**Evidence of Effectiveness of Specialist Supportive Clinical Management for Anorexia Nervosa in Routine Clinical Practice: Outcomes from a Clinical Case Series**

**Word Count (including abstract): 3979**

**Keywords:** Eating Disorders,Anorexia Nervosa,Psychological therapy, SSCM

**The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.**

**Evidence of Effectiveness of Specialist Supportive Clinical Management for Anorexia Nervosa in Routine Clinical Practice: Outcomes from a Clinical Case Series**

Francesca Purvisa, Alexandra Thorpeb, Dr Hannah Turnerc, Dr Pete Lawrenceb,

 aSchool of Health Sciences, University of Southampton

bDepartment of Psychology, University of Southampton

 cHampshire Eating Disorders Service, Southern Health NHS Foundation Trust

Correspondence: f.purvis@soton.ac.uk

**FRANCESCA PURVIS AND ALEXANDRA THORPE ARE TO BE LISTED AS JOINT FIRST AUTHORS**

**Abstract**

**Objective:** This study provides a preliminary report on the effectiveness of Specialist Supportive Clinical Management (SSCM) in a clinical case series of adults with Anorexia Nervosa, to supplement evidence of efficacy from controlled trials.  **Method:** BMI, eating disorder symptoms, mood and anxiety were measured at the start and end of treatment for 42 adults who received SSCM in a community eating disorders service.  **Results:** Significant improvementswere observed on all outcome measures, with larger effect sizes for symptom change than BMI. Recovery rates appear similar to those in clinical trials.

**Discussion:** The study offers preliminary support for the effectiveness of SSCM in routine settings and identifies several areas for further research.

**Introduction**

The treatment of Anorexia Nervosa (AN) poses a challenge to eating disorders (ED) services. The standardised mortality rate is elevated (Arcelus et al., 2011), recovery rates are low (13-50%; Wonderlich et al., 2020), and although psychological therapies are the recommended treatment, dropout rates are consistently high (DeJong et al, 2012). A recent comprehensive review which looked at outcomes for adults with Anorexia Nervosa noted modest positive effects on BMI, ED symptoms and quality of life, with no significant differences between therapies, indicating the lack of a superior treatment (Jansingh et al., 2020). Therefore, it is necessary to identify more effective treatments and the factors associated with greater effectiveness.

One approach requiring further evaluation is Specialist Supportive Clinical Management (SSCM; McIntosh, 2006). This is a supportive therapy that combines two central tenets. The first being the need for clinical management, which focusses on improving weight and normalising eating behaviours using psychoeducation, nutritional advice, and the monitoring of weight and target symptoms. Time can also be given to considering the potential for relapse, with the therapist working alongside the client to encourage them to build upon their progress in between sessions and following the completion of treatment. . Secondly, it is important that whilst clinical management tasks are attended to with the primary aim of weight restoration, clients are encouraged to lead the sessions and may use the time to initiate exploration of broader emotional issues if they wish. The therapist should demonstrate warmth, empathy and reflective encouragement without attempting to ‘fix’ difficulties through use of other psychological models or tools. The overarching aim is to develop a strong therapeutic alliance to foster motivation and enable change through collaborative working (McIntosh, 2006).

SSCM appears to be equally effective to other leading ED therapies (Kiely et al., 2022; NICE, 2017). SSCM was initially developed as an active control intervention in an RCT comparing Cognitive Behavioural Therapy (CBT) and IPT; however, SSCM emerged as superior to IPT in the intent-to-treat analysis, and superior to both IPT and CBT amongst completers (McIntosh et al., 2005). Subsequently, SSCM has featured in a further five treatment trials for adults with AN, as a comparison to CBT (Touyz et al., 2013), CBT-Enhanced (CBT-E; Byrne et al., 2017), the Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA; Byrne et al., 2017; Schmidt et al., 2012; Schmidt et al., 2015) and Mentalisation-based therapy (MBT-ED; Robinson et al., 2016). In all trials, SSCM performed equally to the comparison treatments. It has been suggested that the lack of detectable differences between treatments could be attributed to non-specific factors common to all AN therapies (Byrne et al., 2017, McIntosh, 2006). Nonetheless, the inclusion of these common elements in SSCM suggests intrinsic value as a treatment (Byrne et al., 2017; Jordan et al., 2020).

