A qualitative study of change in a guided self-help intervention for binge eating prior to weight management

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The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

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Abstract

Introduction: Binge eating (BE) is considered the most common eating disorder. It is strongly associated with obesity and presents a barrier to effective weight management (WM). Guided Self Help (GSH) interventions are recommended for BE, but most people have never received any support for this problem. This thesis presents a qualitative study examining guides' and clients' experiences of change using a GSH intervention called 'Working to Overcome Eating Difficulties' (WOED) for adults with BE and obesity, prior to engaging in WM.

Method: After receiving or facilitating WOED, nine clients and four guides were interviewed remotely using an adapted version of the client change interview (CCI). Results were analysed using reflexive thematic analysis.

Results: Analysis indicated that WOED offered something 'new' for both parties and was positively received. Clients were unlikely to have had the space to talk about BE before and guides were not used to offering one-to-one support. The relationship with the guide, intervention itself and client factors (e.g. engagement and access to positive social support) facilitated positive outcomes. Some areas of the manual and other client factors (mental/physical health problems, lack of social support, concrete focus on weight loss) presented barriers to engagement/change.

Discussion: Offering GSH targeting BE was well received prior to WM, but it may not be appropriate for all. Training for guides needs to reflect this and accommodate guides' levels of experience, to enable wider dissemination of the programme. Further research is required to determine whether the addition of GSH prior to WM for BE participants increases the effectiveness and acceptability of subsequent WM interventions. Other clinical and research recommendations are made and strengths and limitations explored.

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Introduction

This chapter begins with a detailed literature review of what is known about binge eating (BE), obesity and the potential benefits of weight loss and the negative relationship between BE and weight management (WM). It then considers the current UK provision of support for these difficulties, including the MoreLife programme (the private company involved in recruitment for this project). Next it explores the concept of Guided Self Help (GSH) interventions for disordered eating, in particular, 'Working to Overcome Eating Difficulties' (WOED), the GSH intervention used within this project. Finally, it discusses the utility of change process research, particularly through qualitative methods. It ends by offering a rationale for this project and stating the research questions and aims.

Literature Review

Binge Eating disorder (BED)

Prevalence and diagnosis

Worldwide, BED is currently considered the most common eating disorder (ED), with prevalence rates estimated at 0.3% in adult men and 1.5% in adult women (Keshen et al., 2022; Keski-Rahkonen, 2021). Difficulties with binge eating (BE) can occur at any age and its impact crosses racial, ethnic and gender groupings (Davis et al., 2020). BED is highly associated with obesity, with over three out of four people who binge eat also classifying as overweight or obese (Agüera et al., 2021; de Zwaan, 2001; Udo & Grilo, 2018).

In the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV, 1994), BED was subsumed within the 'eating disorder not otherwise specified' (EDNOS) category. In DSM-V (2013), BED was developed as its own discrete ED. It is currently defined by the consumption of a large amount of food within a relatively short time frame and is associated with a sense of loss of control regarding the food consumed (Berkman et al., 2015). BE episodes are associated with the following: negative emotional implications such as disgust and guilt; eating alone and/or quickly; eating until very full; and eating not necessarily when hungry (Berkman et al., 2015; Kantilafti et al., 2022). For a formal diagnosis, BE behaviours must occur at least once per week for a period of three months and must not involve compensatory or purging behaviours, resulting in the strong association between BE and obesity (Berkman et al., 2015).

The change in diagnostic criteria between DSM-IV and DSM-V has made determining accurate prevalence rates difficult, as DSM-V lowered the diagnostic threshold, thus increasing the numbers of people eligible for diagnosis (Brownley et al., 2016). In addition, prevalence rates vary widely depending on the criteria used for definition and the sample under investigation, and previous prevalence rates are thought to be under-representative, (Agüera et al., 2021; Davis et al., 2020). Within the UK, BED rates were calculated at 3.6% across 1698 ethnically diverse adults from two London boroughs (Solmi et al., 2016). As an approximation, 3.6% of the estimated mid-2022 population of 67.6 million people in the UK (Office for National Statistics, 2024) would give a current estimate of 2,433,600 persons living with BED in the UK. In addition, there are more people living with BE difficulties who do not meet criteria for diagnosis (sometimes deemed 'subthreshold BED'), but still struggle with some of the same physical/emotional associations of BED (Davis et al., 2020). Others may meet criteria for diagnosis, but do not seek support due to the shame surrounding the problem (Coales et al., 2023). Regardless of formal diagnosis, it is clear that there are many people living in the UK that are struggling with BE to various degrees.

Maintenance of BE

According to the 'emotional regulation model', binge eating occurs in response to trying to avoid a difficult emotion, leading to short-term relief but a longer-term problem (Davis et al., 2020). Whilst eating in response to emotions is a common and not inherently problematic behaviour, always using food to regulate difficult emotions may result in a toxic cycle of eating to feel better, then feeling the guilt/shame associated with BE, reinforcing the likelihood of further BE and eventual weight gain (Lillis et al., 2011). Binges are often associated with internalised feelings of guilt, depression, embarrassment, low self-esteem and concerns about body shape and weight (Brownley et al., 2016; de Zwaan, 2001; Jirik-Babb & Geliebter, 2003). Unsurprisingly, BED is strongly associated with anxiety and depression in adults living with obesity (Blaine & Rodman, 2007; Matos et al., 2002). The latter is particularly important due to the known bi-directional relationship between psychological/emotional difficulties and problems with weight (Blaine & Rodman, 2007).

Psychological difficulties may be partly explained and/or perpetuated by experiences of weight stigma that adults living with obesity are likely to have experienced from a young age, from family, school, media and healthcare providers (Puhl et al., 2007). When people internalise weight stigmatising beliefs, they judge themselves negatively based on shape and weight, which is likely to perpetuate difficulties such as low mood and shame. This could then reinforce the cycle of eating to try and feel better and may lead to avoidance of help-seeking from healthcare professionals by whom they may feel (or assume to feel) judged (Ratcliffe & Ellison, 2015). The bi-directional link between BE difficulties and problematic thoughts, feelings and behaviours, is clear.

Difficulties getting support for BE behaviours

Unfortunately, those with BED or BE difficulties are unlikely to have received treatment for this problem. Although BED has been a discrete ED diagnosis since 2013, it often remains undetected (Agüera et al., 2021; Keshen et al., 2022). Its assessment and treatment has lagged behind other EDs such as anorexia nervosa (AN), even though discussions concerning its etiology and management have been present within the literature since at least the early 1980s (e.g. Loro & Orleans, 1981) or arguably the 1950s (as explored in Davis et al., 2020). Kessler et al.'s (2013) review of data from 14 countries found that fewer than 40% of those interviewed with BED had received any ED treatment (though it must be recognised that data included in this review were gathered before the change in diagnostic criteria). More recently, Austin et al.'s (2021) review of data from seven countries found that the average duration of untreated BED was over five and a half years (67.4 months), over twice the average duration of untreated AN (29.9 months). Interestingly, there were also far more studies investigating the latter, indicating a disproportionate focus on different EDs in research.

There are multiple reasons why those with BE difficulties may not be receiving support. Firstly, healthcare providers, and patients themselves, may lack awareness about BED (Davis et al., 2020; Keshen et al., 2022). It could also be partly due to weight stigma in the healthcare system; weight stigma has consistently been shown to negatively impact the quality of care those living with obesity receive (Rubino et al., 2020). It may impact the likelihood of people feeling comfortable discussing BED symptoms with their healthcare providers or seeking support in the first place and/or clinicians' recognition of BED as a problem that needs addressing (Davis et al., 2020; Keshen et al., 2022). Thirdly, it may be partially explained by

researchers' and healthcare providers' understanding of the higher mortality rates of other EDs (e.g. AN) in comparison to BED, which may have impacted the direction of both resources and research. Indeed, ED research has been described as 'anorexic-centric' (Agras, 2001; Bray et al., 2023, p14). Finally, it will also be compounded by biases in referral criteria for ED services. For example, CONNECT: The West Yorkshire and Harrogate Adult ED Service, launched in 2018, include a low BMI cut-off as an inclusion criterion and are by this stipulation only commissioned to support low-weight AN or bulimia nervosa (BN) presentations (Leeds and York Partnership NHS Foundation Trust, n.d.), inadvertently creating a barrier to those with BED accessing specialised support. This leaves a large proportion of people who require support and may not be receiving any from our NHS ED services.

Obesity and WM

Impact of obesity (and BED)

Over 75% of people who binge eat are living with overweight or obesity (Agüera et al., 2021; de Zwaan, 2001; Udo & Grilo, 2018). Obesity is a complex disease influenced by genetics, environmental and psychological factors and should therefore be considered within a biopsychosocial framework (Khan et al., 2018; Thaker, 2017). The World Health Organisation (WHO, 2024) continue to define overweight as an individual living with a body mass index (BMI) of 25 or more, with obesity calculated as a BMI of 30 or more. Use of the BMI as a measure of overweight/obesity has been widely criticised as an oversimplistic tool, as it does not account for factors such as age, gender, ethnicity, muscle or bone density and it cannot accurately identify the amount of excess fat that could increase an individual's risk of various physical health related problems (Humphreys, 2010). However, as this project is restricted by the dominant social discourses surrounding definitions used within the literature, such definitions will also be used within this project.

Prevalence of obesity is continuing to rise, having almost tripled between the 1970s and 2010s (Kantilafti et al., 2022). In 2015, worldwide, 39% of adults were considered overweight, 12.5% were thought to be living with obesity, and these rates were projected to continue increasing (Chooi et al., 2019). Obesity is associated with numerous harmful effects on people's mental and physical health. There is an increased likelihood of problems such as cancers, heart issues, diabetes, pain, depression, anxiety, poor self-esteem, reduced overall wellbeing and health related quality of life (Dixon, 2010; Kolotkin & Andersen, 2017;

Stephenson et al., 2021; Wardle & Cooke, 2005). However, it warrants noting that this is not a simple or linear relationship; not all individuals who live with obesity are automatically unhealthy (this phenomenon has been referred to as the 'metabolically healthy obesity') and there are people living without obesity who are at greater risk of health-related problems for a variety of reasons (Phillips, 2013). Alongside the potential consequences of living with obesity, a considerable body of research indicates that those living in larger bodies (regardless of whether they are metabolically healthy) experience frequent mistreatment and social stigmatisation, serving to predispose or perpetuate the aforementioned difficulties and contributing to increased weight gain (Puhl et al., 2020).

The impacts of obesity and the negative treatment of people living with obesity are well documented as wide-ranging and severe (Dixon, 2010; Puhl et al., 2020; Stephenson et al., 2021). Those living with both obesity and BED demonstrate a lower level of health-related quality of life and a higher level of functional impairment (Ágh et al., 2016). It appears that BED may exacerbate difficulties that those living with obesity may already be more likely to experience.

A true biopsychosocial approach to understanding obesity does not apportion blame to those affected. It is not a simple case of 'calories in, calories' out that weight stigma perpetuated throughout dominant social discourse (including areas of psychological and medical research) would argue. Instead, as a paper commissioned by the British Psychological Society (Chater et al., 2019, p9) states:

'Obesity is not a 'choice'. People become overweight or obese as a result of a complex combination of biological and psychological factors combined with environmental and social influences. Obesity is not simply down to an individual's lack of willpower.

The people who are most likely to be an unhealthy weight are those who have a high genetic risk of developing obesity and whose lives are also shaped by work, school and social environments that promote overeating and inactivity. People who live in deprived areas often experience high levels of stress, including major life challenges and trauma, often their neighbourhoods offer few opportunities and incentives for physical activity and options for accessing affordable healthy food are limited. Psychological experiences also play a big role – up to half of adults attending specialist obesity services have experienced childhood adversity (Hollingsworth et al., 2012).'

Benefits of weight loss

Regardless of the cause of obesity, the positive impact of (appropriate) weight loss on physical health is clear. Instead of targeting a specific ideal weight or BMI, research has demonstrated that even a 5% loss in starting weight can lead to important physical health improvements (Magkos et al., 2016). A 5-10% loss has further positive associations with both blood pressure and cholesterol levels (Ryan & Yockey, 2017). However, these benefits are only thought to occur if weight loss is maintained (Kantilafti et al., 2022).

Whilst most research has focused on physical benefits, a systematic review of 36 studies concerning behavioural and/or dietary interventions showed overall improvements in psychological wellbeing following weight loss. However, improvements in wellbeing were not always related to weight loss (Lasikiewicz et al., 2014). The authors acknowledged that there was significant heterogeneity in the quality of studies, indicating the current difficulty in accurately gauging the psychological impact of weight loss interventions. A further meta-analysis concluded that weight loss is required to see improvements in self-esteem (Blaine et al., 2007). However, McGregor et al. (2016) surveyed over 300 young people living with obesity who attended a month-long weight loss residential camp and found that measures of global self-worth improved, but this was not statistically linked to weight loss. It is possible that in such an intense intervention, improvements in self-esteem could have been the result of new friendships, fewer weight stigmatising experiences, increased physical activity and/or other factors. Overall, this picture appears much more complex than the clear physical health benefits that maintained weight loss can bring.

Additionally, the positive impact on quality of life of weight loss is promising but not currently conclusive. A systematic review of reviews demonstrated that health related quality of life often improved for people living with obesity following weight loss, yet not consistently. The authors queried whether this finding was due to the limited power of studies, patient dropout, inconsistent reporting and heterogeneity in the 23 health related quality of life measures used (Kolotkin & Andersen, 2017). Further research is required.

Relationship between BE, obesity and WM

Three out of four people who binge eat are overweight/obese, and they are more likely to seek support for their relationship with weight, rather than for their difficulties with BE specifically (Agüera et al., 2021; de Zwaan, 2001; Udo & Grilo, 2018). Accordingly, it has been estimated that around 30% of people seeking WM support present with BE behaviours (de Zwaan, 2001). With the increase in obesity rates, reduction in diagnostic threshold for BED and co-occurrence for BED and obesity, BE problems are now likely to be affecting a substantially higher proportion of those seeking support for weight loss (Agha & Agha, 2017; Dixon, 2010). There is need for up-to-date research regarding de Zwaan's figure; 2001 is over 20 years ago and the statistic cannot account for the changes listed.

BE presents a barrier to effective engagement and success in WM interventions. A matched-sample meta-analysis of 36 weight loss treatments (including psychotherapy and drug/surgical treatments) demonstrated that adults living with obesity and BE behaviours lost significantly less weight than those only living with obesity (Blaine & Rodman, 2007). Participants who regularly engaged in BE behaviours lost half the weight compared with those who did not binge eat or whose BE stopped early in a lifestyle modification intervention treatment (Chao et al., 2017). Furthermore, a comparison of those who did and did not binge found that the former achieved only 55% of the weight loss that the latter achieved during a WM intervention (Pagoto et al., 2007). Self-reported BE behaviours were related to greater weight gain over a 2-year period following a weight loss intervention and initial weight loss of 10%, indicating that BE behaviours may also lead to greater weight gain post-intervention (Pacanowski et al., 2014). This has implications for long term sustainability of weight loss. A recent systematic review of research with over 3500 participants with BE behaviours concluded that BE behaviours were negatively associated with weight loss maintenance and as mentioned previously, weight loss must be maintained for the positive benefits on health and quality of life to occur (Kantilafti et al., 2022).

In addition to BE making long-term weight loss maintenance difficult, expectations of weight loss may also play a role. Voss et al. (2023) surveyed 760 adults with and without BE behaviours and found that those who binged and those with a hyperfocus on weight/shape, thought they would lose more weight than those who did not binge and who were less extreme in their focus on weight/shape. In fact, they thought they would lose more weight than could be expected by clinicians or

the evidence base. This is problematic as expectations play a role in treatment adherence, treatment satisfaction and outcomes (Voss et al., 2023).

Overall, whilst not inevitable, research indicates that BE can negatively impact individuals' abilities to effectively engage in and benefit from traditional WM programmes. However, there is significant heterogeneity across samples, interventions and measurements. For example, an intensive residential cognitive behavioural therapy (CBT) intervention for weight loss found no significant difference in weight loss between participants with obesity who did and did not engaging with BE behaviours after five years (Calugi et al., 2016). This conclusion is tentative due to the small sample size (54 with and without BED) and numbers missing to follow-up (33 BED and 38 without BED were reviewed) (Calugi et al., 2016).

With regards to acceptability, a systematic review demonstrated that the relationship between BE behaviours and drop-out rates of WM interventions is unclear; some research has linked BE to increased likelihood of drop out, whilst other research does not support this (Blaine & Rodman, 2007; Moroshko et al., 2011). As a caveat, Moroshko et al.'s (2011) review did note that attrition in WM interventions is tricky to explore due to the wide heterogeneity in the research and lack of consistent reporting and defining. High rates of attrition are a general problem for many WM interventions, regardless of BE behaviours, indicating the need to establish support that is acceptable as well as effective, particularly as drop out is associated with weight regain (Duarte et al., 2021; Lillis et al., 2011).

In conclusion, weight loss and engaging in acceptable WM interventions are important for the health of many people living with obesity (if their weight is putting them at risk). BE behaviours are common in people seeking support for weight loss and may be a barrier to effective WM. It is therefore imperative that this patient group is provided with ways to target their BE first, to subsequently enable sustainable weight loss. Additionally, it is important to determine if there are less intensive and more cost-effective ways to enable this than the positive outcomes found by Calugi et al.'s (2016) resource-heavy 21-day residential treatment. Recent research recognises the need for BED support prior to WM support, based on the information explored so far in this introduction (Kantilafti et al., 2022).

Overview of current UK WM provision

Stepped care model

Living with obesity is problematic and BE affects many people seeking support for weight loss, therefore an overview of what support is currently available for WM is warranted. WM support, provided in the UK by the NHS and local authorities, is currently split across four tiers, from lowest (Tier one) to highest (Tier four) intensity (Obesity Empowerment Network, n.d.).

Tier one refers to universal interventions aimed at the entire population, such as public health campaigns, to increase the population's physical activity and awareness of other health and weight-related behaviours (Obesity Empowerment Network, n.d.). Examples include the detailed advice on the NHS website regarding diet and exercise, a free downloadable application with an NHS weight loss plan and the anti-smoking posters in bus stops.

Tier two refers to lifestyle and WM interventions, often offered in group settings in community/leisure centres and mostly provided by local authorities (Obesity Empowerment Network, n.d; Public Health England, 2015). Aligning with guidance from the National Institute for Health and Care Excellence (NICE, 2014), lifestyle modification interventions (i.e. those focused on diet and exercise) varying in intensity (covering Tiers two-three) are most offered as the initial support for obesity (Puhl et al., 2020).

A recent meta-analysis of behavioural WM interventions including over 8000 participants (predominantly women with a mean age in the late 40s, ethnicities not reported) delivered in primary care, found that such interventions were effective for adults living with obesity in supporting a modest weight loss of around 2kg, maintained at 24 months post intervention. This was the same both when delivered by GPs/nurses and by non-medical practitioners (Madigan et al., 2022). The researchers reported that the number of contacts with a professional was important to efficacy and recommended 12 in-person or online face-to-face contacts. However, a recent qualitative study indicated that over 50% of service-user participants did not feel that their mental health needs were adequately supported within existing tier two services (Marwood et al., 2023). Participants reflected upon the bidirectional relationship between psychological needs and eating behaviours, thus reiterating the importance of embedding psychological support.

Given the rise in obesity rates and recognition of the benefits of such support, in 2021 the UK government promised an increase in funding to support provision of such services, including the expansion of Tier two behavioural WM programme (Office for Health Improvement & Disparities, 2023). Provisional data following this investment indicates that from April 2021 to December 2022, in England specifically, 131,665 adults were referred to Tier two WM services. Subsequently, 65% were enrolled on a programme and 35% completed (OHI&D, 2023), demonstrating some difficulties with acceptability and retention. Potentially, given Marwood et al.'s (2023) findings, this could partly be explained by the high levels of emotional needs that may not be being supported within such services.

