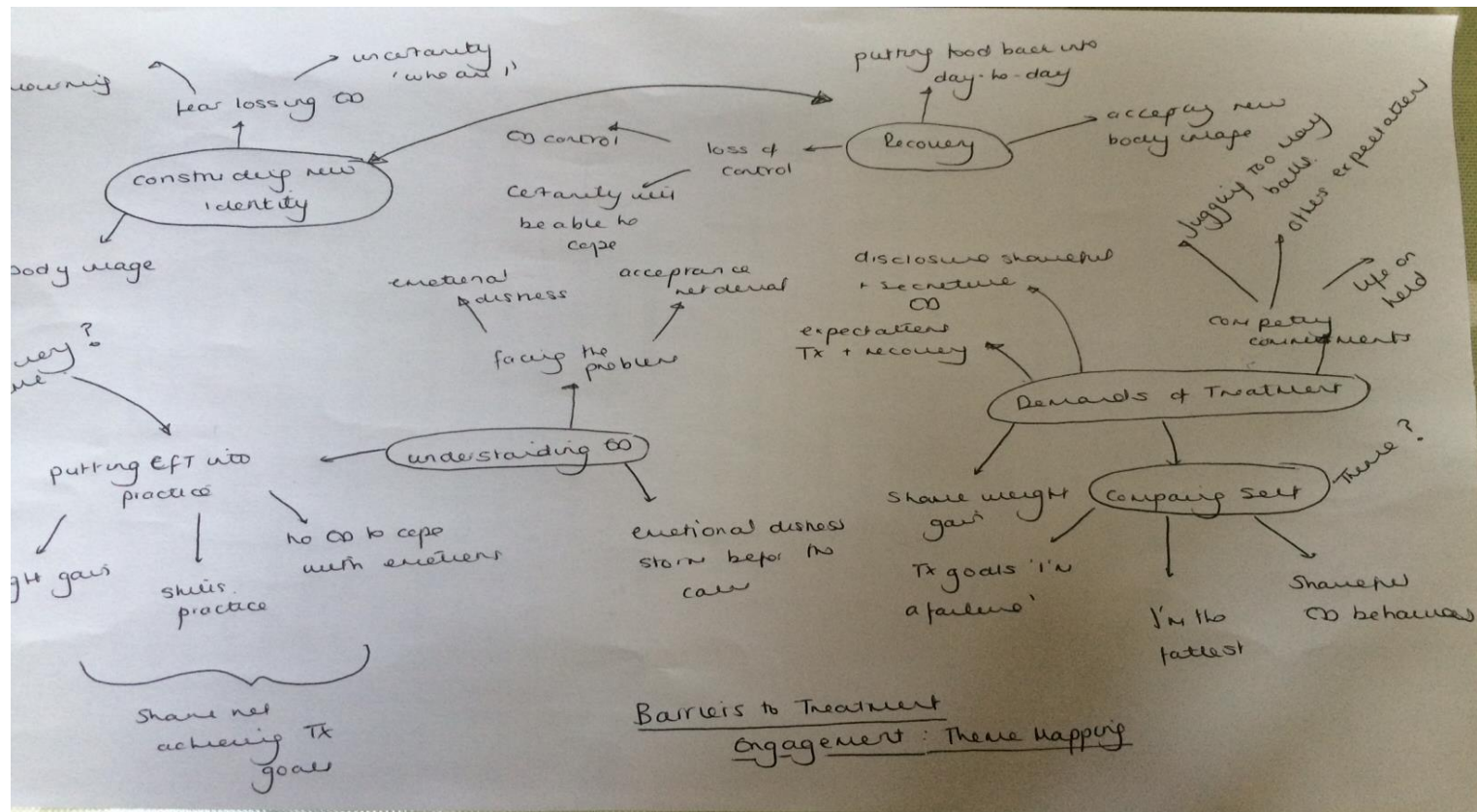
76 Facilitator: Thank you. It sounded like group may have been difficult to start
77 off with, so what helped you to keep coming to group when you found it
78 difficult? *other patients*

79 Participant 3: Well initially other people, the idea of them was problematic but group comparison but
80 then it also really, really helped because through other people coming and if they can, why not me.
81 committing to coming, and if they could do it then why couldn't I, like I know group source of motivation
82 umm, and I think my eating disorder did also change its format slightly, umm to overcome dysphoria
83 like I stopped bingeing and purging as much, got it down to like I don't know, comparing CO.
84 umm very few times in the week but then it sort of like shifted again and it
85 started being more of a restricting type thing so, umm there was less of a
86 shame thing in that sense as well because I wasn't like stuffing myself with eating disorder behaviour
87 food and being sick basically and having to deal with the repercussions of changed > shame.
88 that like physical as well so, yeah umm. *shame binge/purging*

89 Facilitator: Thank you. How did your expectations of psycho-ed compare to
90 your experiences of attending the psycho-ed course?