Nonetheless, the effectiveness of SSCM requires further evaluation. To date, SSCM has only been evaluated in RCTs, which provide moderate indications of efficacy (which is comparable to the other treatments discussed above), but does not demonstrate effectiveness when delivered in routine practice. These trials employ well-controlled designs, observations of therapist adherence, and typically apply tight inclusion criteria targeting mild to moderate illness, although one trial involving SSCM included participants with severe and enduring presentations (Touyz et al., 2013). Therefore, there is a need to conduct effectiveness studies to investigate whether similar outcomes can be achieved in routine clinical settings, where the diversity of cases is greater (including severity or chronicity of illness and presence of comorbidities). This approach has recently been adopted to explore whether evidence-based treatments can be delivered in routine clinical settings with similar patient outcomes (Turner et al., 2015).

The present study reports outcomes from a case series of adults with AN who received SSCM in a routine clinical setting, to provide a preliminary estimate of the effectiveness of this treatment outside controlled trials. The primary outcomes were the change in BMI and ED pathology between the start and end of treatment, whilst secondary outcomes were changes in mood **and anxiety** symptoms. .

**Method**

**Ethics**

The study involved the analysis of data routinely collected by the service, so National Research Ethics Service approval was not required. Approval was granted at a local level for the analysis of secondary data (ERGO ID: 64209).

Individuals accessing the service are routinely given an information sheet explaining that their anonymised data may be used for service evaluation purposes, and encouraged to discuss any concerns. . Completing these measures indicated implicit assent unless stated otherwise.

**Participants**

Participants were 45 individuals referred to an NHS Community Eating Disorders Service in the UK and offered treatment with SSCM. All had an initial assessment based on the Eating Disorders Examination (EDE version 16, Fairburn et al., 2008) or a semi-structured interview (Waller et al., 2007) and had been diagnosed with AN, AN-partial remission or Atypical AN (under the category ‘Other Specified Feeding or Eating Disorder; OSFED), according to the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013). Following assessment treatment options (as per NICE guidelines, 2017) are discussed with patients and this sample consists of those who opted for SSCM. Of the 45 offered, 42 participants agreed to start SSCM, resulting in a sample of 42.

**Outcome Measures**

Several measures are routinely administered by the service to monitor ED symptoms, mood and anxiety, and participants completed all measures at the start and end of treatment.

The Eating Disorder Examination Questionnaire (EDE-Q 6.0; Fairburn & Beglin, 2008) is a self-report version of the Eating Disorder Examination Interview (Fairburn et al., 2008). The EDE-Q assesses core ED-related attitudes and behaviours over the previous 28 days, and has been found to have similar validity to the EDE Interview (Fairburn & Beglin, 1994). Community normative scores are available for both women (Mond et al., 2006) and men (Lavender et al., 2010).

The ED-15 (Tatham et al., 2015) is a validated brief symptom measure of weekly changes in symptoms during treatment. The first ten items capture ED-related attitudes, separated into weight/shape concerns and eating concerns, whilst the remaining items assess the frequency of behavioural symptoms.

Two widely used measures of anxiety and mood, the Generalised Anxiety Disorder Assessment (GAD-7, Spitzer et al., 2006) and the Patient Health Questionnaire (PHQ-9, Kroenke et al., 2001) were used to assess features of anxiety and depression, respectively.