Tier three WM services, commissioned by the NHS and local authorities, offer specialised interventions from trained and specialised staff such as dieticians, doctors and psychologists (Public Health England, 2015). Unfortunately, there are often long waiting times for such services. A recent BBC news report indicated that 660 individuals in Leeds were awaiting specialised support from the Leeds Community Healthcare Tier three WM service; following a severe increase in referral rates, the waiting list was reportedly closed in July 2023 and these individuals are now being signposted elsewhere for support (BBC News, 2024). As there are multiple physical and mental health complications associated with obesity (and BED), the need for more timely support is evident. A review by Public Health England (2015) noted that they were unable to scope out the accurate provision of Tier three WM support across the UK due to a low response rate from services, but surmised that there are at least some areas without access to such services at all.

With regards to efficacy and acceptability, Alkharaji et al. (2018) concluded that it was too difficult to conduct a robust meta-analysis on studies published on Tier 3 service outcome data due to high drop-out rates, poor reporting of the reasons for this, and high levels of bias in the current available literature. Further investigation of the reasons for drop-out, and more robust RCTs that can control for many sources of bias, are warranted (Alkharaiji et al., 2018).

Tier four WM refers to the bariatric surgery options that are available for adults living with obesity (Obesity Empowerment Network, n.d.). A stepped care model approach would indicate that (at least in most circumstances) people wishing to undergo a surgical option have already been through the support offered at lower tiers. There will be exceptions and this may be dependent on individual circumstances and service commissioning.

The MoreLife WM intervention

MoreLife is a private associate company of Leeds Beckett University, offering WM and healthy lifestyle interventions based on evidence-based practice. They offer consultancy, Tier two/three WM interventions, obstetric and family WM interventions, the NHS digital WM programme and integrated lifestyle programmes including support for smoking and physical activity. Most of their support, including the WM programme, is delivered in groups. MoreLife is the company this project has recruited through, as they were offering an individual GSH intervention for BE difficulties for adults living with obesity, prior to their group WM intervention. A hyperlink to their website is included in the references.

Guided self-help (GSH) interventions

The difference between 'pure' and 'guided' self-help

A 'pure' self-help approach involves the provision of self-help materials, with no support from another person (the NHS weight loss app mentioned earlier would represent such an approach). In comparison, GSH interventions involve a combination of self-help materials (e.g. a manual or video guides) with regular short sessions with a guide to help troubleshoot any problems and maintain treatment adherence (Hildebrandt et al., 2017; Keshen et al., 2022). GSH is an evidence-based treatment that most often follows CBT principles (Cromarty & Gallagher, 2023). The participant is expected to complete home tasks in-between sessions, during which they are encouraged to practise the relevant techniques in their everyday life (Khan et al., 2007). Even in face-to-face facilitation, the guide should not fall into the role of traditional 'therapist' and the participant should be encouraged to hold the responsibility in addressing their difficulties (Traviss et al., 2013). GSH should be patient-led; this may be unexpected to some who are expecting to be the passive recipients of an expert authority/treatment (particularly within a healthcare setting), but it is of paramount importance for the engagement of this type of intervention. Recipients must understand that **they** are the mechanism of change, not the guide (Khan et al., 2007). This difference between GSH and more traditional psychological treatments is thought to have a positive impact on the power dynamics between guide and participant, enabling a more balanced relationship (Yim & Schmidt, 2019).

GSH for BED

A systematic review of 30 randomised controlled trials (RCTs) of GSH interventions utilised with a range of EDs (including BED, BN and EDNOS) found that GSH was superior to active control interventions and waiting lists in significantly improving ED psychopathology (moderate effect size) and BE abstinence (small effect size) (Traviss-Turner et al., 2017). This indicates that GSH interventions may be particularly appropriate for those with BED due to the positive impact on BE (Traviss-Turner et al., 2017). The suitability of CBT-GSH for BED specifically has already been recognised in a review by Wilson and Zandberg (2012). Additionally, Grilo and Masheb's (2005) comparison of a CBT-GSH intervention with a behavioural weight loss treatment found significantly higher retention rates for the former, suggesting that this may be a more acceptable treatment for the BED population than traditional WM treatments. More recently, GSH based on Dialectical Behaviour Therapy (DBT) principles, a therapy that aligns well with the emotional regulation model of BED, has been demonstrated as effective too (Kenny et al., 2020).

In light of such findings, NICE (2020) currently recommends that GSH interventions should be offered to all adults with BE difficulties as a first-line treatment and suggest that four to nine sessions with a practitioner whilst working through a self-help manual is typical. This advice has continued to be echoed as appropriate in a recent review of BE aetiology and treatment (Keshen et al., 2022). Whilst there is emerging evidence into the effectiveness of other therapeutic interventions such as mindfulness (e.g. Godfrey et al., 2015), interpersonal psychotherapy (IPT: e.g. Wilson et al., 2010) and DBT-GSH (e.g. Kenny et al., 2020) developments of CBT interventions, including GSH, are now considered the 'gold-standard' intervention for BED.

More intensive treatments for BED recommended by NICE (2020) include individual (typically 16 weekly sessions lasting 1.5 hours) and group (typically 16 – 20 sessions) ED-focused CBT. Both represent around double the clinician hours required in comparison to a GSH intervention (albeit delivering an intervention in a group format may mitigate some of the increase in hours per person). Similar to the WM support described earlier, a 'stepped care' approach of providing the least intense effective and acceptable intervention first makes both economical and clinical sense, particularly when considering the resources and cost required to deliver full therapist-led CBT and the potential for an increase in accessibility through disseminating more self-help models (Keshen et al., 2022; Traviss et al.,

2011; Traviss-Turner et al., 2017; Vocks et al., 2010). For example, in one study, GSH was found to be similarly effective to IPT in treating BED and involved roughly 13-15 fewer contact hours with a therapist (Wilson et al., 2010). Another demonstrated that in treating BED, CBT-GSH had comparable efficacy to the individual psychotherapy intervention 'Integrative Cognitive-Affective Therapy' (ICAT-BED), which involved 10 sessions for the former and 21 for the latter (Peterson et al., 2020).

CBT-GSH interventions for BED do not directly target weight loss, they focus on achieving a regular eating pattern and gaining better control over eating (e.g. Grilo & Masheb, 2005; Streigel-Moore et al., 2010). NICE (2020) guidance therefore states that all participants should be made aware that this is not an aim, or necessarily an outcome, of these interventions. As expectations for and a hyper-fixation on weight loss may be increased in this population group, thus potentially negatively impacting treatment satisfaction, sharing this information becomes particularly vital (Voss et al., 2023).

Background and training of guides

Over 25 years ago, Carter and Fairburn (1998) demonstrated that low-intensity interventions for BED need not be facilitated by specialist practitioners. The skills required of a guide are more generic than specialist therapeutic skills, with more emphasis on interpersonal qualities such as being non-judgmental, supportive, motivational and responsive, rather than an 'expert' in the treatment of EDs (Traviss-Turner et al., 2017; Yim & Schmidt, 2019). With appropriate support, a range of non-specialist professionals are therefore suitable (Wilson & Zandberg, 2012). The range of backgrounds for guides within the literature and clinical practice has included: psychological wellbeing practitioners (e.g. iCope NHS talking therapies service, n.d.); health professionals (Naeem et al., 2016); graduate/doctoral students, dieticians and GPs (Traviss-Turner et al., 2017, 2018). Whilst professional background can vary, it is useful if the practitioner has an interest and/or qualifications in working psychologically (Traviss-Turner et al., 2017).

A broader facilitator base is key to dissemination of and access to GSH interventions, as the delivery of more intense therapies can be impeded by the lack of practitioners with specialist training (Wilson & Zandberg, 2012), contributing to the long wait lists already mentioned. For example, due to the high numbers of people living with obesity and BE difficulties who are seeking WM support (e.g. 30%: de Zwaan, 2001) dietitians may be well placed to provide such interventions, particularly as they are able to offer additional expertise in nutrition and food intake

(Keshen et al., 2022; Traviss-Turner et al., 2018). A broader clinician base may also provide one method to reach minoritised groups, if a more diverse population can be trained as GSH practitioners to facilitate interventions within their community (Wilson & Zandberg, 2012).

Whilst broader professional backgrounds of Guides may be beneficial, a systematic review of GSH interventions for EDs concluded that thorough training and supervision for guides remains essential (and is not always evidenced within the research) (Traviss-Turner et al., 2017). Quality training/supervision may be even more relevant when guides represent a range of professional backgrounds, for quality and consistency control to maintain treatment fidelity. Professional training may influence intervention facilitation in ways both conscious and unconscious, making it harder to evaluate, if training/supervision are not consistent in their messaging.

GSH intervention 'Working to Overcome Eating Difficulties' (WOED)

An overview of the intervention

WOED is a GSH intervention for disordered eating based on a transdiagnostic model and CBT principles. It also incorporates aspects of mindfulness, DBT, compassion focused therapy (CFT) and motivational interviewing (MI) (Traviss et al., 2011; Winckley, 2019). One of the guiding principles of WOED is that under all eating problems is a common core psychopathology (including an intense focus on shape, weight and control to monitor self-worth) and the same/similar maintaining factors (high self-criticism and perfectionism leading to negative self-evaluation when the individual inevitably 'fails') (Fairburn et al., 2003). This is reflected in the transdiagnostic description of EDs provided online by the NHS (2024, no page number) as 'a mental health condition where you use the control of food to cope with feelings and other situations.' In challenging this, CBT aims to re-frame the thoughts and behaviours that maintain the problem eating, such as the hyperfocus on weight/shape and unhealthy eating behaviours including restrictive eating (Davis et al., 2020).

WOED comprises of a written manual, typically seven one-hour sessions with a Guide over around 12 weeks (commencing weekly then tapering off in frequency) and between session tasks (Traviss et al., 2011). Descriptions of the seven sessions involved in WOED (one introduction and six content) can be found in Figure 1 (Coales et al., 2023). Note the addition of information in chapter three

concerning diabetes, added for the population under study in Coales et al.'s (2023) paper, and not included in the standard version under investigation within this project.

Figure 1.*WOED session descriptions.*

Session	Title	Key topics
1	Introduction: Working to Overcome Eating Difficulties	Introduction to the programme; Readiness for change; Introduction to guided self-help (GSH)
2	Chapter 1: Eating Disorders and this Treatment Approach	Background on eating disorders and their causes; Cognitive Behavioural Therapy (CBT) and the Transdiagnostic Approach
3	Chapter 2: Physical and Psychological Health	Impacts of restriction and binge-restrict cycle; Compensatory behaviours; Keeping an eating diary
4	Chapter 3: Food and Health, and Unwanted Behaviours	Determinants of body weight; Role of different nutrients in the body; Eating for health with diabetes; Recognising hunger and stopping compensatory behaviours
5	Chapter 4: Thoughts	Identifying unhelpful thoughts; Psychological flexibility; Mindfulness
6	Chapter 5: Learning to Feel Good About Yourself	Emotions in Cognitive Behavioural Therapy; Self-soothing when stressed; Improving relationships; The role of mobile apps in eating problems
7	Chapter 6: Planning for the Future	Meeting goals and maintaining change; Building resilience

Note. This image is taken from Coales et al., 2023. Permission for image reproduction was granted by paper co-author G.T.T.

Crucially, guide sessions are participant led; they involve discussing the chapter content, any activities that the participant has completed or had trouble completing and any other relevant topic they wish to bring (Coales et al., 2023). WOED is designed for use across the spectrum of ED severity, across different ED presentations and has been adapted for use with specific populations including children and young people and those with Type two diabetes (Coales et al., 2023; Winckley, 2019). WOED has been described in a review of GSH interventions for

EDs as the 'most comprehensive self-help intervention based on CBT principles to date' (Wilson et al., 2012, p.354).

It is important to reiterate that, mirroring the evidence described earlier, weight loss is NOT an aim or expected outcome of this intervention.

Training and facilitation model

It is mandated that before a guide can facilitate WOED, they must have received the appropriate training. This is normally delivered by one of the intervention authors and is typically a one-day face-to-face workshop (Coales et al., 2023). Training focuses on the skills underpinning CBT, plus MI (including working with ambivalence), psychological formulation and supporting clients to create behavioural experiments (Traviss-Turner et al., 2018). The facilitation model also stipulates that guides should have ongoing supervision from an appropriately qualified professional such as a clinical psychologist. This aligns with advice from a recent systematic review and the recent consensus statement for the improvement of programme-led interventions for EDs (Davey et al., 2023; Traviss-Turner et al., 2017).

Effectiveness and acceptability

In an RCT, in comparison to a wait list, a small group of adults (36/37 female) with a range of eating difficulties (including 14 that would meet criteria for BED) were found to benefit from WOED, demonstrated through a reduction in distress levels and an improvement in worries around shape and eating (Traviss et al., 2011). Additionally, reports of BE episodes were found to improve but this change was not statistically significant.

A qualitative study with a sample of the guides and participants in Traviss et al. (2011) highlighted that both parties agreed that the ‘necessity’ of the guide led to the intervention's success (Traviss et al., 2013). The sample interviewed included three people living with BED and overweight/obesity. Examples of their input included one BED participant highlighting the collaborative nature of working alongside a guide and another noting that they did not feel they would have completed the intervention without the guide (Traviss et al., 2013). Whilst the RCT was conducted with adults with a range of eating difficulties, it was thought to be most suitable for those presenting with BE problems and less suited for those with AN presentations (Traviss et al., 2013). The centrality of the guide has been demonstrated elsewhere; a review of seven papers using qualitative research in

self-help interventions across EDs (including Traviss et al., 2013) noted that every study highlighted the importance of the guide and in-person face-to-face support specifically may help with the motivation levels of participants (Yim & Schmidt, 2019). Importantly, this review included only studies with female participants, demonstrating a) the gender bias within this field of literature and b) that the conclusions drawn may not necessarily be representative of all of those requiring treatment, as BED affects both men and women (Striegel et al., 2012).

Specifically in treating BED, WOED has subsequently been found to demonstrate short-term effectiveness in a sample of 24 participants with obesity and BE difficulties accessing a community WM service. Here the intervention was facilitated by community dieticians. Results demonstrated significant improvements in ED psychopathology, internalisation symptoms and lack of control over their eating (Traviss-Turner et al., 2018). Again, reductions in BE frequency were demonstrated but did not reach statistical significance. Consistent with previous research, there was no significant impact of the intervention on participants' weight (Traviss-Turner et al., 2018). Supporting the fact that guides need not be psychological therapists or ED specialists, the alliance measures used yielded consistently high responses, indicating positive relationships between dietician guides and clients (Traviss-Turner et al., 2018).

Recently and most directly relevant to this project, MoreLife conducted a service evaluation to explore the preliminary effectiveness of WOED in a pilot study as a precursor to WM for clients identified as having BE difficulties (Edwards et al., 2023). The results were promising, with a reduction/cessation of BE in 11 out of the 13 participants who completed the intervention and the facilitation of WOED was recommissioned. Participants and guides were not interviewed in Traviss-Turner et al.'s (2018) study or Edwards et al.'s (2023) service evaluation project, so there is little information known about what aspects of the intervention were the greatest help and what needs to be improved, to enhance engagement and outcomes.

Change process research

'Common factors' of change in therapy

Change research is specifically concerned with what supports someone to do well in an intervention and what might get in the way. There are multiple psychological therapies targeting similar difficulties, each with comparable degrees of demonstrated efficacy; this has been recognised for almost 90 years (Rosenzweig, 1936). Research into 'common factors' suggests that more important than therapist model or technique in influencing positive change are factors stable

across interventions, including (but not exclusive to): the therapeutic alliance; client factors (e.g. motivation, expectation, hope, alignment with the model) and therapist factors (e.g. confidence, experience of the intervention, personality) (Drisko, 2013; Fife et al., 2014; Rosenzweig, 1936). Such factors cannot exist independently in practice, but overlap/depend on each other, even though research has attempted to isolate their individual contributions (Fife et al., 2014). Much research indicates that the therapeutic alliance is fundamental, but this does not negate the importance of specific techniques or models, simply highlighting that their utility exists within the therapeutic relationship (Fife et al., 2014). In addition, the common factors model holds that we must consider any measure of change within the context of the person, relationship and intervention, rather than seeing an intervention in isolation as wholly causal of change (Drisko, 2013). Finally, it must be recognised that much of the research in this area often focuses on factors at the individual level, negating the importance of context (e.g. environmental and social factors such as institutionalised racism or poverty), perhaps because these are much harder to quantify and target for change (Davis et al., 2015).

Change in GSH

Most of the research into the common factors model is based on investigations of change within psychotherapies, rather than lower intensity or programme-led interventions. However, similarly, GSH interventions involve a human relationship between guide and client. As already outlined, the skills required of guides are interpersonal in nature (Traviss-Turner et al., 2017) and both guides and clients have reflected on the importance of having a guide (Traviss et al., 2013). It therefore makes intuitive sense that at least some of the factors important in therapy, such as the therapeutic alliance, may be helpful in promoting positive change in GSH.

A qualitative exploration of client experiences of low intensity interventions for depression and anxiety (including GSH) found that unrealistic expectations of therapy, experiences of stigma regarding mental health problems (both external and internal; particularly problematic for male participants), a perceived lack of time and a more manualised rather than individualised therapist approach were associated with an absence of positive psychological change (Amos et al., 2019). A participant's ability to change perspective and their perceptions of the therapist as personal in their approach and enabling enough time to talk were positively associated with psychological change (Amos et al., 2019). It appears that a combination of client and therapist factors may be important for clients to feel the

benefits of such approaches. It must be noted that the interventions under review within this small sample of eight interviewees included computerised support, GSH and one-to-one therapy, so conclusions drawn are not specific to GSH per se. The same paper highlighted the lack of qualitative exploration of client perspectives of change in such interventions, noting it as an area requiring further research (Amos et al., 2019).

Within GSH interventions specifically, Headley (2021) suggests that client factors may be particularly important due to the increased expectations and requirements of the client and the restricted and boundaried involvement of a therapist/guide. Indeed, across a range of GSH interventions for BN (including those based on CBT), the client factors of motivation to change and belief in one's ability to change were found to be positively associated with better outcomes (Steele et al., 2011). In fact, motivation to change was found to be the most robust predictor of positive change.

Mirroring this, DiClemente and Velasquez (2002) highlight the importance of client motivation in any behaviour change and thus feel that MI techniques are of paramount importance when working with individuals. Indeed, the addition of MI techniques within a behavioural weight loss programme indicated improvements in: participants' eating-related guilt and fear of loss of control over their eating; unrestrained eating; drop-out rates; and an indication towards improved mood and quality of life (DiMarco et al., 2009). Not all of these changes reached statistical significance; the authors hypothesise that this could be due to the small sample size. However, these findings demonstrate the positive association of motivation on psychological wellbeing, eating behaviours and programme retention.

Alongside the importance of motivation, specifically in supporting clients with BE, a GSH intervention based on DBT skills demonstrated that improvements in BE behaviours were associated with positive shifts in the ability to regulate emotions, aligning with the understanding that particularly in BED, there is a strong emotional component in eating behaviours (Wallace et al., 2014). This mirrors the emotional regulation model of binge eating already explored and previous research with WOED, which demonstrated improvements in internalisation symptoms and reductions in distress levels following engagement in the programme (Traviss et al., 2011; Traviss-Turner et al., 2018).