91 Participant 5: I was personally disappointed in that, umm, basically I was like,
92 I mean umm, I realise how far I have come since I came in but umm, uhh, the taking steps to
93 only issue is kind of like I think I was really, really ill a year and a half ago and recovery.
94 I have a panic disorder so it kind of like, the two go hand by hand, my eating
disorder and my panic disorder, so my panic disorder actually forced me to
become anorexic because if I was, I didn't eat I started to have panic attacks
because I had a panic attack the first time because I OD'ed on caffeine trying
to stop myself from eating and umm, so it was kind of the alarm telling me like negative experiences CO
that you really need to do something about it and so because I was so scared motivation to engage.
about having another panic attack I would eat, but like for some other people lost control.
it would mean being on a diet but for me it was eating and so I came here and
I felt like I was like a step ahead from kind of a lot of people and initially felt
that and had the impression that I wasn't ill because I was eating while you comparing CO behaviours - I'm
girls were not, the day before my panic attack I purged and I was like 'never not ill
that again' that is obviously going to trigger a panic attack so, and it took me a
long time to kind of like see where I was standing because I umm, I didn't
have, I don't really have as many fear foods, I just felt that I wasn't bad Serenity CO
enough to be here I just felt like constantly like so many people struggle with not bad enough for the serenity
like eating stuff that I've been eating, like I think I eat without thinking about it of CO compared to others.
and so I just really, umm umm, for like the meal plan for example like I

Appendix R: Process of Defining the Themes



Appendix S: Assessing Normality

	Mean			Kolmogorov-Smirnov			Skewness		Kurtosis	
	Mean	Std. Error	5% Trimmed Mean	Statistic	df	Sig.	Statistic	Std. Error	Statistic	Std. Error
Age	27.58	.452	26.72	.140	403	.000	1.349	.122	1.790	.243
CORE Wellbeing	2.509	.044	2.541	.096	403	.000	-.435	.122	-.191	.243
CORE Problem	2.134	.0428	2.138	.051	403	.000	-.045	.122	-.591	.243
CORE Functioning	1.835	.390	1.835	.033	403	.200*	-.004	.122	-.409	.243
CORE Risk	.581	.036	.503	.210	402	.000	1.500	.122	1.864	.243
CORE Total	1.799	.359	1.799	.031	403	.200	.024	.122	-.448	.243
EDE Restraint	3.909	.832	4.007	.105	402	.000	-.755	.122	-.264	.243
EDE Eating Concern	3.590	.071	3.645	.104	402	.000	-.569	.122	-.097	.243
EDE Shape Concern	4.753	.066	4.890	.176	403	.000	-1.374	.122	1.407	.243
EDE Weight Concern	4.359	.0699	4.800	.125	401	.000	-.931	.122	.236	.243
Total OAS	33.295	.861	33.091	.051	390	.016	.189	.124	-.691	.247
ISS Self-Esteem	8.652	.227	8.534	.078	396	.000	.359	.123	.024	.245
ISS Shame	58.103	1.105	58.763	.045	400	.049	-.366	.122	-.543	.243
Total SCS	57.233	1.197	56.627	.055	176	.200*	.557	.183	.529	.364
FSCS Self-Correction	22.417	.9001	22.095	.046	218	.200*	.293	.165	-.079	.328
FSCS Self-Persecution	13.529	.594	13.390	.085	218	.001	.137	.165	-1.101	.328
FSCRS Self Criticalness	25.363	.542	25.835	.123	223	.000	-.726	.163	-.232	.324
FSCRS Self-Reassurance	9.996	.418	9.728	.083	221	.001	.642	.164	.053	.326
FSCRS Inadequate Self/ Hated	10.153	.378	10.180	.089	223	.000	-.137	.163	-1.037	.324

*Lower bound of the true significance

Appendix T: Transformations Assessing Normality

	Kolmogorov-Smirnov		
	Statistic	df	Sig.
Age	.12	403	.00
CORE Risk	.23	268	.00
EDE Shape Concerns	.10	403	.00
FSCS Self-Persecution	.09	218	.00
FCSCR Inadequate Self/ Hated Self	.08	223	.00

Appendix U: Authors guidelines for the literature review target journal: Clinical Psychology Review

Guidelines retrieved from <https://www.elsevier.com/journals/clinical-psychology-review/0272-7358/guide-for-authors#25000> on the 24th April 2016

Article structure: Manuscripts should be prepared according to the guidelines set forth in the Publication Manual of the American Psychological Association (6th ed., 2009). Of note, section headings should not be numbered.