**Treatment**

Treatment was delivered by an experienced Eating Disorders Nurse Specialist, who received regular clinical supervision and had attended a 2 day training course on SSCM run by the British Psychological Society. This was delivered by one of the authors of the SSCM manual. Essential components of treatment included weekly weighing and monitoring of behavioural symptoms, collaborative goal-setting, psychoeducation, practical advice and support and, in later sessions, relapse prevention (McIntosh et al., 2006). Sessions were usually weekly, but could be flexible depending on clients’ needs. Most clients were treated prior to the covid-19 pandemic, and therefore attended face-to-face sessions. Treatment was initially contracted for six sessions, then reviewed and extended up to a maximum of 20, depending on the client’s progress towards their goals and active engagement in treatment. Treatment was reviewed earlier if there were concerns regarding progress, engagement or risk.

**Data Analysis**

All analyses were conducted following the intention-to-treat principle, involving carrying forward the last available observation point.The number of participants included in the sample varied due to the variability of completed questionnaires and the resulting missing data (see N values in Table 1). After determining suitability for parametric tests, changes in BMI, eating pathology, mood and anxiety between the start and end of treatment were investigated using paired samples t-tests. Bonferroni corrections were applied to the EDE-Q and ED-15 subscales, to correct for multiple tests. Both measures were analysed as the EDE-Q is reported in previous research and the ED-15 was administered weekly, therefore providing the most recent information for each participant. Due to the lack of previous research in routine clinical samples to inform expected effect sizes, achieved power was calculated post hoc using GPower 3.1 (Faul et al., 2007). Recovery was measured based on participants restoring weight to BMI > 18.5 kg/m2, and/or achieving an EDE-Q global score less than 1SD above the community mean (2.77 for females and 2.09 formales). Recovery rates at last observation were calculated as percentages.

**Results**

***Participant Characteristics***

Of the 45 participants offered SSCM, 3 chose not to take up treatment and are not involved in the analysis, leaving a sample of 42, of whom 38 were female and 4 were male, with an average age of 27.65 years (SD = 11.32, range = 18–56). The average BMI at the start of treatment was 16.78 kg/m2 (SD = 1.53, range = 12.60–20.10). Participants attended an average of 9.32 sessions (SD = 4.86, range = 2–20).

Did not start treatment = 3

(Declined = 1; did not opt in = 2)

Considered appropriate and offered SSCM

*N* = 45

Nnn

Lost to treatment = 25

(Transferred to another therapy = 8; disengaged = 16; admitted to SEDU = 2

Started SSCM

*N* = 42

Completed treatment

*N* = 16

Figure 1: CONSORT diagram showing recruitment, retention and attrition of patients undertaking SSCM

***Treatment Outcomes***

Table 1 shows the changes in primary and secondary outcomes from the start to end of treatment. The average change in BMI was an increase of 0.52 kg/m2, reaching statistical significance with a small effect size. Significant improvements were observed on all scales of both eating pathology measures (indicated by a reduction in scores), with medium to large effect sizes.

Significant reductions in scores were also observed on the GAD-7 and PHQ-9, with medium effect sizes, indicating improvements in anxiety and depression symptoms.

***Recovery Rates***

In this clinical case series, recovery was defined in three ways, based on achieving BMI > 18.5 kg/m2, reporting an EDE-Q global score less than 1SD above the community mean (2.77 for females and 2.09 for males), or meeting both criteria. Using intent-to-treat analysis, 18.18% (n= 3 of the completers) of participants had achieved BMI > 18.5, 58.06% (n =6 of the completers) reported a normal EDE-Q score and 16.67% (n = 6 of the completers) met both criteria.

 *Key abbreviations: BMI (Body Mass Index); ED-15 (Eating Disorder-15 item); EDE-Q (Eating Disorder Examination Questionnaire); GAD-7 (Generalised Anxiety Disorder-7 item); PHQ-9 (Patient Health Questionnaire-9 item)*

Table 1

*Change in primary and secondary outcomes between the start and end of treatment (using intention-to-treat analysis).*

**Discussion**

This study offers a preliminary evaluation of the effectiveness of SSCM in a clinical case series of adults with AN. Significant improvements were observed for all outcomes, with a small effect size for BMI, and medium to large effect sizes for ED symptoms and mood. One possible explanation for this discrepancy is that weight gain may rely on behavioural and attitudinal change (as captured in symptom measures), and therefore requires more time, which is particularly pertinent as the mean number of sessions attended was lower than in RCTs.