'Stages of change' model

Holding in mind that client factors may be particularly pertinent to the success of GSH interventions, this model provides an easily accessible way of

determining where an individual might be in their journey of change. Developed by Prochaska and DiClemente (1983) and explored in several subsequent revisions, the ‘stages of change’ model includes precontemplation (not ready/recognising the problem), contemplation (considering the pros and cons of change but taking no action), preparation (ready to change but may feel unsure/apprehensive), action (actively changing) and maintenance (working on sustaining the change) (DiClemente & Velasquez, 2002; Prochaska et al., 2013). Whilst these could be interpreted as linear and discrete stages that individuals move through seamlessly, they are not thought to be so and it is expected that individuals will move between them through incremental changes; this serves to normalise relapse without considering it to demonstrate a ‘failure’ (Prochaska et al., 2013). These stages are thought to be involved whether the change involves starting, changing or stopping a behaviour and whether behaviour change occurs with/without an intervention (DiClemente & Velasquez, 2002).

This model is presented in the first section of the WOED manual, to encourage clients to consider where they may be on the cycle and to recognize when they have moved into a different stage. It also integrates relapse into the change cycle and states that relapse is expected and not a sign of failure. The aim of this is to encourage clients to keep going even when they perceive they have ‘failed’. Given the high likelihood of self-criticism and perfectionism in this population group (Fairburn et al., 2003), this will be essential for maintaining a sense of hope in clients. The final session of WOED focuses exclusively on ‘planning for the future’, how to continue to make positive changes and cope with relapses.

Utility of exploring service users’ perspectives

WOED has shown promising efficacy findings, but what remains unclear are the components that contribute to its effectiveness and acceptability for BED participants. Qualitative research enables us to explore this complexity and offer another angle for understanding what part(s) of GSH feel effective and acceptable to the end user, enabling a deeper, richer understanding of individual experience than quantitative research alone can achieve (Khan et al., 2007; Tenny et al., 2022). Qualitative research is a powerful tool enabling service users to convey their opinion on what works and what does not work (Elliott, 2010). Additionally, quantitative research does not typically enable participant perspectives on the mechanisms of change, another area in which qualitative research can support

(Amos et al, 2019). If used appropriately, it can enable clinicians to subsequently improve delivery models and perhaps enhance efficacy (Plateau et al., 2018).

Much of the research explored thus far concerning BED and GSH interventions (other than Traviss et al., 2013) is quantitative and is concerned with the statistical examination of clinical effectiveness. However, it remains that guides and participants views are not often captured. Traviss et al.'s (2013) study involved only three participants with BED and it is unclear whether the guides interviewed had experience supporting participants with BED, BN or ENDOS. Qualitative research enables a richer understanding of the experiences and attitudes of service users, which in turn can lead to a greater understanding of factors impacting engagement and/or acceptability of an intervention (Yim & Schmidt, 2019). With this goal, methods such as interviews can capture the complexity that quantitative methods such as standardised outcome measures cannot (Traviss et al., 2013).

Additionally, clients' and guides' views may differ on their understanding of an intervention and what promotes positive change. For example, Winckley (2019) interviewed eight guides and four clients (adolescents) on their experience of using WOED in a Child and Adolescent Mental Health Service (CAMHS) setting. Winckley (2019) found that although there were overlaps between what guides and clients reported was helpful about the intervention, the weighting they placed on different aspects varied. Guides focused on the importance of behavioural change, whilst clients placed more emphasis on internal (i.e. thought) changes. This demonstrates the importance of capturing both parties' views.

Clinically, it is encouraged to involve service user feedback in the delivery of care; this has been the case for the last several decades in the UK (Omeni et al., 2014). NHS England Patient and Public Participation Policy (2017, p.6) states 'NHS England believes that by listening to people who use and care about services, it can understand their diverse health needs better, and focus on and respond to what matters to them'. A relatively recent study concerning three NHS Trusts in England found that both community mental health service users and staff perceived service user feedback overall as beneficial, with benefits including improvements in services, service users being involved in decision making and positive therapeutic impacts of such involvement (Omeni et al. 2014). Semi-structured interviews provide such a platform for the generation of meaningful service user feedback that can be analysed to generate meaningful clinical recommendations. In this setting, both the Clients and Guides could be considered service-users of this intervention as it is new to both.

Client change interview CCI (Elliott, 1999; Elliott & Rogers, 2008).

There are multiple ways that we can assess change during and following an intervention. Standardised quantitative outcome measures are typically used, particularly within clinical services, to establish 'cut off' points and determine whether the change made by a person was 'clinically' and/or ‘statistically' meaningful. Whilst helpful in determining efficacy and deciding how to commission services/fund training, the use of standardised outcomes measures alone does not capture the range of individual changes that may occur, particularly if such changes were unexpected. For example, use of an anxiety-specific measure may be helpful when evaluating CBT for ‘generalised anxiety disorder’, but without asking an individual person what they thought contributed to this change, we may not know what specifically was helpful, whether any of it was either irrelevant or potentially unhelpful/harmful, or whether an external factor (e.g. changing jobs) contributed to the change. It is particularly important to capture the range of possible outcomes/changes when an intervention is new, or when an established intervention is being delivered within a new population.

The client change interview (CCI) was developed in response to this understanding. Typically lasting 30-90 minutes, the CCI focuses on the process of change, asking the client to identify what they found helpful/unhelpful during therapy and, if changes are identified, why they think they occurred (Elliott, 1999; Elliott & Rogers, 2008). It is a semi-structured interview comprised of open-ended questions, purposefully designed to support interviewees to reflect on their experiences and find their own words to describe changes (Elliott et al., 2001). It is therefore purported to be a useful therapeutic tool in its own right, as it prompts reflection and may support a client to adopt a more positive point of view about their therapy and the changes they have made, as well as providing a tool for assessing outcomes (Elliott et al., 2001). Researchers are advised to be empathetic and curious when administering this interview schedule (Elliott et al., 2001) (qualities that strongly align with the primary researcher’s values and clinical experience as a trainee clinical psychologist) and equally feel appropriate when interviewing clients who may have co-occurring difficulties such as anxiety and depression. Elliott and Rogers (2008) CCI version five was adapted for use in this project. Demonstrating utility and ethical acceptability, an adapted use of the CCI has already been used to good effect within similar research which considered use of WOED with young people and clinicians within ED services (Winckley, 2019). Both

parties were interviewed using this schedule, demonstrating that it can be used to gather information on both guide and client perspectives.

Utility of mixed methods research in exploring change

Quantitative research alone does not typically enable participant perspectives on the mechanisms of change (Amos et al, 2019). However, quantitative outcome measures can be used to verify whether how a participant reports to feel, aligns with standardised measures of clinical and significant change. Where there is a discrepancy, this warrants investigation. MoreLife routinely collect data using standardised outcome measures – these are described in Methods and explored in Results. Qualitative methods have been recommended to complement quantitative methods that objectively measure efficacy outcomes; this was one of the aims of this project and the reason for obtaining quantitative data from MoreLife (Elliott, 2010).

Rationale and Research Questions (RQs)

BE is strongly associated with obesity and presents a potential barrier to effective and sustained WM. The GSH intervention WOED has demonstrated some promising outcomes in supporting individuals to reduce their BE, but we do not know enough about the mechanisms of change in a WM setting. It is therefore essential that we gather data concerning efficacy and acceptability from both the service users' (clients') and service providers' (guides') perspectives (Traviss-Turner et al., 2018). This is particularly pertinent because this is a new clinical setting for the facilitation of WOED in a WM service. Use of the CCI is an appropriate and acceptable method for exploring facilitators of and barriers to change.

The RQs were as follows:

1. What were Clients'/Guides' experiences of facilitating/receiving WOED in a weight management setting?
2. What changes were made?
3. What were the facilitators and barriers to change?

Method

Design

This project used a qualitative design by adapting the client change interview (CCI) version five (Elliott, 1999; Elliott & Rogers, 2008) to explore the individual experiences of guides and clients who had facilitated or received the CBT-GSH intervention WOED. Routinely collected quantitative data from MoreLife was used to add context to the qualitative findings.

Service Context

WOED was being provided by MoreLife, a private company commissioned to provide the service to a certain number of NHS patients in the Essex area over 2023 and 2024. Clients referred for MoreLife's WM intervention were screened for BE difficulties and offered WOED as one of their pre-intervention pathways before starting WM. This was the second iteration of WOED delivery within the service; it had been recommissioned following promising preliminary effectiveness results in 2022 and more clinicians had since been trained as guides (Edwards et al., 2023).

Ethical considerations and ethical approval

The GSH intervention was being delivered by an external company and so the ethical considerations for intervention delivery and quantitative data collection had already been addressed.

This project involved conducting remote interviews with adults with binge eating and obesity. Although the interview schedule did not contain any overly sensitive questions, it was possible that through discussion of the nature of people's difficulties, emotional distress could be caused. As a trainee clinical psychologist, the primary researcher was used to managing emotional distress and used their therapeutic skills as required. A signposting to further sources of support document was created prior to interviews, and any risk concerns raised were passed back to a MoreLife clinician post-interview. A statement of confidentiality was read and agreed to by the participant before the interview commenced (and was detailed in the participant information sheets and consent forms too).

To thank client participants for their time, they were reimbursed with a £10 love2shop voucher. This amount was decided upon as it was not considered large enough to be an incentive but a contribution. Guides did not receive this as interviews were organised within their working hours.

To account for the possibility of discrimination based on digital poverty, guides were asked to print the recruitment materials for possible client participants if needed, and then help them complete them digitally, or participants could send them in the post. In this eventuality, the interview would be organised by telephone rather than zoom. See procedure section below for more details on the study's conduct, including informed consent and data management.

This project was reviewed by an NHS Research Ethics Committee review panel and was granted favourable ethical approval on 06.02.2023 (see Appendix A). The approval letter contained several recommendations such as adding to the interview schedule a reminder for participants that participation was voluntary and they had the right to refuse to answer any questions and terminate the interview, and withdraw their consent up until the point of data analysis. Recommendations were met before the project commenced.

Note that as MoreLife is not part of the NHS, the project did not require Health Research Authority (HRA) approval. This was clarified in communications with the HRA.

Participants

13 participants were interviewed, four guides and nine clients. Inclusion criteria stipulated that client participants had either completed the intervention or were awaiting their final session, facilitated by a MoreLife guide. Guide participants were staff members of MoreLife trained in delivering WOED who had supported at least one client to complete the intervention.

As MoreLife have their own inclusion/exclusion criteria for the offer of WOED, their inclusion/exclusion criteria inevitably applied to this research and the client participants interviewed (see Table 1).

Table 1.

MoreLife's inclusion/exclusion criteria for WOED

	Inclusion criteria	**Exclusion criteria**
Age	Age 18+	Below 18
BMI	>35 with co-morbidities	<35 with co-morbidities
	>40 with or without co-morbidities	<40 with or without co-morbidities
Binge Eating Scale score	27+	Below 27
Other individual factors	-	Concurrent treatment for eating or weight problems
		Post-binge purging behaviour
		Previous bariatric surgery
		Pregnancy
		Severe current psychiatric or medical conditions that would preclude full participation in the treatment (e.g. major depression, psychosis)
		Insufficient English language skills to engage with the GSH intervention

Additionally, client participants were excluded if they had already commenced the subsequent WM intervention before interviewing.

Measures

Interview schedule

The CCI was selected as it focuses on identifying changes and causes of change, and an adapted version had previously been used effectively in a similar doctoral thesis investigating WOED with young people (Winckley, 2019). Additional background questions were asked at the beginning of the interviews; date of birth for clients and age, identified gender, job role, professional training and years in practice for guides. See Appendix B for the interview schedules. More modifications were necessary for guide interviews due to the nature of the CCI focusing on individuals who have participated in rather than facilitated a therapeutic intervention.

Prior to conducting interviews, the schedule was piloted with a member of the public, to determine whether the questions flowed and were clear. No changes were recommended.

Quantitative data

For the nine client participants, the following routine data collected by MoreLife was requested by the primary researcher through a data sharing agreement:

- Weight and BMI on referral documentation, on commencing the WM intervention and at 6 and 12 months post WM intervention (if available).
- Gender.
- Date of birth.
- Ethnicity.
- Co-morbidities.
- Information pertaining to their Index of Multiple Deprivation (IMD) code.
- Pre- and post- scores for the Binge Eating Scale, Generalised Anxiety Disorder-7 Scale, the Short Warwick-Edinburgh Mental-Wellbeing Scale and the Patient Health Questionnaire-9 scale (see below for descriptions of each).

The primary researcher also requested for the same information for **all** client participants provided with the recruitment materials to be collated by MoreLife to offer an overall representation of the potential participant pool.

MoreLife quantitative measures

Binge Eating Scale (BES; Gormally et al., 1982).

Designed to assess the severity of BE difficulties, this 16-domain self-report measure covers eight behavioural and eight emotional/cognitive components typical of BE presentations. Gormally et al. (1982) piloted the scale with a relatively small sample of middle class, caucasian and predominantly female sample in the US and found it had high internal consistency. A systematic review into the psychometric properties of self-report tools used to assess BE behaviours reported that the BES had adequate internal consistency and test-retest reliability, deeming it to have overall 'good' psychometric properties in assessing BE specifically (Burton et al., 2016). It must be noted that it was developed before the DSM-IV/V diagnostic criteria, so it cannot be considered a diagnostic tool in isolation (Grupski et al., 2013).

Scores of 17 and below indicate that BE is not present, scores between 18-26 indicate it as a mild to moderate problem and 27+ is indicative of severe BE (Grupski et al., 2013). Note that MoreLife's inclusion criteria (Table 1) stipulated that clients must have scored in the severe range to be offered WOED.

Generalised Anxiety Disorder-7 (GAD-7; Spitzer et al., 2006).

Designed as a brief self-report measure of GAD, this 7-item scale has been demonstrated to have good reliability and validity through its pilot with over 2500 adults (65% female, 80% white) in the US (Spitzer et al., 2006). Further research has demonstrated strong psychometric support for the measure within a range of contexts, highlighting its utility in its length and ease of administration (Rutter & Brown, 2017; Sapra et al., 2020).

Summed scores range from 0-21; a score of 5 is indicative of mild anxiety, 10 moderate and 15 severe (Spitzer et al., 2006, as discussed in Sapra et al., 2020). It is not a diagnostic tool in isolation and raw scores cannot be interpreted as a clinical diagnosis of anxiety.

Short Warwick-Edinburgh Mental-Wellbeing Scale (SWEMWBS; Stewart-Brown et al., 2009).

Developed in the UK, this seven-item self-report version of the original 14-item version provides an overall measure of wellbeing and is widely used clinically

(Ng Fat et al., 2017). It has robust psychometric properties including validity and responsiveness to change in clinical populations (Shah et al., 2018).

Items are scored positively with a one-to-five-point likert scale from ‘not at all’ to ‘all of the time’, giving a raw score between 7-35, with higher scores indicating greater wellbeing (Stewart-Brown et al., 2009).

Whilst the raw scores must be transformed to compare outcomes between studies and to conduct appropriate parametric testing, it is possible to use a categorical approach to data analysis (Warwick Medical School, 2023). Based on data from the UK general population, Warwick Medical School (2023) have proposed that scores of 7.0 to 19.5 indicate low mental wellbeing, 19.6 to 27.4 indicate average mental wellbeing and 27.5 to 35.0 indicate high mental wellbeing. However, they also recognise that due to difficulties conceptualising and measuring wellbeing, such cut off points can be considered arbitrary (Warwick Medical School, 2023).

The Child Outcomes Research Consortium (n.d.) website note that due to copyright law, the following reference must be included when reporting the outcome of any SWEMWBS data: 'Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) © NHS Health Scotland, University of Warwick and University of Edinburgh, 2008, all rights reserved.’

Patient Health Questionnaire-9 (PHQ-9; Kroenke et al., 2001).

The PHQ-9 is a 9-item self-report measure based on DSM-IV criteria for major depression, piloted with over 6000 participants (83% female; 59% white) in the US and demonstrated to be reliable and valid (Kroenke et al., 2001). It is now the most widely used screening tool for major depression globally (Carroll et al., 2020) and has demonstrated similarly strong psychometric properties across different population groups in a systematic review (Kroenke et al., 2010).

Summed scores range from 0-27; a score of 5 is indicative of mild depression, 10 moderate, 15 moderately severe and 20 severe (Kroenke et al., 2001). Again, it is not a diagnostic tool in isolation and raw scores cannot be interpreted as a clinical diagnosis of depression.

Procedure

Recruitment

Sampling was purposive and recruitment used an opt-in method. Possible guide participants were approached by the clinical manager of MoreLife (Dr Edwards) via an email written by the primary researcher, with a participant information sheet and a link to an online consent to be contacted form.

Dr Edwards distributed similar recruitment materials to guides for them to provide to possible client participants after at least two sessions of WOED – an email written by the primary researcher, participant information sheet, link to the online consent to be contacted form (and a PDF copy of the latter that could be printed and posted if needed). See Appendix C for recruitment materials for clients (as the guide recruitment materials were so similar to clients, there was no need to include both).

Potential guide/client participants were sent a reminder email around a week later by Dr Edwards/their guide and they were given two weeks to complete the consent to be contacted form (this time frame was later removed via the amendment on 28.06.23). Once the consent to be contacted form had been completed, the primary researcher contacted potential participants to discuss the project, verbally gain informed consent (documented via another online form that they could have on request) and organise the interview. Four guide participants completed the consent to be contacted form and all four were interviewed. Twelve client participants completed the consent to be contacted form and nine were interviewed. Reasons for not interviewing were: not responding to the researcher's attempts at contact (two clients) and taking a lengthy break from the intervention after only two sessions due to personal circumstances (one client).

Dr Edwards and the primary researcher met fortnightly to discuss recruitment and she prompted guides regularly about the ongoing client recruitment. In addition, the primary researcher was available via email to answer any queries about the project from guides or clients and attended a peer supervision meeting for MoreLife guides to encourage engagement.

Interview procedure

Interviews were conducted remotely, via Zoom or telephone, by the primary researcher. They lasted approximately 35-60 minutes. In-person interviews were considered but deemed inappropriate due to the location of participants (Essex

area) and the primary researcher (Bradford). Additionally, as MoreLife was primarily facilitating WOED using remote methods, it was not thought that remote interviews would be off-putting to many potential participants.

At the start of the interview, there was a conversation about the privacy of the primary researcher and interviewee, a contingency plan for loss of signal/contact and a statement of confidentiality was read and agreed to. Participants were reminded they had the right to withdraw (and to refuse to answer any questions). No participant chose to withdraw their data or terminate the interview.

The interview schedule was used flexibly to make it as conversational and relaxed as possible and to ensure that the primary researcher could explore areas that had not been foreseen and participants were given the space to share what they wanted to. Additionally, questions were omitted when they were felt to be inappropriate by the primary researcher. For example, when a participant was distressed and did not feel they had made many/any positive changes, it would have been inappropriate to ask 'What personal strengths do you think have helped you make use of the GSH intervention to deal with your problems?'. Clients were signposted to further support (e.g. BEAT eating disorder charity website/phone line) when needed. A MoreLife clinician was on-call for the primary researcher during every interview and any risk concerns were passed to them.

At the end of the interview, participants were asked if they had any feedback regarding the research, whether they would be interested in its outcome and client participants were asked how they would like to receive their £10 voucher for reimbursing their time. Everyone was thanked for participating.

If anything struck the primary researcher, particularly a difficult feeling, after an interview, this was noted in their reflexive log and extra supervision was sought when needed. The log was revisited throughout analysis and write up.

Zoom was used to record and transcribe the interviews (if the interview was via the telephone the telephone was on speaker and Zoom still used). Video recordings were immediately deleted and audio recordings were encrypted and only held for as long as it took to check the accuracy of the interview transcripts (held in MS word). Transcripts were freed from identifying information – participants were given a code and name-code links and other confidential data were held separately to the interview data. The researcher completed all the interview transcribing. Completed transcripts were then imported to NVIVO for coding.