Manuscripts should ordinarily not exceed 50 pages, including references and tabular material. Exceptions may be made with prior approval of the Editor in Chief. Manuscript length can often be managed through the judicious use of appendices. In general the References section should be limited to citations actually discussed in the text. References to articles solely included in meta-analyses should be included in an appendix, which will appear in the on line version of the paper but not in the print copy. Similarly, extensive Tables describing study characteristics, containing material published elsewhere, or presenting formulas and other technical material should also be included in an appendix. Authors can direct readers to the appendices in appropriate places in the text.

It is authors' responsibility to ensure their reviews are comprehensive and as up to date as possible (at least through the prior calendar year) so the data are still current at the time of publication. Authors are referred to the PRISMA Guidelines (<http://www.prisma-statement.org/statement.htm>) for guidance in conducting reviews and preparing manuscripts. Adherence to the Guidelines is not required, but is recommended to enhance quality of submissions and impact of published papers on the field.

Appendices: If there is more than one appendix, they should be identified as A, B, etc. Formulae and equations in appendices should be given separate numbering: Eq. (A.1), Eq. (A.2), etc.; in a subsequent appendix, Eq. (B.1) and so on. Similarly for tables and figures: Table A.1; Fig. A.1, etc.

Essential title page information : Title. Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible. Note: The title page should be the first page of the manuscript document indicating the author's names and affiliations and the corresponding author's complete contact information.

Author names and affiliations. Where the family name may be ambiguous (e.g., a double name), please indicate this clearly. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name, and, if available, the e-mail address of each author within the cover letter.

Corresponding author. Clearly indicate who is willing to handle correspondence at all stages of refereeing and publication, also post-publication. Ensure that telephone and fax numbers (with country and area code) are provided in addition to the e-mail address and the complete postal address.

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Abstract: *A concise and factual abstract is required (not exceeding 200 words). This should be typed on a separate page following the title page. The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separate from the article, so it must be able to stand alone. References should therefore be avoided, but if essential, they must be cited in full, without reference to the reference list.*

Graphical abstract: *Although a graphical abstract is optional, its use is encouraged as it draws more attention to the online article. The graphical abstract should summarize the contents of the article in a concise, pictorial form designed to capture the attention of a wide readership. Graphical abstracts should be submitted as a separate file in the online submission system. Image size: Please provide an image with a minimum of 531 × 1328 pixels (h × w) or proportionally more. The image should be readable at a size of 5 × 13 cm using a regular screen resolution of 96 dpi. Preferred file types: TIFF, EPS, PDF or MS Office files. See <http://www.elsevier.com/graphicalabstracts> for examples. Authors can make use of Elsevier's Illustration and Enhancement service to ensure the best presentation of their images and in accordance with all technical requirements: Illustration Service.*

Highlights: *Highlights are mandatory for this journal. They consist of a short collection of bullet points that convey the core findings of the article and should be submitted in a separate editable file in the online submission system. Please use 'Highlights' in the file name and include 3 to 5 bullet points (maximum 85 characters, including spaces, per bullet point). See <http://www.elsevier.com/highlights> for examples.*

Keywords: *Immediately after the abstract, provide a maximum of 6 keywords, using American spelling and avoiding general and plural terms and multiple concepts (avoid, for example, 'and', 'of'). Be sparing with abbreviations: only abbreviations firmly established in the field may be eligible. These keywords will be used for indexing purposes.*

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Acknowledgements: *Collate acknowledgements in a separate section at the end of the article before the references and do not, therefore, include them on the title page, as a footnote to the title or otherwise. List here those individuals who provided help during the research (e.g., providing language help, writing assistance or proof reading the article, etc.).*

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Reference style: References should be arranged first alphabetically and then further sorted chronologically if necessary. More than one reference from the same author(s) in the same year must be identified by the letters "a", "b", "c", etc., placed after the year of publication. References should be

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