Overall recovery rates in this case series (18.18% of participants achieved BMI > 18.5, 58.06% reported a normal EDE-Q score and 16.67% met both criteria) appear intermediate to those for SSCM in RCTs, where this information was available (12.73% - 32.5%; Schmidt et al., 2012; Schmidt et al., 2015; Byrne et al., 2017), though this study had a lower proportion of participants achieving a BMI > 18.5. Although the treatment outcomes appear generally consistent with those reported in RCTs, (whilst acknowledging the limitations of a significantly smaller sample size) definitive comparisons of the magnitude of change would not be reliable without standardisation to account for the greater variability in this sample. Therefore direct comparison with previous RCTs may not be possible due to the potential heterogeneity within respective data sets related to factors such as severity, duration of illness and presence of any co-morbidities.

Nonetheless, the degree of improvement in BMI required to indicate effectiveness is unclear, as clinically significant change (Jacobsen & Truax, 1991) is difficult to define with respect to BMI and is necessarily individually determined (Schlegl et al., 2014). Furthermore, it is often challenging to accurately define recovery, with definitions varying between studies and challenges evident when attempting to in reach a consensus. (Dawson, Rhodes & Touyz,2015). A further reflection relates to treatment dose. Within the current study, length of treatment was determined collaboratively between patient and therapist. Ending of treatment was indicated normally through a mutual discussion and agreement that the patient had achieved their own personal therapy goals and felt a subjective improvement in their quality of life and symptoms, the timing of which varying across the sample. . Therefore treatment dose did not always replicate those of previously discussed RCTs. Whilst arguably a limitation of this study, the nature of personalised care plans (with flexible treatment dose) within this clinical setting is likely to reflect routine clinical practice..

Another consideration is the potential limitation of using a single therapist and the implications this may have for treatment outcomes and generalisability. A future direction for research should include data obtained by a group of therapists delivering SSCM from across different services. This would ensure better generalisability of clinical effectiveness both across clinicians and services.

This was the first study to evaluate SSCM in a routine clinical setting, and several areas for improvement and further study are noted. The study was underpowered with respect to BMI, and analysis of follow-up data was not feasible. Replication with a larger sample would allow a more reliable indication of BMI change, ensure that the substantial changes in ED symptom scores were not spurious, and ascertain possible predictors of attrition. Analysing follow-up data would indicate whether BMI continues to improve, and whether treatment effects are sustained. Additionally, comparing SSCM outcomes with another recommended therapy in the same setting would provide an additional means of investigating effectiveness.

Overall, there is preliminary support for SSCM as an effective treatment in routine clinical practice. Future research should consider possible predictors of treatment outcome, and whether treatment effects are sustained over time.

**References**

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Arcelus, J., Mitchell, A. J., Wales, J., & Nielsen, S. (2011). Mortality rates in patients with anorexia nervosa and other eating disorders: A meta-analysis of 36 studies. *Archives of General Psychiatry, 68(7), 724-731.* https://doi.org/10.1001/archgenpsychiatry.2011.74

Braun, V., & Clarke, V. (2020). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology, 18*(3), 328-352. https://doi.org/10.1080/14780887.2020.1769238

Byrne, S., Wade, T., Hay, P., Touyz, S., Fairburn, C. G., Treasure, J., Schmidt, U., McIntosh, V., Allen, K., Fursland, A., & Crosby, R. D. (2017). A randomised controlled trial of three psychological treatments for anorexia nervosa. *Psychological Medicine, 47*(16), 2823-2833. https://doi.org/10.1017/S0033291717001349

Crawford, M. J., Weaver, T., Rutter, D., Sensky, T., & Tyrer, P. (2002). Evaluating new treatments in psychiatry: the potential value of combining qualitative and quantitative research methods. *International Review of Psychiatry, 14*(1), 6-11.