Data Analysis

Ontology and Epistemology

Within qualitative research it is considered good practice to explicitly recognise and explore the influence of the researcher over their work (Austin & Sutton, 2014). The philosophical constructs of ontology (the study of what we understand reality to be) and epistemology (the study of how we believe we acquire knowledge and what knowledge is) influence all aspects of research, particularly qualitative research (Al-Saadi, 2014; Braun & Clarke, 2022, p.166). How the researcher makes sense of knowledge and understands the world shapes how they interact with the research process.

Ontological and epistemological positions exist along a continuum. Objectivist (an ontological position) and positivist (an epistemological position) methodologies assume that there is an objective reality that exists independently of us that can be observed/measured and the role of a researcher is to discover this through engaging with the scientific method, minimising sources of bias and retaining the position of 'blank slate' (Al-Saadi, 2014). At the other end, constructivist (an ontological position) and interpretivist (an epistemological position) methodologies assume that knowledge can only be understood through our interpretation and sense making of the social world - reality is considered subjective, it cannot and does not exist independently of our perception of it but is socially constructed and ever-changing (Al-Saadi, 2014).

Developed as an alternative to these more binary approaches, **critical realism** (often used with reflexive thematic analysis, explored below) suggests that there is a reality that exists independently of us, but we only have our own experiences and languages to understand and interpret it; our interpretations are therefore fallible but they are all we have and still warrant investigation (Braun & Clarke, 2022, p.169; Bhaskar et al., 1998, as explored in Lawani, 2021).

Positioning of the researcher

My understanding of what reality is has developed since my late teenage years. As a child my views were more objectivist/positivist – I felt that there was an objective 'right' and 'wrong' and we all should understand the difference. My perspective shifted when I realised that I could experience the same situation as another, but interpret/experience it completely differently. Now, as a trainee clinical psychologist, it makes sense to me that we can all experience the same/similar

situations and because we interpret it through our own lens, influenced by our own assumptions, expectations and experiences, our perspectives (or our 'realities') will inevitably differ. I have shifted from a positivist view of the world to a more interpretivist, but I still feel that there must be some fundamental truths in this world, particularly from a moral standpoint, and therefore I consider myself a critical realist.

I understood on commencing this research that I had certain expectations based on my clinical experiences and reading of the literature (i.e. I assumed the guide would be important and that mental health issues would interfere with change making for some participants). I wanted to recognise these and hold them in mind when exploring the data, to ensure that these ideas did not unwarrantedly hold space if they did not align with what clients and guides reflected. Austin and Sutton's (2014, p.437) suggested questions were helpful in encouraging this reflection:

1. *'Why am I interested in this topic?*
2. *What do I really think the answer is?*
3. *What am I getting out of this?'*

Method of analysis: an overview of Reflexive Thematic Analysis (RTA)

Data were analysed using RTA. Thematic analysis is considered a flexible and accessible qualitative research method (Kiger & Varpio, 2020). Flexibility was important for this project because of the broad aims and the understanding that the research was investigating a relatively new intervention in a new setting with new participants. Flexibility and accessibility were also important for the primary researcher due to their lack of previous qualitative research experience; the researcher needed to be able to take steps 'back' and re-think decisions throughout.

The theoretical positioning of thematic analysis is dependent upon the focus of the research and the orientation of the researcher (Braun & Clarke, 2022, p.176). This project is conducted from a critical realist approach, because it aligns with the primary researcher's understanding of the world and because the overall aim of the project was to provide meaningful clinical recommendations that could be utilised by future services offering WOED with this population group. A fully constructivist positioning would have made the generation of generalisable recommendations difficult (as it posits that there is no shared truth), whilst a fully positivist positioning may have led to overly rigid suggestions that did not account for individual experiences/differences/nuances in interpretations.

Braun and Clarke's (2006) six-stage process was selected, a method frequently used within the social sciences. However, its initial iteration has been widely misused due to a lack of clarity/training/understanding; Byrne (2022) suggests that Braun and Clarke's (2019) discussion of RTA addresses some of these barriers to its effective use, enabling researchers to more accurately adhere to the method's principles.

RTA does not purport to lead to the generation of an objective 'truth' that is completely independent of the researcher's interpretations, thus it does not align well with a fully positivist approach (Braun & Clarke, 2019, 2022). Accordingly, themes are not considered hidden within data but generated through the researcher's immersion in and creative interpretation of the data (Braun & Clarke, 2019). The practical method of how to conduct RTA remains flexible, however the authors state that for research integrity, particularly as coding is a subjective process, it is essential that firstly, researchers own and reflect upon their assumptions and theoretical standpoints, secondly, they are able to interrogate them and their impact upon the coding and thirdly, are transparent about this process (Braun & Clarke, 2019, 2021). Part of this process involves the use of a reflexive journal, advised by Braun and Clarke (2022, p.19) and referenced throughout this thesis, with excerpts included for reference in Appendix D.

Below is a brief overview of the steps taken (Braun & Clarke, 2006); extra detail can be found in Appendix D.

Step one: Become familiar with data.

The primary researcher conducted, listened to and transcribed every interview, so was already familiar with the data at the point of analysis. Transcripts were exported into the application NVIVO and most were read again before coding commenced (if there was a delay between transcribing and coding). Any initial ideas pertaining to possible themes/ideas were noted. These included ideas such as: the training needing to be improved for Guides; the manual potentially being *too* transdiagnostic; and motivational interviewing skills being helpful in the delivery of WOED.

Step two: Generate initial codes.

Within NVIVO the primary researcher coded and re-coded data pertaining to the project's aims using an open coding process and without preset codes, creating a coding framework that developed through coding each interview transcript.

Analysis was predominantly inductive but not exclusively so. This is acceptable in RTA; RTA views the inductive–deductive data analysis as a spectrum to be moved up and down, rather than two binary and opposed concepts (Braun & Clarke, 2022, p.56). The evolving, changing, adding and re-labelling of codes is good practice as it demonstrates that understanding develops through time and immersion with the data (Braun & Clarke, 2022, p.55). At this stage codes were highly specific and plentiful. See Appendix D for the first generation of codes after re-reading two guide interview transcripts.

Step three: Generation of (previously 'Search for') themes.

On post-it notes, alongside academic supervisor G.T.T, each code was gathered under each research question within a thematic venn-diagram map (see Appendix D for a preliminary version). Codes were checked, re-labeled if unclear, removed if not directly addressing a research question (as the aim of RTA is not to report on every single code) and clustered into candidate themes. Discarded codes were held for later re-visiting.

Step four: Developing and reviewing (previously 'Review') themes.

Step four involves re-engaging with coded data and raw transcripts, to ensure that developing themes capture the essence/meaning of the data, whilst allowing the researcher to wonder whether an alternative way of interpreting patterns in the data better addresses the research question(s) (Braun & Clarke, 2022, p.97). It also decreases the likelihood of accidentally misrepresenting the data, by getting back to the raw transcripts (Braun & Clarke, 2022, p.101). The overlapping nature of some themes and sub-themes required addressing at this stage, as 'good themes are distinctive and, to some extent, stand alone' (Braun & Clarke, 2022, p.84). Accordingly, some candidate themes were collapsed into broader overarching themes and those that were too 'thin' were removed. The development and reviewing of themes continued throughout steps five and six.

Step five: Define themes.

As advised by Braun and Clark (2022, p.108) this involved writing 'theme definitions' to ascertain the uniqueness of each theme and to consider how each theme addressed a research question. This also enabled the further collapsing of themes. For example, 'WOED offers something new for clients' and 'New role for Guides' were re-organised and held together by the central organising concept of 'newness'. Writing theme definitions merged into writing theme descriptions,

alongside the selection of appropriate quotes. Discarded quotes were held for later re-visiting.

Step six: Write-up.

This stage involved re-visiting all previous stages and pulling together the data and themes coherently to address the research questions. Editing/refining/changing themes can still occur during step six (Braun & Clarke, 2022, p.89). Through writing theme descriptions, creating thematic maps and re-visiting the raw data, the order and content of themes were consistently revised whilst writing.

Ensuring quality; including the voices of research participants in analysis

Braun and Clarke's (2022, p.269) quality checklist for RTA does not include 'credibility' or 'validity' checks with research participants, perhaps reflecting the conscious shift to move away from quantitative research methods aimed at minimising sources of bias. Indeed, checking that the primary researcher's interpretation matches completely with another's would not align with the methodological assumptions of RTA from a critical realist standpoint.

However, Braun and Clarke (2023, p.273) note that the aim of exploring data with a supervisor/mentor/co-researcher is not to reach an agreed consensus on the 'right' interpretation, but to provide a space for the primary researcher to be challenged, questioned and provided with possible alternative perspectives. From the primary researcher's perspective, this logic need not end with exploring the analysis with more experienced colleagues.

Discussing themes with a guide and a client participant would enable the primary researcher to ensure that they had not lost the voice of participants within the generation of themes and that their interpretation was not being unduly influenced by possible thought processes and positions of privilege outside of their conscious awareness (e.g. thin privilege). Additionally, this process enabled participant involvement that was not possible at any earlier stage. Discussing themes with a participant to check the author's understanding is also advised within previous qualitative research quality checklists, e.g. Elliott et al. (1999).

Therefore, after initial themes had been devised (around the step four mark) a guide and client participant were contacted and provided with draft thematic maps for each research question. A video call was then held individually with each. See Appendix D for reflexive log entries following these calls.

Quantitative data analysis

Quantitative data for the client participant's demographics provided by MoreLife was presented as basic descriptive statistics in tabular form to give context to the qualitative data.

Dissemination of findings

All participants consented to be contacted by email with the results of the project.

Results

Demographic and quantitative data

Characteristics of guide and client participants are explored in turn. Given names are pseudonyms, with ‘G’ and ‘C’ added for guides and clients respectively.

Guide participants (G-Charlie, G-Bobby, G-Ash and G-Alex) were a mix of genders and ages, and all were working as weight management practitioners for MoreLife. None of them were trained psychological therapists or from a psychological therapy background. G-Charlie was the most experienced guide; all others were very new to the role and had only supported one or two clients through WOED.

Table 2 presents the characteristics of clients, with all data provided by MoreLife.

Table 2.

Client characteristics.

Client	Gender	Age bracket	Ethnicity	Co-morbidities	IMD decile*	BMI at referral
C-Ant	Male	31-40	Multiple ethnic backgrounds	None listed	4	46.12
C-Ann	Female	21-30	White British	Asthma, COPD*	9	67.95
C-Ray	Female	41-50	White British	None listed	3	53.00
C-Sue	Female	51-60	White British	Depression, Anxiety, other mental health condition	5	39.9
C-Mol	Female	51-60	White British	None listed	9	39.63
C-Ela	Female	41-50	Multiple ethnic	None listed	8	50.68

			backgrounds			
C-Joy	Female	61-70	White British	Hypertension	10	46.28
C-Bob	Male	51-60	White British	None listed	4	42.84
C-Tia	Female	61-70	White British	Fibromyalgia, inflammatory conditions	3	49.21

Note. *IMD = index of multiple deprivation. Possible scores range from 1-10, with 1 indicating high levels of deprivation within an area and 10 indicating low levels. It cannot be used to assume anything about an individual's situation, but it reflects how deprived the area in which they live is (Department for Communities and Local Government, 2015). *COPD = chronic obstructive pulmonary disease.

Table 2 indicates that client participants were predominantly female (77.78%) and white British (77.78%), with a wide range of ages. The spread of IMD deciles (range of 3-10, average 6) indicates that client participants lived in a range of relatively deprived and highly privileged areas. Almost half of the clients were managing other conditions alongside difficulties with BE; from the interviews the primary researcher would estimate this to be higher than the data presented. For example, C-Bob and C-Ray reported in interview managing anxiety and/or depression and others reported having long covid, multiple sclerosis and other health issues. BMI information demonstrates that all clients were either living with obesity or severe obesity at the point of referral to MoreLife.

Table 3 presents the raw scores for client participants on the BES, GAD-7, PHQ-9 and SWEMWBS, both before and after engaging in WOED.

Table 3.

Client pre- and post- WOED outcome measure raw scores and corresponding severity categories

	BES scores		**PHQ-9 scores**		**GAD-7 scores**		**SWEMWBS scores**	
	Pre-	**Post-**	**Pre-**	**Post-**	**Pre-**	**Post-**	**Pre-**	**Post-**
C-Ant	34 *(sev)*	30 *(sev)*	11 *(mod)*	7 *(mild)*	4 *(min)*	4 *(min)*	20 *(ave)*	22 *(ave)*
C-Ann	35 *(sev)*	17 *(no BE)*	13 *(mod)*	11 *(mod)*	6 *(mild)*	7 *(mild)*	26 *(ave)*	28 *(high)*
C-Ray	35 *(sev)*	30 *(sev)*	20 *(sev)*	20 *(sev)*	18 *(sev)*	14 *(mod)*	13 *(low)*	14 *(low)*
C-Sue	37 *(sev)*	34 (sev)	21 *(sev)*	20 *(sev)*	10 *(mod)*	8 *(mild)*	16 *(low)*	16 *(low)*
C-Mol	38 *(sev)*	32 (*sev)*	19 *(mod sev)*	13 *(mod)*	12 *(mod)*	11 *(mod)*	21 *(ave)*	23 *(ave)*
C-Ela	38 *(sev)*	33 *(sev)*	14 *(mod)*	9 (*mild)*	3 *(min)*	0 *(min)*	23 *(ave)*	25 *(ave)*
C-Joy	36 *(sev)*	18 *(mild-mod)*	12 *(mod)*	9 *(mild)*	8 *(mild)*	3 *(min)*	23 *(ave)*	23 *(ave)*
C-Bob	32 *(sev)*	17 *(no BE)*	22 *(sev)*	19 *(mod sev)*	17 *(sev)*	13 *(mod)*	13 *(low)*	19 *(low-ave)*
C-Tia	34 (*sev)*	05 *(no BE)*	16 *(mod sev)*	12 *(mod)*	10 *(mod)*	10 *(mod)*	20 *(ave)*	23 *(ave)*

Table 3 demonstrates that, reflecting MoreLife's inclusion criteria, before engaging in WOED, all clients were severe in their BE. Whilst raw scores for all clients reduced following WOED, five (55.6%) were still severe in their BE. One (11.11%) was 'mild-moderate' and three (33.3%) were no longer demonstrating clinically significant levels of BE on the BES.

Prior to WOED all clients scored as moderately to severely depressed, as measured by the PHQ-9. For three clients (33.3%) these levels remained consistent pre- and post- WOED and for the other six (66.6%), scores reduced by one clinical category.

Prior to WOED clients presented with a range of scores related to anxiety, from not anxious to severely anxious, as measured by the GAD-7. For five clients (55.6%) these levels remained consistent pre- and post- WOED and for the other four (44.4%), scores reduced by one clinical category.

Prior to WOED clients presented as low or average in their mental wellbeing, as measured by the SWEMWBS. For most, these categories remained consistent post-WOED, with some increase in raw scores demonstrated.

Note that no client showed a worsening on any outcome measure following WOED and even if they remained within the same severity category, mostly the raw scores were moving in a positive direction.

Reflexive Thematic Analysis

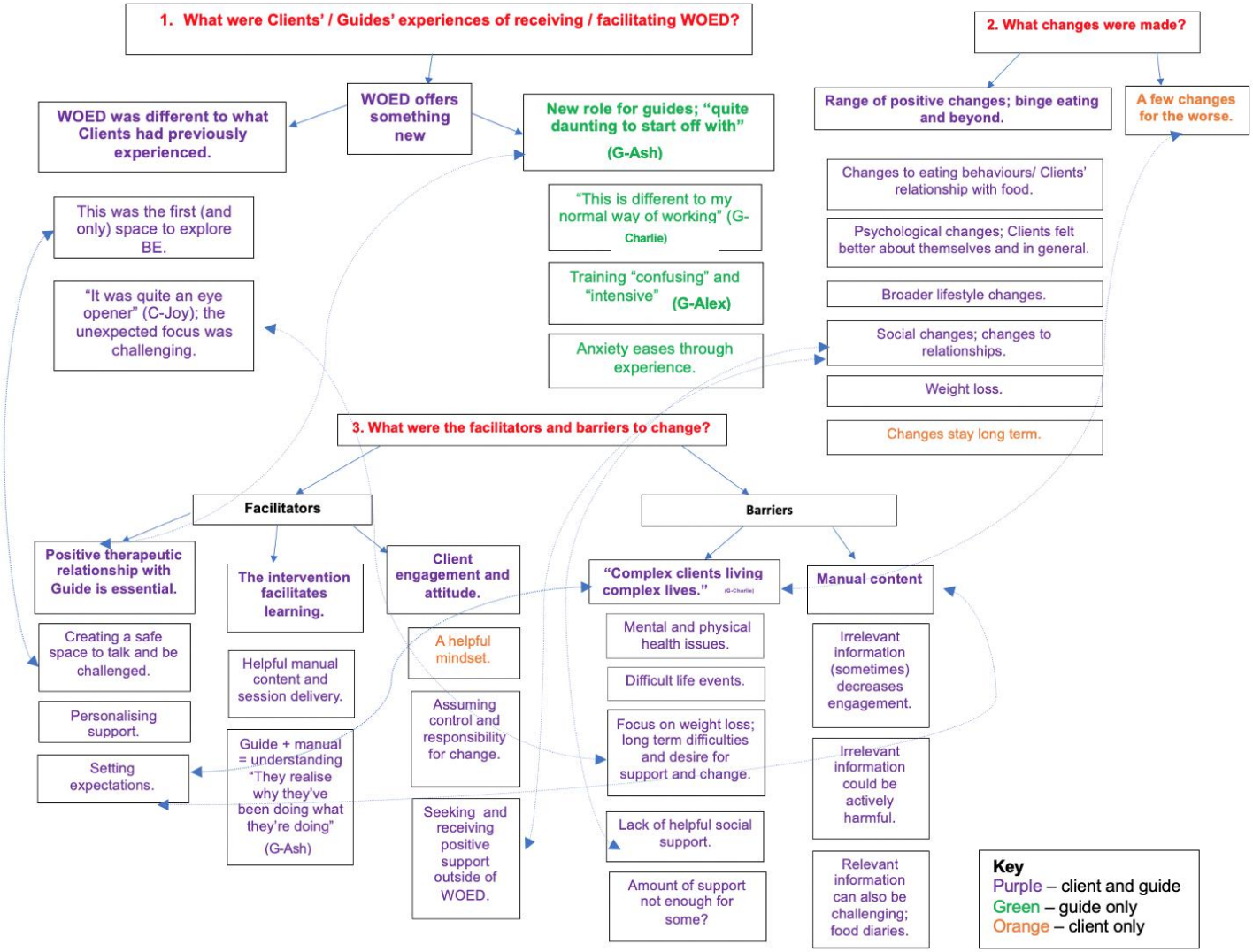
Figure 2 offers a visual representation of the themes and sub-themes from the qualitative analysis, organised within each research question:

1. What were clients'/guides' experiences of facilitating/receiving WOED in a weight management setting?
2. What changes were made?
3. What were the facilitators and barriers to change?

In the following section each research question and its themes and sub-themes will be explored in turn, with supporting excerpts from the transcripts. Where content is relevant across research questions (as represented by the blue dotted lines within Figure 2), this will be noted and the reader signposted. The key in Figure 2 indicates which party or parties contributed to the theme content.

Figure 2

Thematic map of all themes and sub-themes

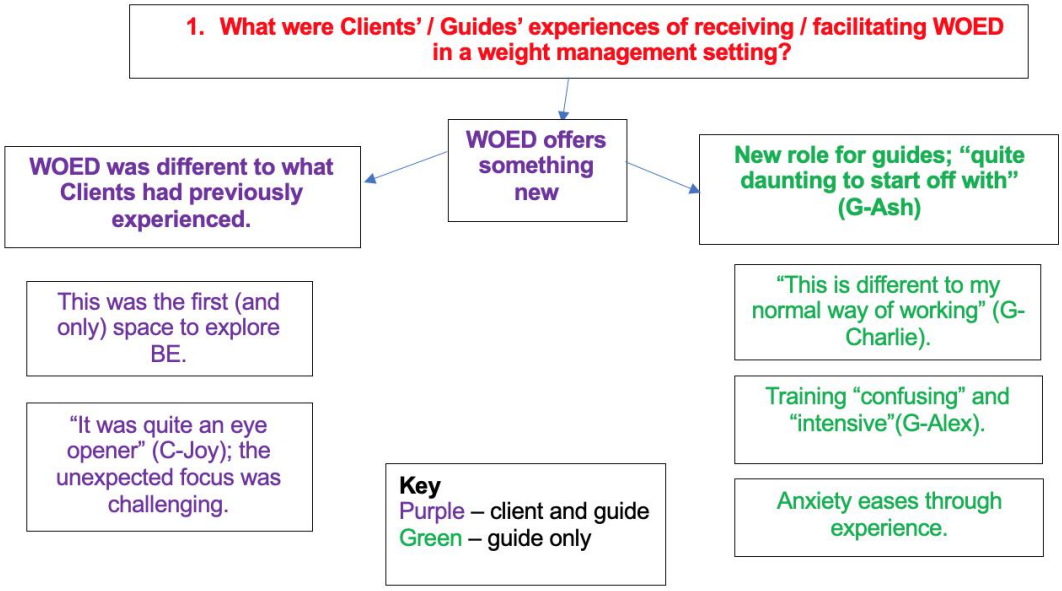


RQ1. What were Clients'/Guides' experiences of receiving/facilitating WOED in a weight management setting?

Figure 3 depicts the themes and sub-themes related to research question 1. The key indicates which party or parties contributed to theme content.

Figure 3

Thematic map for RQ1



The overarching theme was that WOED offered something 'new' in comparison to other interventions that guides had experience in facilitating and clients had experience in receiving. This section begins by considering what was new for clients.

Theme 1: WOED was different to what clients had previously experienced

Sub-theme: This was the first (and only) space to explore BE.

Clients had often struggled with their relationship with food, since childhood or early adulthood. They described repeatedly trying to lose weight and feeling embarrassed and frustrated at not being able to maintain weight loss. WOED offered some clients the first opportunity to explore 'why' they struggled with weight and BE (rather than focusing on a behavioural approach to weight loss), in a holistic, person-centered and reflective way through one-to-one conversations with a non-judgmental other. This will be explored in RQ3 as it is considered a key facilitator of change. This new approach was gratefully received:

I was crying out, I was going to my doctors and I said like 'I binge eat and I've got to stop it and I don't know how to, I really need help…' 'Sorry, no we don't do anything' and I was like 'awwww you know'... 'oh you know we could do WM' I said, 'no, but that's... WM is the same as… don't really have this, don't really have that, you know, just, have loads of fruit and vegetables, I know that. But I need to have a better understanding of it all. (C-Sue)

Engaged clients wanted the space to talk about **why** they binge ate with someone they felt could understand their problems. Many had not had this opportunity before, even after trying to contact national charities such as BEAT. Guides and clients reported that outside of WOED, if clients tried to discuss BE, their family/friends/professionals often focused on calorie reduction rather than trying to help the client address the cause of the problem:

*I suppose I kind of like I'm angry at the doctors' service because all they just say is you know 'Eat less move about more' and don't go into the **why** hadn't I achieved what I wanted to achieve.* (C-Joy)

Reflecting the recognition that WOED offered something new, clients and guides largely described WOED as useful; it addressed what clients wanted it to and they changed what they wanted to (some understandably noted that they still wished to lose weight). Some reflected anger/sadness that they had not had this support sooner (*'I wish I'd have done this years ago'* C-Tia), or that they felt that they had had to fight to get the support.

Additionally, in their quest for weight loss, clients had often engaged in commercial group WM interventions. Overall, these were considered unhelpful by both clients and guides, reiterating why it was so helpful that WOED offered something different:

'I mean, I've been doing… all the all of them [weight watchers/slimming world etc]*, probably all different things since I was probably 18, maybe a little bit older, and they're all just basically the same but slightly different, and no one has ever said to me, there's got to be a reason, you're not just greedy, you're not just unhealthy...'* (C-Ela)

Overall, a space to explore 'why' the problem exists rather than engage with the directly behavioural approach of calorie reduction was valued by clients:

'I just think, without this, I would still be stuck where I was. I'm really, I know there's gonna be bad days, I know I have more good days than the bad days now with it, so that's a bonus, isn't it? It's a bonus. So, I couldn't ask for more. I couldn't.'

(C-Sue)

Sub-theme: 'It was quite an eye opener' (C-Joy); the unexpected focus was challenging.

Clients were predominantly referred to MoreLife for WM support. They were screened for BE and then offered WOED first if appropriate. This meant that some clients came to WOED without knowing that they binge ate, with a clear focus on losing weight and without knowing this intervention would involve unpicking their relationship with food from a psychological perspective. For many, WOED encouraged clients to think about their problems in a way they had not before. At times, particularly initially, this felt challenging (*'I was a bit frightened at first because I didn't know what to expect'* - C-Tia). 'Frightened' conveys an extreme level of apprehension. Others noted that '*some of it was hard to do'* (C-Ann), *'some of the weeks I found quite hard going emotionally'* (C-Ela), *'it hasn't been easy'* (C-Bob) and *'I really struggled with it. I was really surprised.'* (C-Joy). There was also a reflection that clients wished they had understood their difficulties earlier in life and this led to a sense of sadness. Reflecting on the past and the development of their difficulties with food, whilst sometimes difficult, was also viewed as necessary by some clients. Therefore, whilst the intervention focus was a challenge, as it increased clients' understanding of the etiology of their difficulties, this was not deemed a negative experience, but a necessary one:

'*I think it's the first time I have been able to explore my childhood, and my past and look at it through a different lens. Things I didn't see before, things that I wasn't cognizant of. I really found it to be… very much enlightening. An introspective journey that I wasn't expecting honestly.'* (C-Ant)

Alongside the emotional impact, all Guides identified that it was difficult for clients that WOED did not target weight loss, as this was most often their goal in seeking support and what they expected the intervention to be focused on. This will be explored further in RQ3 as it was considered a barrier to change.

Theme 2: New role for Guides; 'quite daunting to start off with' (G-Ash)

Sub-theme: 'This is different to my normal way of working' (G-Charlie).

MoreLife clinicians typically offer group WM interventions in which they are the expert and they deliver information to a group of recipients. WOED felt very different to guides' usual roles as weight management practitioners and they described feeling like they had to prepare for this shift in role. Not only was the method of contact (one-to-one) and intervention (GSH) different, but there was a recognition that being a guide required a shift from the usual 'expert' position of offering advice, to providing 'guidance' instead:

'You're not really there to give any advice so much, which is very different to my current role. You're just really there, just to listen and then just kind of work through and ask about some of the the activities in the booklet and everything like that so it's yeah, it was quite daunting to start off with, cause it's almost like you've got nothing to AIM for.' (G-Ash)

The perception that there is nothing to aim for does not quite align with the aims and evidence base of WOED, but it reflects the uncertainty surrounding not working to a more restricted and concrete manualised approach, that Guides will have been used to.

Additionally, the idea of providing one-to-one support led some to worry that the role may move them away from their usual 'expert' position of teaching a structured group, into more of a 'therapist' role (rather than the required 'guide' role):

'I guess it was just something completely different for me. It was just new…I think just not my perspective, I think other people have said to me, they had gotten quite worried about the intervention, because they thought that they would have to solve everyone's problems….' (G-Alex)

This view perhaps represents a misunderstanding of the ethos of GSH (client-led and client is responsible for change), a natural assumption for guides to hold before engaging with the intervention if they have not delivered similar programmes before. It reiterates that not only was the content of WOED new to guides, but the entire model of delivery was too. The sense of initial anxiety/apprehension is therefore understandable. It needs noting that most guides interviewed had only

supported one or two clients through the full programme, so it was still very new to them.

Sub-theme: Training 'confusing' and 'intensive' (G-Alex).

Prior to engaging in WOED guides received external training on the intervention and how to be a guide. Some guides were enthusiastic as they believed they would be receiving training on BE, a difficulty they had often come across from working in WM services. This possibly contributed to some confusion, as BE is not the focus of the training:

'A lot of people go into the training wanting to know more about BE thinking it's a very, very complex, abstract topic that they've not covered before so I think a lot of people left the training feeling more confused' (G-Charlie)

Certain aspects of the training were identified as helpful and guides found that the skills they developed were relevant to their other work as MoreLife clinicians too. However, parts of the training were described by some as *'confusing'* and *'intensive'* (G-Alex). There were also delays in receiving it, which resulted in delays in facilitating WOED.

'I think the training was quite, it was good in certain aspects, but probably kind of quite confusing for people as well. So the people, the Guides that are actually delivering it, and I think it dived into a lot of examples, and what people might come up with, but not necessarily how the intervention flows and what's normal.'

(G-Alex)

It is possible that the training was not pitched at the right level for this group of guides. These clinicians do not routinely offer one-to-one support and they are not from a psychology/therapy/ED service background. In other words, '*I'd probably say the training was good on a more intensive thing, but not on the basic level*' (G-Alex). Guides provided a list of ideas for how to improve the training (these are listed within clinical recommendations later on).

Whilst there was mixed feedback regarding the helpfulness of the training, the formalised ongoing peer supervision provided by MoreLife was considered helpful in providing a space to think about clients and work out what was/was not working as a group.

Sub-theme: Anxiety eases through experience.

Guides' initial anxiety about facilitating a new intervention was easing with experience by the point of interview. This may be due to familiarity with the intervention's content and the learnt understanding that clinicians already had a lot of the transferable skills, experience and previous training (e.g. MI) required to be a guide:

'As you progressed on, you realize that oh, this is just, it's just all, it's all you know, communication skills and listening skills and, yeah, I'm I'm not actually here to lift any kind of expectation, it's just listening to them, and then maybe asking a few questions to get them to explore something a little bit more deeply. So yeah, it's definitely got less challenging over time.' (G-Ash)

'*I did quite a lot of motivational interviewing training as well, and that was really key in this particular intervention. And so I've just found it was very, very useful, just, you know, using that kind of similar approach.'* (G-Alex)

Additionally, through experience in facilitating WOED, Guides described enjoying the newfound freedom of not offering a structured group intervention and getting to know people better (and faster) through offering individualised and flexible support in one-to-one conversations:

'I've actually really enjoyed it, because it just there's not a huge restriction, so it's more just you're just guiding people rather than it being cause in our main sort of bulk of sessions, it's very much you know, there's different topics that you've got to cover within the session, so with this it's just more about how much you know, they wanna talk about each topic, you don't feel pressured, I guess, and it means you can get to know people on a really nice level' (G-Alex)

As anxiety eased through experience, Guides appeared to realise that the therapeutic relationship was more important than their being an expert in facilitating WOED. Having a Guide and a positive therapeutic relationship are considered facilitators of change and will be explored further in RQ3.

RQ1. What are Clients'/Guides' experiences of receiving/facilitating WOED?

Theme summary

There is rarely space to talk about BE and this opportunity was gratefully received by clients, who wanted to understand 'why' they had eating difficulties and struggled with their weight. WOED offered something different that clients were not perhaps expecting, particularly for those who had been referred to MoreLife purely for a WM intervention. Overall, WOED was positively received and considered helpful, even if it was difficult to talk and think about tricky topics.

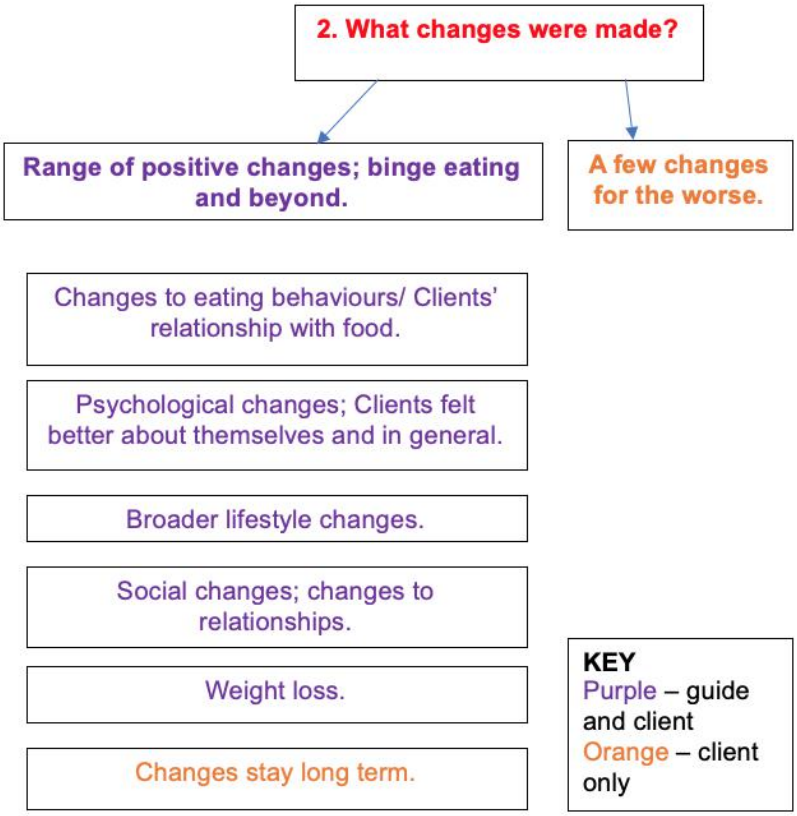
The content and model delivery of WOED was new (and therefore daunting) for guides. However, they described enjoying the opportunity to get to know their clients better in a one-to-one setting and the anxiety/apprehension around being a guide appeared to be settling through experience (rather than following the external training). Most of the guides had only supported around two people through WOED, so it was still very new to them at the point of interviewing for this project.

RQ 2. What changes were made?

Figure 4 depicts the themes and sub-themes related to this research question. The key indicates which party or parties contributed to the theme content.

Figure 4

Thematic map for RQ2



Clients and guides described a wide range of changes following WOED. These could be mostly separated into positive and negative experiences for clients. The positive changes are explored first.

Theme 1: Range of positive changes; BE and beyond

Clients and guides overwhelmingly reported positive changes that they were sometimes surprised by and mostly believed would have been unlikely to occur without WOED. Whilst explored in turn below, it is likely that through holding a biopsychosocial understanding of obesity and eating difficulties, that these positive changes are interrelated rather than discrete. Furthermore, one client noted *'It's not till you start speaking to people like yourself that you actually realize that you are*

doing something without really knowing it' (C-Bob). This indicates that there may be more unidentified changes that clients are yet to recognise.

Sub-theme: Changes to eating behaviours/Clients' relationship with food.

Clients and guides identified a range of positive changes in clients' eating behaviours including: a reduction in BE; having a more balanced/healthy diet; experimenting more with new foods; eating in moderation; eating regular meals; not eating for the sake of eating; not eating unless hungry; not hiding food; not restricting food; pausing before eating to think about how it may make them feel; and reduced appetite and cravings for highly calorific foods. Specific examples for these were given such as choosing fish instead of a burger in a restaurant, being able to have a big bar of chocolate in the fridge and not eat it all instantly and having a few Maltesers a night to prevent any cravings and subsequent binges. Guides often felt that the change in not restricting foods was the most important for their clients.

These changes were sometimes described as ongoing works in progress - *'I am changing my eating habits or lack of them so yeah, I'd say that's another major…. hurdle that I've overcome…'* (C-Bob). Another noted *'Well my BE has diminished, not stopped but diminished. It's moving in the right direction.'* (C-Joy). C-Joy's reflection mirrors her BES scores, from severe to mild-moderate pre-post WOED. She is inferring her belief that this will continue to reduce with time.

These positive changes appeared to be related to clients' increased ability to problem-solve their difficulties with food, explored in session five of the intervention. Food related problem-solving behaviours included: buying more groceries (to ensure more regular eating); buying fewer sweets and buying healthier options; not shopping when hungry; using distractions such as scrabble instead of eating; not keeping food in the bedroom and getting up and going to bed earlier, to prevent night-time BE. For example: '*I said to her I play Scrabble now online and like that takes me away from thinking about the food.'* (C-Sue)

Another important change for some was that clients felt better able to deal with relapses in their BE. Prior to WOED clients described that following a binge they were more likely to cycle into experiencing difficult feelings (shame/guilt) and then continue BE and this had changed. *'I'm much much better at just drawing a line underneath. When I know I've behaved inappropriately around food I can just draw a line under it, you know.'* (C-Joy)

These changes relate to the positive psychological shifts for clients in feeling kinder to themselves, less guilty and more in control of their BE and their relationship with food, explored below.

Sub-theme: Psychological changes; clients felt better about themselves and in general.

Session four of the intervention involves an exploration of the thoughts and feelings relating to eating difficulties and how to recognise and manage them. Correspondingly, some clients reported feeling better about themselves, *'I sort of feel a bit… a bit better about myself, whereas before I didn't.'* (C-Bob). Others described reductions in their: guilt; self-criticism; perfectionism; fear of failure; and focus on what they thought others thought of them:

'I still do get those when I'm walking the dog I think 'are people looking out their window thinking 'hmm she's put on weight since the last time we seen her or gosh' - and I say to myself, 'who gives a damn?' 'who are you to comment?' 'who are you – you're no one to me." (C-Sue)

Linked to these positive psychological shifts was an understanding that through helping themselves and developing a better understanding of their problems, clients experienced an increase in self-efficacy through feeling more in control, more capable/confident and more prepared for the WM intervention:

'it's all kind of a knock-on effect from, you know, I'm feeling better because I am in control of it [BE] *and I'm not feeling those guilt feelings and those shame feelings and all that kind of stuff.'* (C-Ela)

'It makes me a little more contented to know now that if I get on a diet programme I think I'm better prepared' (C-Ant)

Interestingly, both of these clients were 'severe' in their BES scores both pre- and post- WOED, even though they described feeling more in control of the problem and better prepared for WM afterwards.

Additionally, more clients reported these internal changes than guides, perhaps indicating that these felt like very personal changes that clients either did not share with their guide, or that they had not recognised until asked in an interview setting. Additionally, these internal shifts may be harder to identify for guides than behavioural ones, particularly given guides' backgrounds in delivering lifestyle and WM programmes, inherently behavioural in nature.

Sub-theme: Broader lifestyle changes.

Perhaps again linked to an increase in self-efficacy and feeling better about themselves in general, other changes were wider positive health-related behaviour changes such as exercising:

'I'm more inclined to get up and move around, like physically and mentally, just for the benefits of both, whereas before I'd make excuses, but now I'll go the long way, take the stairs. Only little things, but it's still to me a lot more than I was doing before.' (C-Ela)

Guides identified further changes which involved clients behaviourally challenging their anxieties. This included examples such as leaving the house more, getting a volunteering job and actively talking to people. This is highly likely to be bi-directionally linked to the positive change of feeling better (and being less worried that others are judging them) already outlined above:

'When we were discussing about the trigger, she says 'the boredom and the loneliness', and I said, what do you think you would like to do about it? How do you want to engage yourself? She ... doesn't have a job or something and she, really, you know, took it, took up to it, and found herself a volunteering job and she started her volunteering job, even though it was, I think, once a week, but I think that boosted her confidence a lot' (G-Bobby)

Guides described the anxiety of their clients and the importance of building confidence and self-esteem through WOED to try and do something differently:

'I remember one of them say, like, you know, I feel now more comfortable going out, and you know, because she she was like, you know, when we initially started she said that, you know, she really feels that everybody is looking at her when she's out out, she feels low confidence, low esteem.' (G-Bobby)

These examples demonstrate that the problem-solving skills and information on 'thinking traps' outlined in the manual are applicable to clients' whole lives. It is also possible that through feeling more in control of their eating and bingeing and better about themselves, clients increased in their overall confidence (i.e. self-efficacy) and this transferred to wider positive lifestyle/behavioural changes.