Dawson, L., Rhodes, P., & Touyz, S. (2015). Defining recovery from anorexia nervosa: A Delphi study to determine expert practitioners’ views. Advances in Eating Disorders, 3 (2), 165–176.

DeJong, H., Broadbent, H., & Schmidt, U. (2012). A systematic review of dropout from treatment in outpatients with anorexia nervosa. *International Journal of Eating Disorders, 45*(5), 635-647. https://doi.org/10.1002/eat.20956

Fairburn, C.G. (2008). *Cognitive Behavior Therapy and Eating Disorders*. The Guilford Press.

Fairburn, C. G., & Beglin, S. J. (1994). Assessment of eating disorders: Interview or self‐report questionnaire? *International journal of eating disorders, 16*(4), 363-370.

Fairburn, C. G., & Beglin, S. J. (2008). Eating disorder examination questionnaire. Cognitive behavior therapy and eating disorders, 309-313.

Faul, F., Erdfelder, E., Lang, A.-G., & Buchner, A. (2007). G\*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods*, *39*, 175-191.

Hoskins, J. I., Blood, L., Stokes, H. R., Tatham, M., Waller, G., & Turner, H. (2019). Patients’ experiences of brief cognitive behavioral therapy for eating disorders: A qualitative investigation. *International Journal of Eating Disorders, 52*(5), 530–537. https://doi.org/10.1002/eat.23039

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. Qualitative health research, 15(9), 1277-1288.

Jacobson N.S., & Truax P (1991). Clinical significance: a statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*(1):12–19.

Jansingh, A., Danner, U. N., Hoek, H. W., & van Elburg, A. A. (2020). Developments in the psychological treatment of anorexia nervosa and their implications for daily practice*. Current Opinion in Psychiatry, 33*(6), 534-541. https://doi.org/10.1097/YCO.0000000000000642

Jordan, J., McIntosh, V. V., & Bulik, C. M. (2020). Specialist Supportive Clinical Management for anorexia nervosa: what it is (and what it is not). *Australasian Psychiatry, 28*(2), 156-159.

Kiely, L., Touyz, S., Conti, J., & Hay, P. (2022). Conceptualising specialist supportive clinical management (SSCM): current evidence and future directions. *Journal of Eating Disorders,* 10(32) https://doi.org/10.1186/s40337-022-00557-2

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of general internal medicine, 16*(9), 606–613. doi:10.1046/j.1525-1497.2001.016009606.x

Lavender, J. M., De Young, K. P., & Anderson, D. A. (2010). Eating Disorder Examination Questionnaire (EDE-Q): Norms for undergraduate men. *Eating Behaviors, 11*(2), 119-121. https://doi.org/10.1016/j.eatbeh.2009.09.005

Lose, A., Davies, C., Renwick, B., Kenyon, M., Treasure, J., & Schmidt, U. (2014). Process evaluation of the Maudsley Model for Treatment of Adults with Anorexia Nervosa trial Part II: Patient experiences of two psychological therapies for treatment of anorexia nervosa. *European Eating Disorders Review, 22*(2), 131-139. https://doi.org/10.1002/erv.2279 McClay et al., 2013

McIntosh, V. V. W., Jordan, J., Carter, F. A., Luty, S. E., McKenzie, J. M., Bulik, C. M., Frampton, C. M. A., & Joyce, P. R. (2005). Three Psychotherapies for Anorexia Nervosa: A Randomized, Controlled Trial. *The American Journal of Psychiatry, 162*(4), 741-747. https://doi.org/10.1176/appi.ajp.162.4.741

McIntosh, V. V. W., Jordan, J., Luty, S. E., Carter, F. A., McKenzie, J. M., Bulik, C. M., & Joyce, P. R. (2006). Specialist Supportive Clinical Management for Anorexia Nervosa. *International Journal of Eating Disorders, 39*(8), 625-632. https://doi.org/10.1002/eat.20297

Mond, J.M., Hay, P.J., Rodgers, B., & Owen, C. (2006). Eating Disorder Examination Questionnaire (EDE-Q): Norms for young adult women. *Behaviour Research and Therapy, 44*, 53-62.