Sub-theme: Social changes; changes to relationships.

Session five of the intervention outlines the importance of eliciting positive social support to manage problems with eating. Clients and guides recognised some positive shifts in clients' relationships, particularly with regards to initiating support and choosing to divulge difficulties with family/friends/colleagues:

'I have had a few Clients that are then able to initiate some more support from family members, as well. So, erm whether that be around asking a partner to maybe do an activity with them during the day, to break up the day a little bit and provide some routine, or is it help with making a breakfast to try and get some regular eating pattern in, so I've had a few Clients definitely where they've been I've been able to encourage them to sort of bring in their friends and family and relevant people for more social support' (G-Charlie)

'Now I feel like I've got more of a support network. Where before I was all on my own. So, and so they teach that in that course. You know, find people you can trust that you can tell them how you feel and they'd be able to help you and I did. So that worked out well.' (C-Tia)

Guides were clear that they felt helpful social support was essential in the success of WOED (indicating that, while it was a positive change, it was also a facilitator of other positive changes – see RQ3). Unfortunately, both guides and clients described how not all clients have access to supportive and helpful people; some may be actively unhelpful (see barriers to change in RQ3).

Sub-theme: Weight loss.

Whilst explicitly **not** a goal of WOED, weight loss was indicated to be an outcome by some clients - *'Every now and again it* [BE] *happens but because it's not happening on like a daily basis anymore I have started to lose weight.'* (C-Ann)

Other clients described losing weight but dismissing its significance; perhaps due to their high weight, their desire to lose weight and potentially previous experiences of weight cycling, they could not perceive a small change as a positive change. Further clients described feeling like they were losing weight but not weighing themselves yet. It must be noted that clients were encouraged not to weigh themselves during the intervention.

Guides also recognised positive weight-related changes during WOED and noted that some clients appeared less focused on weight loss following WOED. In addition, some suggested that WOED may support clients' later weight loss - *'You know the weight loss results have been better after people participated in the BE and engagements better so that just shows us that there was a need as well this intervention.'* (G-Alex)

The primary researcher believes G-Alex is implying that engagement and outcomes of the subsequent WM intervention may improve following completion of WOED first. This is the primary aim of placing WOED prior to WM programmes.

Sub-theme: Changes stay long term.

Clients who finished the intervention a while before interviewing reflected that overall, the positive changes, particularly their outlook, had been maintained:

'In the course you learn that there's no right and wrong, there's no food you shouldn't eat. But if I do eat a bit more, then within a day I'm back on it because I know, you've gone down and now you need to get back up again. Where normally if I've gone down, I'll just stay at that way' (C-Tia)

'Interviewer: have all of those changes stayed?

Client: Yes, they have indeed. yeah, they've stayed massively. Yeah, a lot, you know, obviously you get to think about things. Obviously so yeah it's made me feel more aware of like what I can change in myself and it made me feel I have a real good positivity in my life.' (C-Mol)

These comments appear to indicate clients' increased awareness, understanding and self-efficacy. Interestingly, C-Tia's BES scores had reduced from 'severe' to 'no BE' and C-Mol's had stayed 'severe'. Even without a reduction in BES scores, C-Mol described feeling better following WOED.

Theme 2: A few changes for the worse.

There were negative changes identified by some clients. The amount of content in the intervention was overwhelming to some and they subsequently put pressure on themselves to be able to change everything at once:

'Because it you know the course covers quite a lot of different errm avenues… I, so I feel like I haven't been able to achieve them all. So it sort of in some ways it's sort of errm given me a high expectation that I would feel better about all these different

issues that come up during the course so in some ways it's had a negative effect, even though there are the positives, it's the negatives that always take over the positives' (C-Bob)

The amount of content/ideas in the manual led some clients to believe they would improve in all areas and this prevented them from focusing on the positive changes they had made. Interestingly, compared to other clients, C-Bob's quantitative outcome measures demonstrated some of the most positive changes. Their BES score reduced from 'severe' to 'no BE' and their anxiety, depression and wellbeing outcomes improved also. However, due to this negative mindset described within their quote above, they appeared to not be able to assimilate this information. This 'thinking trap' of focusing on the negatives and disregarding the positives is explored in session four of the intervention.

Another talked about the short-term benefits they experienced during the intervention, but experienced a dip in mood when it ended because they felt like they did not maintain any changes - *'I hate myself a bit more... because I was doing so well and I've just slipped back.'* (C-Ray)

C-Ray does not describe a negative change that occurred due to the intervention per se; it appeared that ending WOED and struggling to manage relapses in their BE led to this dip in mood. Contextually it is important to note that both C-Bob and C-Ray described their co-occurring difficulties with anxiety and/or depression (they were the only clients scoring 'severe' on both the PHQ-9 and GAD-7 pre-WOED) and lack of social support leading to feelings of isolation. The implications of this will be discussed as possible barriers to change (RQ3).

None of the guides interviewed identified any changes for the worse, perhaps reflecting clients' reticence to share them, or that these negatives did not occur during the intervention, but as a response to the intervention ending and the withdrawal of guide support.

RQ 2. What changes were made?

Theme summary

Clients and guides identified a wide range of likely interrelated positive changes following WOED. All described positive shifts in clients' relationship with food and eating, such as decreased BE frequency and an increase in eating healthier foods. Other related changes included feeling better about themselves and in general, more able to elicit positive social support, behavioural changes such as increased exercise and more able to challenge some of their other difficulties. These appear to be underpinned by an increase in confidence and self-efficacy. Weight loss was also a possible positive change but this is less conclusive. Two clients identified that their positive changes were sustained over time.

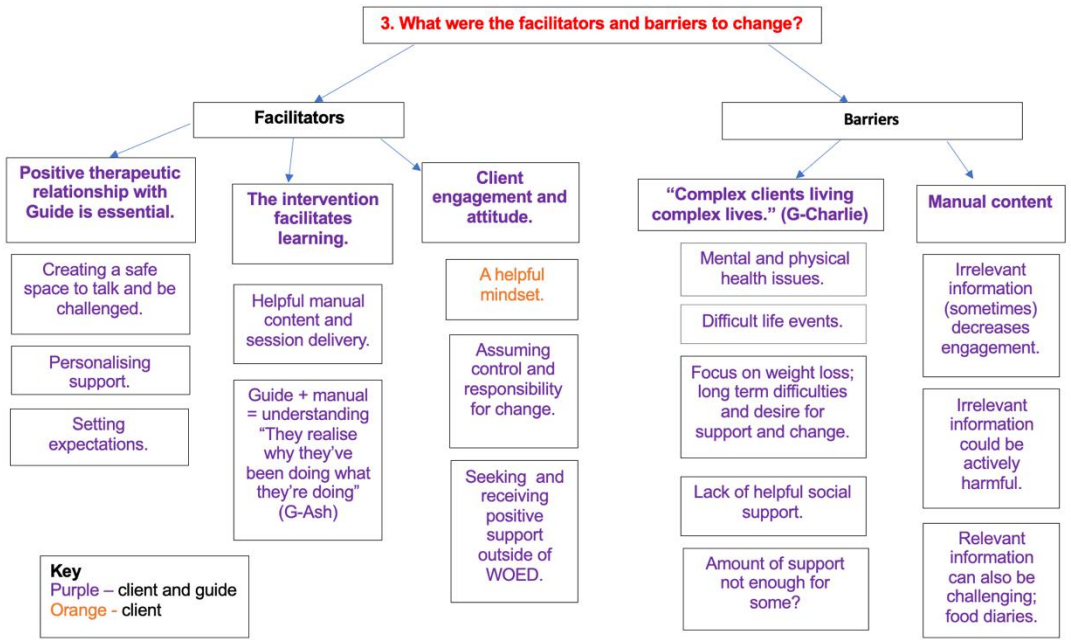
A minority of clients reported changes for the worse; feeling overwhelmed, focusing on what they had not achieved and feeling like they were slipping backwards. These may be compounded by co-occurring difficulties including anxiety and depression, lack of social support and the ending of the intervention.

RQ3. What were the facilitators and barriers to change?

There were many facilitators and barriers to change, both directly identified by clients and guides and otherwise implied (see Figure 5 for the themes and sub-themes).

Figure 5

Thematic map for RQ3



The facilitators and barriers often linked to how clients and guides experienced the intervention, in what they found helpful and challenging (RQ1). Themes and sub-themes are explored below in turn, starting with facilitators.

Theme 1: Facilitator – Positive therapeutic relationship with Guide is essential

To benefit from any intervention, clients must engage with it. Clients felt their relationship with their guides was essential in facilitating their engagement with WOED:

'If I didn't have the intervention from the people or obviously one to one on those days, I think the book would have just sat there. I don't think it would have been looked at. I think it would have just had a coffee cup stuck on the top of it.' (C-Mol)

Without the guide, WOED would not have had the same impact. Guides supported clients through: creating a safe space to talk and be challenged; offering personalised support; and setting clear expectations.

Sub-theme: Creating a safe space to talk and be challenged.

Described in RQ1, WOED offered the first space for clients to explore their relationship with BE. To explore such a sensitive topic, clients needed to feel safe. Clients described guides' interpersonal qualities that facilitated a safe space as: *'lovely', 'brilliant', 'calm', 'kind', 'sensitive', 'smart'* (C-Ray), *'supportive', 'helpful'* (C-Mol), '*a nice person'* (C-Ann), *'understanding' and 'good at listening'* (C-Sue). Perhaps most importantly, *'you didn't feel judged'* (C-Ant). Some liked the fact that this was client-led and not psychological therapy: *'I think, that what made it comfortable. I didn't feel like I was under a therapist, or a therapist is helping me. I just felt like every time it was a productive discussion.'* (C-Ant)

Guides described important skills such as normalising, listening, reflecting, encouraging, *'empathy and counselling skills'* (G-Bobby), *'being a reassurance'* (G-Charlie) and offering '*a little hand holding'* (G-Bobby). Due to these qualities, clients described feeling able to be honest with their guides and fully engage in the intervention, without hiding aspects of themselves and their behaviours that they felt ashamed of. All of these reflect elements of a positive therapeutic relationship. For some this felt like the key factor in resulting positive changes:

'Interviewer: What do you think has caused these changes?

Client: I think since I've had [Guide] *listening and guiding me through this, and giving me that understanding. I think that's been quite a big change to my thoughts and feelings and moving on with how I'm going to deal with this now.'* (C-Sue)

'My Client says like, you know, I look forward to this because that's the only time I can you know… I can very… not confidently, she's like, you know, she said this is the time I feel free to talk about my issues, and that's the only time I feel safe.'

(G-Bobby)

The term 'safe' captures exactly what a positive therapeutic relationship between client and guide can create. It also re-emphasises that there is not always this space for clients outside of such interventions.

Finally, part of creating a safe space to talk and aligning with the CBT framework of WOED, guides also felt it was important that they used their positive therapeutic relationship to encourage clients to think differently and to problem solve. Guides '*can almost challenge the Client'* (G-Alex) if they recognise an unhelpful thought or way of thinking, that clients may not be able to recognise on

their own. They can also help clients plan for possible problems - *'X would say, what about if you have a tough week, what would you do?'* (C-Mol). Questions such as these align with the problem-solving and relapse management sections of the manual and MI techniques that some guides were trained in.

Sub-theme: Personalising support.

Clients described guides as *'flexible'* (C-Ant) and *'personal'* (C-Ela), demonstrated through: rescheduling appointments; facilitating breaks during sessions; skipping over content that did not feel relevant to the client (necessary as WOED is a transdiagnostic ED intervention); providing the opportunity for clients to contact guides between sessions; texting clients to see how they were; and organising a follow-up 'check-in' with clients after the intervention ended. Guides described the importance of helping clients identify their individual values and then tailoring their questions and problem-solving prompts accordingly and some described writing to their clients after WOED to acknowledge/reflect their achievements. Due to all these factors clients felt the intervention was more personal and tailored to their needs than previous experiences of group WM interventions and this encouraged engagement and motivation:

'I think the fact that she's offered to you know I don't even know if it's part of it, but the fact that she's going to message me in a couple of weeks just to check in, is really, I really like that. That's made me feel really, you know I can do this, and she's also said to me, if you're struggling, text me' (C-Ela)

'Because some sessions I found really, really good and other sessions I thought oh, well, you know that's not really me, but I was honest with the ermm you know the lady that run it and we talked about it where we didn't necessarily focus on them bits as much as the bits that I was more interested in.' (C-Bob)

Reflecting a person-centered individualised approach, guides were able to give some advice and recognise and signpost clients to further sources of support, such as mental health services, when needed.

Sub-theme: Setting expectations.

Guides highlighted the necessity of setting clear expectations for clients at the start of WOED. This links to the setting in which WOED was being delivered, as a precursor to a WM intervention that clients may not have been expecting to receive. To understand the rationale for engaging in WOED first and to be able to

approach it with *'the right mindset'* (G-Bobby), clients needed to understand the following:

- This is a client-led intervention rather than therapist-led intervention (and guides are not trained therapists):

'It's just trying to wipe the wipe the slate clean in terms of kind of like I'm not trying to get you to do anything. I'm just there to kind of be along with you as you as you explore it and try different things' (G-Ash)

- Weight loss is not an aim or expected outcome:

'We are basically with this programme looking at improving the relationship with the food. No, weight is, you know, not the primary outcome, you might change weight as a process of this but again, you know we try and reinforce that, you know, we're not going to look at the weighing scales, or we're not going to, you know, focus on the weight.' (G-Bobby)

- This intervention is designed to be delivered transdiagnostically across ED presentations:

'I've made that very clear with the Clients at the start that this is not just, for BE, or disordered eating in that way, and there will be content in there that doesn't, isn't relevant to you' (G-Charlie)

- Not all the ideas in the manual will lead to positive changes for every client. This reflects C-Bob's focus on what they had not achieved rather than what they had achieved (see RQ2), due to the volume of manual content and their negative thinking pattern.

If clients do not understand what they have signed up for, this might increase the likelihood of them feeling '*frightened*' (C-Tia) and potentially dropping out and/or not completing home tasks. Whilst all the above expectations are explicitly documented within the WOED manual, it is likely that having a conversation with a Guide to reiterate the above points was important.

Theme 2: Facilitator – The intervention facilitates learning

Sub-theme: Helpful manual content and session delivery.

With regards to the WOED manual content, clients described liking: the exercises; the space to write their thoughts and answer questions; the *'self-help things'* (C-Mol); the recommended applications (particularly 'Recovery Record:

Eating Disorder Management'); and the manual's focus on *their* experience. Guides noted it was important the manual recommended the *'right kind of resources'* (G-Bobby), indicating an understanding that not all apps or information available to clients may be beneficial (e.g. calorie counting apps). In contrast, the manual was described as *'very engaging'* with *'a lot of reflection activities'* (G-Bobby) *'very good for suggestions, very good for ideas and very good for trying to get things thought out'* (C-Joy). Messages such as *'there's no right and wrong, there's no food you shouldn't eat'* (C-Joy) were felt to be particularly impactful. One guide felt that the positive changes they saw in clients were *'definitely from what they read in the book'* (G-Charlie).

Additionally, having a physical manual (or '*my Bible*', C-Sue) provided a source of support between sessions that clients could rely on if they felt *'stuck with something'* (C-Ann). Those who had completed the intervention described re-visiting the manual for reminders.

With regards to delivery, the structured session model was considered beneficial because it gave clients time to put changes into practise before the next session without feeling rushed; '*it's helpful that it was split up into nice, manageable chunks'* (C-Ela). In addition, clients and guides highlighted the importance of WOED being delivered one-to-one in helping *'people feel a bit more open to talk about things'* (G-Alex), again reiterating a contrast between WOED and previous experiences of group WM interventions:

'I quite like it's one to one, there's no group, there's no, because it's not about what everybody else is doing or thinking it's about what I'm doing and what I'm thinking, yeah. It's about me.' (C-Joy)

Whilst overall clients were complimentary about the content and delivery of material, there were plenty of recommendations for the manual's improvement including: emailing chapters; re-considering the overly *'wordy'* (C-Bob) nature of the manual; having a more discrete cover; more notes pages; more resources/coping strategies; and inclusion of videos of other clients who had and had not benefited from WOED. Some of these are explored within clinical and research recommendations in the discussion.

Sub-theme: Guide + manual = understanding; 'They realize why they've been doing what they're doing' (G-Ash).

Clients and guides noted that the intervention facilitated an overall increase in awareness and understanding about the problem, through clients reflecting on their historical relationship with food, where their difficulties have come from, what

their triggers are, what keeps their difficulties with food going and what they can do about it. In other words, WOED *'opened my eyes to exactly what's going on'* (C-Sue) and *'It's made me feel more aware of like what I can change in myself'* (C-Mol). This increase in awareness and understanding led to an increased confidence in problem-solving their difficulties and doing something differently. This was facilitated by a one-to-one psychologically informed intervention with a helpful guide who created a safe space to talk about their individual difficulties, centered on the thought-provoking and reflective content of the manual and sessions:

'What caused these changes... Becoming aware. Becoming self-aware and reflecting. And getting to the root causes of Why I'm am, Why I am, who I am, you know, why I am like I am… And then acceptance. And you know, that's something that perhaps I've never ever done before.' (C-Joy)

Both guides and clients discussed the importance of clients understanding the predisposing factors and maintenance triggers for their BE behaviours, such as: growing up in poverty; experiencing bereavements; childhood abuse and family eating behaviours; and psychological factors such as eating in response to difficult emotions; worries about finances; boredom and loneliness. Guides noted that through understanding why they behave how they do and recognising their own thoughts and feelings and ways their problems were being maintained, clients could choose to do something differently and build up their confidence in helping themselves:

'I think the biggest change comes from them learning about the impact of over restriction, and then building some sort of confidence up to then try this newer way of doing things, and then sticking to it long enough I suppose that the effects start happening and then they have some positive experience that then encourages them to keep that lifestyle going.' (G-Charlie)

Through the content of the manual and drawing upon their own experiences as WM clinicians, guides were able to re-educate clients on some unhelpful myths surrounding eating behaviours and dieting, including popular fad diets/weight loss initiatives such as not having breakfast and the overly simplified 'calories in = calories out' mantra. Guides reflected that they repeatedly saw people in their work in WM who had attempted diets that involved restrictive eating and how unhelpful that was. WOED, with a guide experienced in WM and a manual that outlines how restrictive eating can present, offered an alternative to this narrative.

Theme 3: Facilitator – Client engagement and attitude

'I think for those that have engaged it has been, it has been pretty successful.' (G-Charlie). Having a helpful mindset, assuming control and responsibility for change and actively seeking support outside of WOED (including social support), were key indicators of fully engaged Clients.

Sub-theme: A helpful mindset.

When asked what personal strengths enabled them to make use of WOED, clients identified the following characteristics: '*willingness to be open'* (C-Joy), '*able to self-reflect'* (C-Joy) and *'resilience' - particularly when discussing difficult topics* (C-Ela). In addition, clients recognised the need to have *'the staying power to do the whole course'* (C-Tia).

These clients appeared to recognise that this intervention required some level of self-awareness and then self-disclosure (i.e. the ability to be honest with themselves and then their guide) and a lot of thinking. WOED aims to address a problem likely associated with shame and guilt and is a client-led intervention. If participants do not feel able or willing to think/talk about their difficulties, it is less likely to be beneficial. In contrast - *'I think when you immerse yourself, and you give yourself a chance it is really helpful'* (C-Ant)

Other identified aspects of a helpful mindset were: client's positivity that the intervention could help them and their commitment to try - '*I will do my best'* (C-Sue); a balanced understanding that change will not occur only within the time frame of the seven sessions but continue after the intervention has finished; and the understanding that ‘relapses’ may occur but that clients will be able to cope (explored in session six of the intervention).