Mulkens, S., de Vos, C., de Graaff, A., & Waller, G. (2018). To deliver or not to deliver cognitive behavioral therapy for eating disorders: Replication and extension of our understanding of why therapists fail to do what they should do. *Behaviour Research and Therapy*, *106*, 57-63.

National Institute for Health and Care Excellence, (2017). Eating Disorders: Recognition and Treatment (NG 69). Retrieved from [Update information | Eating disorders: recognition and treatment | Guidance | NICE](https://www.nice.org.uk/guidance/ng69/chapter/Update-information).

Peterson, C. B., Becker, C. B., Treasure, J., Shafran, R., & Bryant-Waugh, R. (2016). The three-legged stool of evidence-based practice in eating disorder treatment: research, clinical, and patient perspectives. *BMC medicine, 14*(1), 1-8.

Robinson, P., Hellier, J., Barrett, B., Barzdaitiene, D., Bateman, A., Bogaardt, A., ... & Fonagy, P. (2016). The NOURISHED randomised controlled trial comparing mentalisation-based treatment for eating disorders (MBT-ED) with specialist supportive clinical management (SSCM-ED) for patients with eating disorders and symptoms of borderline personality disorder. *Trials, 17*(1), 1-15.

Sackett, D.L., Rosenberg, W.M., Gray, J.A., Haynes, R.B., Richardson, W.S. (1996). Evidence based medicine: what it is and what it isn’t. *British Medical Journal*, *312*, 71–2.

Sánchez-Ortiz, V. C., House, J., Munro, C., Treasure, J., Startup, H., Williams, C., & Schmidt, U. (2011). 'A computer isn't gonna judge you': A qualitative study of users' views of an internet-based cognitive behavioural guided self-care treatment package for bulimia nervosa and related disorders. *Eating and Weight Disorders, 16*(2), e93-e101. https://doi.org/10.1007/BF03325314

Schlegl, S., Quadflieg, N., Löwe, B., Cuntz, U., & Voderholzer, U. (2014). Specialized inpatient treatment of adult anorexia nervosa: effectiveness and clinical significance of changes. *BMC psychiatry, 14*(1), 1-12.

Schmidt, U., Oldershaw, A., Jichi, F., Sternheim, L., Startup, H., McIntosh, V., Jordan, J., Tchanturia, K., Wolff, G., Rooney, M., Landau, S., & Treasure, J. (2012). Out-patient psychological therapies for adults with anorexia nervosa: Randomised controlled trial. *The British Journal of Psychiatry, 201*(5), 392-399. https://doi.org/10.1192/bjp.bp.112.112078

Schmidt, U., Magill, N., Renwick, B., Keyes, A., Kenyon, M., Dejong, H., Lose, A., Broadbent, H., Loomes, R., Yasin, H., Watson, C., Ghelani, S., Bonin, E.-M., Serpell, L., Richards, L., Johnson-Sabine, E., Boughton, N., Whitehead, L., Beecham, J., Treasure, J., & Landau, S. (2015). The Maudsley Outpatient Study of Treatments for Anorexia Nervosa and Related Conditions (MOSAIC): Comparison of the Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA) with specialist supportive clinical management (SSCM) in outpatients with broadly defined anorexia nervosa: A randomized controlled trial. *Journal of Consulting and Clinical Psychology, 83*(4), 796-807. https://doi.org/10.1037/ccp000001910.1037/ccp0000019.supp (Supplemental)

Simmons, A. M., Milnes, S. M., & Anderson, D. A. (2008). Factors influencing the utilization of empirically supported treatments for eating disorders. *Eating Disorders*, *16*(4), 342-354.

Spitzer, R.E., Kroenke, K., Williams, J.B., & Lowe, B. (2006). A brief measure for assessing Generalised Anxiety Disorder. *Archives of Internal Medicine, 166*, 1092-1097.

Stiles‐Shields, C., Touyz, S., Hay, P., Lacey, H., Crosby, R. D., Rieger, E., ... & Le Grange, D. (2013). Therapeutic alliance in two treatments for adults with severe and enduring anorexia nervosa. *International Journal of Eating Disorders, 46*(8), 783-789.

Tatham, M., Turner, H., Mountford, V. A., Tritt, A., Dyas, R., & Waller, G. (2015). Development, psychometric properties and preliminary clinical validation of a brief, session‐by‐session measure of eating disorder cognitions and behaviors: The ED‐15. *International Journal of Eating Disorders, 48*(7), 1005-1015.

Touyz, S., Le Grange, D., Lacey, H., Hay, P., Smith, R., Maguire, S., Bamford, B., Pike, K. M., & Crosby, R. D. (2013). Treating severe and enduring anorexia nervosa: A randomized controlled trial. *Psychological Medicine, 43*(12), 2501-2511. https://doi.org/10.1017/S0033291713000949

Traviss, G. D., Heywood‐Everett, S., & Hill, A. J. (2013). Understanding the ‘guide’ in guided self‐help for disordered eating: A qualitative process study. *Psychology and Psychotherapy: Theory, Research and Practice, 86*(1), 86-104. https://doi.org/10.1111/j.2044-8341.2011.02049.x

Turner, H., Marshall, E., Stopa, L., & Waller, G. (2015). Cognitive-behavioural therapy for outpatients with eating disorders: Effectiveness for a transdiagnostic group in a routine clinical setting. *Behaviour Research and Therapy, 68*, 70-75. https://doi.org/10.1016/j.brat.2015.03.001

van den Berg, E., Houtzager, L., de Vos, J., Daemen, I., Katsaragaki, G., Karyotaki, E., Cuijpers, P., & Dekker, J. (2019). Meta‐analysis on the efficacy of psychological treatments for anorexia nervosa. *European Eating Disorders Review, 27*(4), 331-351. https://doi.org/10.1002/erv.2683

von Ranson, K. M., & Robinson, K. E. (2006). Who is providing what type of psychotherapy to eating disorder clients? A survey. *International Journal of Eating Disorders*, *39*(1), 27-34.

Waller, G., Cordery, H., Corstorphine, E., Hinrichsen, H., Lawson, R., Mountford, V., & Russell, K. (2007). *Cognitive Behavioral Therapy for Eating Disorders: A Comprehensive Treatment Guide.* Cambridge: Cambridge University Press. doi:10.1017/CBO9781139644204

Waller, G. stringer, h., & Meyer, C.(2012). What Cognitive Behavioral Techniques Do Therapists Report Using When Delivering Cognitive Behavioral Therapy for the Eating Disorders. *Journal of Consulting and Clinical Psychology*, *80*(1), 171.

Wonderlich, S. A., Bulik, C. M., Schmidt, U., Steiger, H., & Hoek, H. W. (2020). Severe and enduring anorexia nervosa: Update and observations about the current clinical reality. *International Journal of Eating Disorders, 53*(8), 1303-1312. https://doi.org/10.1002/eat.23283

Zainal, K. A., Renwick, B., Keyes, A., Lose, A., Kenyon, M., DeJong, H., Broadbent, H., Serpell, L., Richards, L., Johnson-Sabine, E., Boughton, N., Whitehead, L., Treasure, J., & Schmidt, U. (2016). Process evaluation of the MOSAIC trial: treatment experience of two psychological therapies for out-patient treatment of Anorexia Nervosa. *Journal of Eating Disorders, 4*(1), 2. <https://doi.org/10.1186/s40337-016-0091-5>