Interestingly, most clients contributing to this theme scored relatively low (in comparison to other clients) on the GAD-7, indicating that lower levels of anxiety may be associated with clients’ capacity to be open, honest and positive. This is not a causal inference but an observation.

Sub-theme: Assuming control and responsibility for change.

WOED is a client-led GSH intervention; clients are responsible for their own change and guides were explicit about this. To take responsibility, clients must first recognise and accept they have a problem that needs addressing:

'Interviewer: in general, what do you think caused these changes?

Guide: I think you know, engaging with the intervention to be able to recognize the issue. So one is, you know, accepting that, you know they do have an issue with this, and looking at it in details.' (G-Bobby)

Then, Clients need to be '*willing to change. You've got to be able to do things differently.'* (C-Joy). Clients and guides were explicit about the client's active role in taking control with WOED, both during the intervention and after:

'Obviously you had to prepare yourself so you had to read session one before you could start session one, if you see what I mean and then session two, then you got to speak about session 2 and I think that helped massively because you it's like having homework. It's got to be done. You can't exactly not do it.' (C-Mol).

'Any intervention works when you know there's a participation's engagement, and the model allows the intervention this intervention allows engagement and taking responsibility. I think that's something has worked because, you know, they are not coming for a therapy session, and they're they know that, you know, it's just, you know, we'll listen to them, and they're not expecting me to find, or you know, give them like a ready solution' (G-Bobby)

Those clients who completed the pre-reading and between-session tasks were thought to be more likely to benefit from the intervention than those who only focused on these problems during the conversations with their guides and were not active in supporting themselves outside of this.

Sub-theme: Accessing positive support outside of WOED.

As advised in session five of the intervention and explored in positive changes in RQ2, some clients were able to seek positive social support from friends/family/colleagues following WOED and this was considered essential in facilitating their other positive changes - *'Without their social support, without you know, getting that sort of help from their own family it won't be possible to be successful at this'* (G-Bobby)

In addition, demonstrating the motivation to help themselves more broadly and not necessarily an outcome of WOED but a pre-existing inclination, some clients described engaging in activities such as mindfulness classes, hypnotherapy, wellbeing classes and previous/upcoming courses of psychological therapy. It is likely that any of the positive benefits from these other sources of support could be helpful in their engagement with and positive changes following WOED - *'I think it's it's a mixture of all the things I've been doing for myself all coming together to make this better.'* (C-Tia)

This indicates that whilst WOED was vital in contributing to all the positive changes described, it cannot be deemed wholly accountable – other factors may have supported the positive changes too. It must also be noted that whilst the motivation to seek support from close people could be considered an internal factor, the capacity for friends/family/colleagues to be supportive rather than harmful, is an external one.

Theme 4: Barrier - 'Complex clients living complex lives' (G-Charlie).

To benefit from any intervention clients must be willing and able to engage. Therefore, any barrier to engagement is a barrier to positive change. BE and obesity are associated with a range of biopsychosocial difficulties. Guides were aware of this and described its impact on attendance and engagement:

'I know, from speaking to colleagues and the people I've been supporting to run it that there's often issues with just very complex clients, living complex lives, and sort of finding it quite difficult to maintain their attendance and engagement. So, either we have lots of cancellations during the course, or we have people that aren't necessarily able to apply what they're doing in the sessions outside' (G-Charlie)

The following sub-themes will explore what issues clients were facing that may have impacted their attendance and engagement with WOED: mental and physical health issues; external pressures; lack of helpful social support; and a fixed focus on weight loss. These complexities may be why the limited number of sessions (7) did not feel like enough for some clients.

Sub-theme: Mental and physical health issues.

Clients identifying changes for the worse (RQ2) following WOED/the ending of support described co-occurring difficulties with anxiety and/or depression, reflected in their 'severe' scores on the PHQ-9 and GAD-7 and their low SWEMWBS scores. Forgetfulness, low self-esteem, embarrassment, difficulties with motivation/commitment and symptoms relating to traumatic experiences were also described by clients. Guides described having to pause/stop WOED with clients who needed to focus on their mental health and referring them to the more appropriate agencies. The impact on clients' capacity to engage fully with WOED was clear - *'I know it's only me that can change it but it's hard when your brain doesn't allow you to.'* (C-Ray)

From the primary researcher's clinical experience, having mental health difficulties may have impacted clients' sense of self-efficacy, perhaps whether they could feel hopeful that things could change and/or whether they believed they deserved for their difficulties to improve. However, C-Bob, despite their 'severe'

scores, greatly improved in their BES scores (from ‘severe’ to ‘no BE’). This indicates that mental health difficulties are not an automatic barrier to at least some success in WOED.

Regarding physical health difficulties, clients described managing: pain; operations; injuries; menopause; multiple sclerosis; stomach issues/dietary requirements and long covid. Table 3 indicates further conditions of fibromyalgia, COPD, hypertension and asthma. Again, this was thought to have a detrimental impact on engagement for some:

'I think the main reasons I've had clients not being successful is things like medication, health problems that have either prevented them… like, I've had a couple of clients that probably weren't actually looking back on it that suitable… I think a couple of them they did drop out for this reason was because of like stomach issues or medication that was preventing them from establishing a healthy eating routine' (G-Charlie)

Clients also reflected on the impact of their physical health difficulties on their motivation and mood - *'I don’t want to do anything, I can barely walk.'* (C-Ray), reiterating the complex relationship between mental and physical health difficulties. GSH is an active intervention that requires full client engagement, in and out of sessions. Managing mental/physical health difficulties may have prevented some from being able to either fully engage, or engage at all.

Sub-theme: Difficult life events.

Multiple external events occurred that could have impacted clients’ engagement with WOED including: bereavements; house moves; leaving/moving jobs and financial concerns. For some this may not have impacted their engagement, if they had the resources to manage these difficulties, but for others it did. One guide described an initial session with a possible client who was driving two hours each way for a new job and wanted to be coached on the individual sessions without having to complete between-session tasks. Together they decided that now was not the time to engage in WOED (again emphasising the importance of setting clear expectations as described earlier in RQ3).

One client that identified changes for the worse (described in RQ2) had recently left a job and this was impacting their mental health and eating behaviours. They understood that this was a contributing factor to why their BE had not resolved/improved:

'I literally just walked away from a job after X years, because of my mental health and they could no longer support me for my health issues that I have, so you know, having to walk away from a job it's been hard, so that's why I probably slipped back' (C-Ray)

External complications that may get in the way of clients being/feeling able to engage, may present a barrier to positive change. As with any intervention, timing is important and there are external factors beyond clients' and guides' control.

Sub-theme: Stuck focus on weight loss.

Most clients were referred to MoreLife for a WM intervention. Therefore, for many, their focus was explicitly on weight loss, rather than understanding their relationship with food. Additionally, guides were WM intervention specialists. All guides recognised this as problematic for clients:

'I think it was quite difficult to try to disassociate the weight loss element with the actual BE element. So I'd explain quite a bit that you know this has nothing to do with with weight loss or trying to lose weight but quite often the client would, could kind of transfix on that.' (G-Ash)

The longevity of clients' difficulties with weight, the setting in which WOED was being delivered and the clinical backgrounds of some guides may have made it challenging for some clients to put their weight loss goal to one side and engage fully in the aims of WOED. A mismatch between client goals and intervention goals may have had an impact on whether clients agreed to engage in WOED at all and if they did, on their subsequent engagement and intervention success:

'Interviewer: Is there anything else that's been tricky?

Client: I think it's knowing that you want to lose weight, and knowing that you are on a programme that is supporting you to prevent you or minimize your BE, but not seeing the evidence of weight loss.' (C-Ant)

This reiterates the importance of guides setting clients' expectations at the start of WOED, as explored earlier in RQ3.

Sub-theme: Lack of helpful social support.

Clients who identified changes for the worse (RQ2) also described not having anyone in their personal lives to talk to about their difficulties who would understand, leading them to feel isolated:

'It makes you do you know makes you feel that you're sort of on your own. You know, you're okay during the course, because you've got like support from

you're the, you know the person who's running the course but then afterwards you've got nothing.' (C-Bob)

The brief introduction and withdrawal of someone who did understand their difficulties (the guide) may have exacerbated this feeling. In addition, clients described friends/family telling them to *'just stop eating'* (C-Ray) and how unhelpful this was. Not only did some clients not have access to people who would understand their difficulties, others had family who degraded their attempts to change through rubbishing WOED and/or who perpetuated an obesogenic environment through buying unhealthy food:

'She'd [family member] *turn up at mine and I'd think awwww, it wouldn't be one bag, it would be like 5 family sized bags of jellies, which is my downfall, and then a big bar of chocolate and of course if you put it in front of me I'm gonna eat it... if it's not there I won't'* (C-Sue)

In unpacking the complexity of seeking support from friends/family, there were reflections around the impact of stigma in silencing people who experience BE and obesity:

'I know some of the clients have found it quite difficult talking about this particular topic, it's very sensitive, they've buried it for many, many years, or maybe never spoken about it, so don't feel comfortable talking about it, and I think a lot of that has to do with the stigma around it as well.' (G-Alex)

Societal-level stigma concerning obesity and BE may be contributing to clients' experiences of shame and embarrassment, effectively silencing this population group. It may also prevent clients from engaging in WOED at all; guides noted that some clients who were offered WOED rejected the intervention through not aligning themselves with the term 'BE' and wondered whether this was also linked to stigma surrounding the problem.

Sub-theme: Amount of support not enough for some?

WOED is a 7-session intervention offered over around 12 weeks. Several clients mentioned that they wished it had been longer. This may be linked to the compounded difficulties already mentioned within this theme, such as having anxiety/depression and not having anyone else to talk to about their difficulties with food that understands.

Some guides offered for clients to contact them between sessions for extra support, but not everyone felt able to do this and for some clients it was difficult when the gaps between sessions increased. Some clients described wanting a

support line to manage this. Additionally, once the intervention was over, there may have been a gap between WOED and the WM intervention, or access to other sources of support. Lack of follow-up support in general was considered problematic:

'It's like anything, it's like, it's all or nothing you get it all at once, and then all of a sudden, there's nothing. So you think… oh, well, I've done all that, I'm still in the same place so I'm just gonna go back to the way it was.' (C-Bob)

This reflection may have been perpetuated by the sense of hopelessness and negativity associated with depression. This feeling reiterated why it was so helpful for some that their guides had offered a follow-up check-in - *'We've agreed that in a couple of weeks time we'll check in just to see how things are going, because for me, it's a weird thing to say, but to have that kind of accountability is really helpful'* (C-Ela)

Guides recognised the importance of this too and described checking-in with clients, even after WOED had finished. This is explored in facilitators to change, described earlier in RQ3.

Theme 5: Barrier – Manual content

Designed to be delivered transdiagnostically across EDs and different services, throughout the WOED manual there is information on compensatory behaviours (e.g. vomiting, laxatives, weight loss pills) and other difficulties such as self-harm. Much of this will not be relevant to the BE population accessing support through MoreLife, particularly as some of those difficulties were screened for to assess eligibility to the programme:

'It [manual] *goes through a lot about, things that I think are a little bit irrelevant, considering the criteria that that they're referred to us on, so for example, there's a lot of stuff about the err you know the bulimic and the diuretics and etc, but if they had any of those issues they weren't referred to us'* (G-Ash).

Guides and clients mentioned the irrelevant content and reflected upon the impact of it. Responses fell along the continuum of irrelevant to actively unhelpful for different clients.

Sub-theme: Irrelevant information (sometimes) decreases engagement.

For some clients, having information that was not relevant to them in the manual led them to feel less engaged with the intervention:

'I was complaining, I was like [Guide], *like, some of these things don't apply to me. And she was like, yeah, I know just skip it through I say, yeah, but I think when it is, you see, stuff that don't apply to you you kinda lose focus or you lose that desire'* (C-Ant)

Guides noted that being given the autonomy to be able to tailor the manual to the people they are working with and to other MoreLife resources would perhaps be beneficial:

'It does have an impact, because you know so when I speak to.. err normally, they're quite engaged, but when as soon as they get to that bit, I think it it sort of starts a cascade of oh, that's not relevant, that's not relevant, that's not relevant, and then before you know it, they've not done that much because they've just kind of went, oh, well, yeah, I did some at the beginning but now this whole chunk here isn't relevant so they just sort of skip it over, so I think it kind of acts as a as a catalyst to not to not put as much effort into the rest of it' (G-Ash)

For others, particularly if they understood that WOED is designed to be delivered across different eating disorders (again reiterating the importance of setting expectations mentioned earlier in RQ3), moving through irrelevant information was not problematic.

Sub-theme: Irrelevant information could be actively harmful.

At the other end of the spectrum, because of their desire to lose weight, some clients found the presentation of information around AN and BN behaviours really unhelpful:

'I don't think it was good, because I'll be, you know, very open and honest here is that I was reading things about what bulimic and anorexic patients do to lose weight, and it was so tempting, especially to someone who really wants to stop over eating, and to see like oh, these are things that people who are doing to lose weight and you know anorexics are literally skinny so that temptation was literally great, I had to find a way to staple those pages not to do any of those unhealthy habits.' (C-Ant)

'I'm like a sponge, I'll take it in and I'll take on that problem... my brain will think 'Oh, if I make myself sick I'll be skinny' so I didn't want to read that, because I know that my brain will take that in and want to do it.' (C-Ray)

Guides reflected that having access to such information could be challenging/harmful too, through being upsetting and/or providing ideas for maladaptive ways in which clients could lose weight:

'They're not keen on, there's a lot of talk about sort of the way what word it gives you, but sort of unpleasant or purging behaviors, I think, so it might talk about I mean it does mention like self harming there, it mentions making yourself sick, it mentions… because it is covering a whole host of topics, and I even myself I've made that very clear with the Clients at the start that this is not just, for BE, or disordered eating in that way, and there will be content in there that doesn't, isn't relevant to you, and for a lot of Clients that I think even just reading it you know, even if you've not experienced it you might have friends or family, you know its still quite tough sometimes for people to read' (G-Charlie)

This statement indicates that even after emphasising that this is a transdiagnostic intervention and some information will not be relevant, the emotional impact on the clients of having access to this information could still persist. Interestingly these reflections occurred in spite of the fact that the manual explicitly outlines why compensatory behaviours **do not** support weight loss and why they put our physical health at greater risk.

Sub-theme: Relevant information can also be challenging; food diaries.

For some clients, as a recommendation in session two of the intervention, keeping a log of their food intake was either difficult or unhelpful. It must be noted that the manual is clear that food diaries will not be helpful for everyone (and may be unhelpful) and encourages clients to discuss this with their guide if needed:

'The recommendation was writing down what they eat, a diary. It didn't say anything about calories, but a lot of the clients because losing weight it kind of goes hand in hand with calories, even though we didn't recommend it, this one client went away and started doing the calories, and then sort of came back and said you know it really triggered me this week, and so we kind of went off that quite quickly' (G-Alex)

Whilst none of the interviewed Clients described the food diary as triggering, some reported not really wanting to engage with it:

'Client: To begin with I was like, I really don't wanna do this.

Interviewer: Yeah, and what made you not want to do it X?

Client: It was I think it was like a little bit of embarrassment... of like what I was eating.' (C-Ann)

RQ3. What were the facilitators and barriers to change?

Theme summary

Facilitators:

Guides were considered kind, helpful and non-judgmental. They created a safe space to talk, were flexible to the clients' needs and what content was relevant to them, whilst setting clear expectations, challenging clients and supporting them to problem solve. Without the guide, clients did not think that WOED would have had the same (if any) impact.

With regards to the intervention itself, the content of a psychologically informed intervention with an accessible manual and sessions facilitated by a knowledgeable guide enabled clients to better understand their difficulties with food, eating and previous attempts at weight loss. This was considered instrumental in all the positive changes outlined in RQ2.

Clients with positive attitudes towards WOED were considered more likely to benefit from the intervention. Having a helpful mindset, assuming control and responsibility for change and actively seeking and receiving support outside of WOED, were key indicators of fully engaged clients.

Barriers:

Clients and guides described client-specific difficulties that may impact engagement and success in WOED: mental/physical health concerns; external pressures/life events; pervasive focus on weight loss; and lack of helpful social support (perhaps perpetuated by the impact of stigma*). This may lead to difficulties with the short-term and brief nature of the intervention for some.

*stigma concerning obesity and BE is both client specific and found throughout society such as in the media and healthcare campaigns. It has been explored here for ease but that is not to state that it is solely an internal problem and does not exist within wider discourse.

Intervention-specific barriers were the irrelevant/unhelpful content in the manual. For a population group focused on losing weight, having information about what other ED presentations associated with very low weight do, appears at the least to be irrelevant and for some, possibly harmful. Guides appeared more comfortable with it being in the manual and moving through it, but some clients

were clear about its negative impact. Additionally, asking clients who binge eat to complete food diaries might be uncomfortable and/or unhelpful.

In considering these facilitators and barriers, clients and guides noted ways in which the intervention could be improved and these will be explored in the discussion/clinical recommendations.

Discussion

This chapter provides an overview of the key findings, before discussing the project's strengths and limitations and ending with clinical and research recommendations.

Aims of the project

This is the first project to investigate in detail, through use of semi-structured interviews, the experiences of guides and clients in facilitating and receiving a GSH intervention addressing BE, prior to WM. The goal was to create service-user informed clinical recommendations for future dissemination of WOED with clients who binge eat, outside of mainstream ED services (who are not often commissioned to support this group). To do this, the primary researcher wanted to understand more about clients'/guides' experiences of WOED, what changes were made and what the facilitators and barriers to change were.

Key findings

1. WOED offered something new; guides and clients were positive about this style of support.
2. Positive changes included improvements to BE, psychological wellbeing and wider behavioural/lifestyle changes; these were likely underpinned by an increase in self-efficacy.
3. Positive changes were facilitated by the therapeutic relationship between client and guide, the intervention and client engagement.
4. WOED may not help everyone; clients and guides must be aware of the potential barriers to success and clients must be supported holistically.
5. Training for guides needs to be adapted to the guide's professional experience and background.

These will be explored in turn below.

WOED offered something new.

Whilst GSH for BE is a first-line NICE (2020) recommended intervention and the literature clearly demonstrates that BE is associated with obesity and presents a barrier to effective weight loss (e.g. Blaine & Rodman, 2007; Chao et al., 2017;

Khan et al, 2018; Thaker, 2017), to the primary researcher's knowledge, MoreLife is the first UK WM service provider to offer a GSH intervention targeting BE prior to WM. In exploring clients' and guides' experiences of WOED (RQ1), results showed that for people experienced in WM interventions, WOED offered something different and new. Instead of focusing on weight loss, WOED created a space to talk about the etiology of the problem rather than immediately focusing on behavioural changes. Factors identified that may have prevented clients from speaking about this topic and/or receiving similar support sooner were: emotional experiences (shame, embarrassment, guilt); previous unhelpful experiences of trying to talk about their problems with friends/family/professionals (including experiences of weight stigma – mirroring Amos et al.,'s 2019 findings); a national lack of services that provide support for BE; a lack of awareness that BE was part of the problem; and a concrete focus on weight loss, rather than a desire to explore what was leading to their weight difficulties.

Instead of focusing on losing weight, WOED involves multiple one-to-one conversations with a guide, focused on a psychologically informed manual that encourages clients to consider the etiology and maintenance of their difficulties from a biopsychosocial perspective. In other words, it provides the space to ask 'why' the problem exists, rather than focusing on the symptoms of the problem itself (i.e. the BE). Clients expressed their gratitude for this change in how they were being supported; some wished they had completed WOED sooner and/or reflected anger that they felt they had to fight to get it. Having the space to talk and be listened to was considered a great facilitator of positive change and both guides and clients were positive about the utility of the intervention. The unexpected focus of the intervention was challenging for some, as it was difficult to reflect on the past-present links that had led to their current problems, but this was not deemed to be a negative experience but a necessary one.

As expected within a WM service, clients emphasised the longevity of their difficulties in their relationship with food, their desire for support and change and their frustration/confusion around not achieving their goals. Whilst not directly part of the CCI and questions about WOED per se (positively demonstrating the flexibility of the research tool chosen), many clients volunteered information on the lack of support provided for their difficulties to date and their dedicated involvement in seeking it. Multiple reports of help-seeking from NHS services (e.g. GPs), charities (e.g. BEAT) and commercial WM programmes (e.g. Slimming World/ Weight Watchers) so far had not been helpful in enabling clients to either tackle

their BE or effectively maintain weight loss. Indeed, most people living with BE difficulties have never received any support for this problem; this was the case for all client participants in this project, even though some had sought it for years (Austin et al., 2021; Kessler et al., 2013). Given that BED is the most common ED, this should change (Keshen et al., 2022). Understanding this context reiterates why clients were so grateful to receive WOED, and were so positive about the support overall.

There is currently a lack of literature on clinicians' perspectives of facilitating GSH outside of traditional ED or mental health services. Capturing the voices of guides has been recommended by previous investigations of clients' perspectives, in order to broaden our understanding of how GSH works (Plateau et al., 2018). Previous qualitative explorations capturing guides' perspectives on WOED concern guides working in mental health, as counsellors, mental health workers and psychotherapists and as clinicians in CAMHS ED services (Traviss et al., 2013; Winckley, 2019). Guides from MoreLife, used to offering structured group WM interventions, reflected their anxieties about moving away from delivering group interventions to facilitating a one-to-one participant-led GSH intervention. Many were understandably apprehensive about the new role, but all reported that they felt it was beneficial to the people they were working with and that their anxiety was easing through experience. This indicates that WOED can be acceptable to clinicians outside of mainstream ED services (reflecting the ethos of GSH interventions not needing to be delivered by specialist ED practitioners), if they are supported appropriately to prepare for a different role (Carter & Fairburn, 1998; Davey et al., 2023; Traviss-Turner et al., 2018). Whilst WOED felt new and this was challenging, guides recognised that the skills developed within their previous experience/training of health behaviour change, for example MI, were directly applicable. MI techniques, explored in the WOED manual and guide training, are considered particularly important within health behaviour change work due to the necessity of clients feeling motivated to change (DiClemente & Velasquez, 2002; Steele et al., 2011). Guides' previous experience/training in MI reflects prior research indicating that these clinicians represent a particularly appropriate pool of guides (Traviss-Turner et al., 2018).

Most of the guides in this project had only supported around two clients to completion of the intervention, therefore the new intervention still felt very new. It would be interesting to determine whether over time guide anxiety about the new role continues to reduce and if any of their perspectives on the acceptability/efficacy

of WOED change. Additionally, there was a comment around engaging in WOED supporting guides' other roles; it would be prudent to determine through further research whether upskilling in a low intensity psychological intervention such as WOED positively impacts guides' other work.

Positive changes - improvements to BE, psychological wellbeing and wider behavioural/lifestyle changes.

Moving on to what changes were made (RQ2), clients and guides described WOED supporting positive changes relating to the diagnostic criteria for BED (Berkman et al., 2015; DSM-V, 2013). All clients improved in their understanding of their relationship with food and most subsequently described changes such as: fewer binges; eating in moderation; eating regularly; not restricting food; pausing before eating; not eating unless hungry; not hiding food to eat alone; not eating for the 'sake' of eating; feeling more in control of their eating; and feeling better able to deal with relapses in BE behaviours. Improvements in loss of control around eating have been mirrored in quantitative research into WOED (Traviss-Turner et al., 2018) but this is the first qualitative exploration into the *variety* of ways in which eating behaviours can improve. It was apparent that these changes were considered inter-related rather than discrete. Guides were clear that decreasing clients' restrictions around their eating and increasing the regularity of eating, was key in reducing their BE; they had witnessed this within their wider practice when delivering WM interventions. This reflection mirrors the importance of regular eating explored in CBT-E (De Young & Bottera, 2022) and session three of WOED and highlights again the utility of guides' pre-existing clinical experience and knowledge in WM.

Nearly half of the client participants demonstrated marked improvements in their BES scores. This mirrors the approximately 50% success rate in other low-intensity interventions for EDs and indicates WOEDs suitability within a weight management context (Davey et al., 2023). Previous quantitative research has demonstrated that WOED improves BE behaviours, but so far this change has not reached statistical significance, even in larger samples (Edwards et al., 2023; Traviss et al., 2011; Traviss-Turner et al., 2018). Perhaps, within a pre-post quantitative study for a brief intervention, the positive effects of WOED on BE cannot be fully demonstrated, as sustained change may take longer than 12 weeks. This project's findings support this theory. Even clients who did not demonstrate statistically significant change on the BES scores described their eating behaviours *'moving in the right direction'* and an increased understanding and control over their relationship with food. The hope that positive changes would continue post-WOED

was mirrored in the reflection of clinicians in Traviss-Turner et al.'s (2018) study. This highlights the need for follow-up outcome measures, to determine whether changes in BE reach statistical significance over time. Additionally, it is plausible that the quantitative measures typically used (e.g. BES) do not capture the *range* of positive changes in eating behaviours that were described in this project and perhaps experienced by clients (but not captured) in previous quantitative research. Further consideration for other eating-related outcome measures is warranted to determine if there is any clinically significant change in other aspects of eating that may support future WM outcomes.

In addition, prior to engaging in WOED, some clients did not know that part of their relationship with food and difficulty losing weight was related to binge eating, reflecting the understanding that clinicians and clients alike are not always aware of this issue (Davis et al., 2020). These clients would fall within the 'pre-contemplative phase' of Prochaska and DiClemente's (1983) model of change. Without WOED they were likely to continue to seek support for weight loss but struggle to maintain any benefits due to lack of awareness concerning what was maintaining their problems. This highlights the utility of MoreLife's recruitment methods into WOED and suggests it may be useful within other WM services to capture clients who would otherwise not seek/receive this support, but would likely continue to struggle with their weight due to their BE. Indeed, people who binge eat are more likely to seek support for their weight than their BE difficulties (de Zwaan, 2001). In addition, broadening the provision of GSH for EDs into non-mainstream ED services, to increase their dissemination, has recently been recommended by experts in the field (Davey et al., 2023).

Alongside improvements in BE, clients reported positive changes in their wellbeing. BE does not present as a behaviour in isolation but alongside the difficult thoughts and feelings related to guilt, anxiety, depression, embarrassment, low self-esteem and concerns about body shape and weight (Brownley et al., 2016; de Zwaan, 2001; Fairburn et al., 2003; Jirik-Babb & Geliebter, 2003). The common core psychopathology thought to underlie all EDs (that WOED is based on), suggests that clients will present as having an intense focus on shape, weight and control to monitor their own self-worth alongside high levels of self-criticism and perfectionism related to their eating (Fairburn et al., 2003). Indeed, experiencing negative/difficult emotions before/during/after BE is part of the diagnostic criteria for BED (Berkman, 2015; DSM-V, 2013). It therefore makes intuitive sense that improvements to BE behaviours would be associated with positive psychological

benefits. This project confirmed this. Identified psychological changes included decreases in clients' shame, guilt, perfectionism, self-criticism, focus on other peoples' perceptions of them and increases in confidence and self-esteem, including feeling more in control of their eating (and better prepared for future WM support). In addition, shame, embarrassment and guilt were identified psychological barriers that prevented clients from speaking about their difficulties with their relationship with food sooner. This is unsurprising as the development of internal shame is thought to be related to fears around other people's perceptions, and individuals living with obesity are likely to have experienced shaming from society at different levels (Gilbert & Proctor, 2006). Consequently, shame, self-criticism, and negative social comparisons are thought to be significantly associated with the development and maintenance of maladaptive eating behaviours, and therefore warrant further exploration within this context as the long-term goal of providing WOED pre-WM intervention was to enhance later weight loss outcomes (Duarte et al., 2017; Steindl et al., 2017). Finally, positive long-term changes to clients' outlook were indicated, in their ability to manage relapses and feel positive about what changes they were able to make for themselves. Correspondingly, most clients demonstrated some (albeit small) improvement within the GAD-7, PHQ-9 and SWEMWBS scores.

The bi-directional relationship between feeling better, with reduced shame, embarrassment and guilt, and an improvement in problematic eating behaviours aligns with the emotional regulation model of BE (Davis et al., 2020). Binges are associated with difficult emotions and food may be used to try and control these feelings, leading to short-term relief but an increased likelihood of future difficult emotions resulting in subsequent binges (Lillis et al., 2011). Indeed, a recent study found that targeting emotional regulation skills in people presenting with BED was associated with a reduction in their BE (Berking et al., 2022). Similarly, improvements in emotional regulation have been positively associated with BE cessation at follow-up following a DBT-GSH intervention (Wallace et al., 2014). WOED specifically, alongside supporting improvements in eating difficulties, is associated with decreased distress, improvement in worries around shape and BE and reductions in anxiety and depression (Traviss et al., 2011; Traviss-Turner et al., 2018). Furthering these quantitative findings, this project is the first to capture the wider impact of WOED in relation to improved confidence and emotional wellbeing. Due to feeling better, more in control of their difficulties and less self-critical, clients made wider lifestyle changes and began to re-engage in social activities such as

increased exercise, volunteering, cooking with friends, challenging their social anxieties and seeking support from loved ones. Session five is entitled ‘Learning to Feel Good about You’, reflecting the wider remit of WOED in what the content offers support for.

In this project, following WOED, clients described feeling more capable, better able to problem solve and in control of making further changes to their lives, demonstrating an increase in self-efficacy. Self-efficacy refers to the belief in one’s ability to be able to positively influence outcomes based on changing one’s behaviours (Bandura, 1997). Levels of self-efficacy can be context/task specific and are amenable to change (Eller et al., 2018). The recent consensus statement for the improvement of programme-led interventions for EDs reports that *'Early change is critical to treatment success, so greater efforts need to be made early on to help the patient to navigate challenges and to build the self-efficacy to experiment with initial early change'* (Davey et al., 2023, pg. 13). Indeed, low self-efficacy is a predictor of weight gain post WM intervention, highlighting the need for interventions that actively address this (Latner et al., 2013). Unfortunately, levels of self-efficacy concerning eating behaviours are often low within individuals with BED and obesity and important for predicting positive treatment outcomes in other healthy lifestyle behaviour changes; one needs to believe that they will be able to change in order to make the change (Wolff & Clark, 2001). Promisingly, improvements in self-efficacy have been demonstrated following group CBT interventions for individuals with BED and obesity (Wolff & Clark, 2001). Future evaluations of WOED may consider including an appropriate measure of self-efficacy such as the Self-Efficacy for Self-Help scale (Tomczyk et al., 2023). This would enable researchers to ascertain whether self-efficacy levels at baseline are associated with more positive outcomes following GSH, or whether the level of improvement in self-efficacy during/following the intervention is a stronger predictor of positive change.

There is a positive relationship between improvements in self-efficacy and improvements in problem-solving abilities, which in turn are related to feelings of hope (Çam et al., 2020). Indeed, the Adult Hope Scale (Snyder et al., 1991) incorporates four items related to personal agency. Clients in this project described an increase in self-efficacy and in turn, an increase in their sense of hope, through their awareness and positivity of what they could change for themselves. This mirrors McGregor et al.’s (2016) findings that global self-worth can improve following a weight loss camp, apparently independently of weight loss. A focus on

increasing participants' levels of hope has been recommended within weight loss programmes (such as McGregor's) and the same logic for its value applies to all health-related change interventions, such as WOED (Kelsey et al., 2011). In fact, instilling hope has been recognised as an important part of the guides' role (Traviss et al., 2013). The construct of hope was not explicitly explored with guides or clients in this project, but warrants further investigation as it is related to increased self-efficacy and problem-solving skills.

The hypothesis that improvements to wellbeing were related to improvements in self-esteem/self-efficacy/hope (rather than a reduction in depression or anxiety specifically) may explain why there were not more consistent and/or significant improvements to client scores on GAD-7, PHQ-9 and SWEMWBS. The small changes presented in Table 3 do not seem to adequately reflect the positive impact of WOED on clients' reported sense of self-esteem or confidence. For example, the phrase *'I couldn't ask for more* [from WOED]' was provided by a client who only made a small improvement on their GAD-7 and no change on any other outcome measure. This reiterates the importance of qualitative methods and additional/alternative quantitative outcome measures already discussed.

Change facilitators – therapeutic relationship, intervention and client engagement.

Regarding facilitators of positive change (RQ3), clients did not believe they would have made any positive changes, or engaged in the intervention at all, on their own, citing the guide as essential. A note on context; due to the internal and external experiences of stigma surrounding their difficulties, most clients were unlikely to have had a private and one-to-one safe space to discuss these problems before, either with professionals or family/friends, reinforcing a sense of isolation and embarrassment. Contrastingly, all clients described effective guides as having interpersonal qualities that led clients to feel safe, understood and not judged. This enabled clients to talk openly, aligning with the skills important to the role of guide and possibly offering a corrective experience to previous (stigmatising) interactions (Traviss-Turner et al., 2017; Yim & Schmidt, 2019). In ED support especially, the impact of simply being listened to by someone who presents as wanting to hear cannot be underestimated and particularly with obesity and BED, the importance of not feeling judged is critical (Davis et al., 2020; Keshen et al., 2022; Zerbe & Satir, 2016). As already mentioned, most guides had experience/training in MI, a behaviour change technique that focuses on the importance of fostering a positive

therapeutic relationship through being non-judgmental and empathetic (Miller & Rose, 2009). Mirroring wider literature, the centrality of the guide as a facilitator of positive change and motivating client engagement has been demonstrated in WOED, other CBT-GSH interventions such as 'Overcoming BE' and across wider low-intensity programmes for EDs, anxiety and depression (Amos et al., 2019; Plateau et al., 2018; Traviss et al., 2013; Winckley, 2019; Yim & Schmidt, 2019). This also reflects the common factors literature on the importance of the therapeutic alliance in psychotherapies (Drisko, 2013; Fife et al., 2014; Rosenzweig, 1936).

Qualitative research has explored the concept of shame as an interpersonal process, as our shame is often developed through over-consideration of how we have been or may be viewed by other people, highlighting the centrality of safe exploration with another person as a process by which people can overcome their shame (Leeming & Boyle, 2011). Reductions in shame are considered common within a range of effective psychological interventions, regardless of whether a decrease in shame is an identified and measured goal (Goffnet et al., 2020). The importance of the guide being non-judgmental therefore cannot be underestimated. Binge eating is a stigmatised difficulty across multiple layers of society, and participants are likely to have internalised the negative social discourses surrounding binge eating and obesity, and internalised them as true, thus leading to shame. Having an opportunity to explore an alternative narrative is likely essential in all the changes identified, and the reduction of shame. In addition, the WOED manual directly incorporates aspects of CFT, a therapeutic model designed to specifically address high levels of shame and self-criticism in its clients (Gilbert, 2014). The recognition of shame and self-criticism as core components in the maintenance of EDs is reflected within the development of Compassion Focused Therapy for EDs (CFT-E), another transdiagnostic model that aligns with Fairburn et al.,'s (2003) common core psychopathology of EDs. CFT-E is gaining traction within current research and practice with different groups (Goss & Kelly, 2022; Steindl et al., 2017).

To nurture a positive therapeutic relationship the practitioner must view the individual within their context, responding accordingly and respectfully to their individual needs (Clarke et al., 2017). This was evidenced within WOED through clients' appreciation of their guides' ability to: tailor the intervention to them; treat them as individuals; check-in between sessions and after the intervention ended; make the programme feel personal; cancel/re-arrange appointments when needed; and signpost to further support when necessary. Again, this felt different to previous

experiences of structured group WM interventions. Across other low-intensity interventions, a personal approach has been identified as important in facilitating positive change (with a restricted/manualised approach thought to prevent positive changes) and within other CBT-GSH interventions for EDs, effective guides have been described supporting clients *'beyond the call of duty'* through their flexibility and adaptability (Amos et al., 2019; Plateau et al., 2018, p.12).

Personalising support and tailoring the intervention is especially necessary in WOED as it is a transdiagnostic ED intervention (Traviss et al., 2013). This is particularly pertinent within a WM service context; information on compensatory behaviours associated with AN and BN presented in the manual was described by some as '*tempting'* due to their associations (however misguided) with weight loss, reflecting the strong desire of this group of clients to lose weight. It must be noted that other clients stated that whilst this information was not relevant or helpful to them, they felt it needed to stay in the manual to support other people. Therefore, it need not be removed automatically for clients living with BED and obesity and engaging in support with a WM service, but the guide will need to manage this content very sensitively and this should be highlighted within their training. Assessing possible harm as a result of any low-intensity ED intervention aligns with advice from experts in the field (Davey et al., 2023).

Finally, part of a positive therapeutic relationship is the collaborative understanding or contract between facilitator and recipient; in GSH this involves setting expectations for what an intervention can/cannot achieve and what the responsibilities of each party are (Bordin, 1979). Expectations are known to influence adherence, treatment satisfaction and outcomes; having unrealistic expectations for an intervention is associated with an absence of positive psychological change (Amos et al., 2019; Voss et al., 2023). An explicit exploration of client assumptions, expectations and concerns, before commencing WOED, is particularly pertinent due to the context of delivery; clients were unlikely to have approached MoreLife seeking support for BE and therefore may have felt particularly hesitant to engage with an intervention that was not targeting weight loss. This mirrors the initial skepticism identified for some participants at the start of other CBT-GSH interventions aimed at BE and may be why not all clients accepted the offer of WOED (Plateau et al., 2018). As GSH for BED is widely understood not to directly lead to weight loss outcomes and NICE (2020) recommends that this should be explored with clients within any GSH intervention for BED, the first conversation in which expectations/concerns/assumptions are explored should

include this, especially when WOED is being delivered as a precursor to WM. However, hope should be generated within the client by reflecting the understanding that BE is a barrier to WM and by removing this barrier, the anticipation is that WM will be more effective. The list of what guides could include to set clear expectations for clients is explored within clinical recommendations at the end of the discussion.

Moving on from the therapeutic relationship, a second facilitator of positive change was the focus, design and delivery of the manual and one-to-one sessions, i.e. the intervention itself. Through offering a biopsychosocial understanding of the development of EDs through a CBT framework, in conversations with guides and through reading the manual, WOED encouraged clients to consider where their difficulties had come from, what behaviours/thoughts/feelings were maintaining them and what they could problem solve and change (thus increasing their sense of self-efficacy). This increase in client self-awareness was also found following the CBT-GSH intervention 'Overcoming BE' (Fairburn, 2013) and this was surmised to have facilitated the motivation for clients to continue with the intervention (Plateau et al., 2018). In addition, the content of the WOED manual (especially sessions two and three) and conversations with guides offered clients the opportunity to explore and address many of the unhelpful beliefs/assumptions/behaviours that they were presenting with to try and lose weight (but were actually reinforcing the likelihood of BE). Session topics were also broadly applicable to other areas of life (e.g. how to recognise unhelpful thoughts, how to problem solve and the importance of mindfulness – sessions four and five) and this is likely to have contributed to the broader changes identified (e.g. increase in exercise and socialising). In addition, clients were grateful to have a physical manual that they could rely on for support in-between sessions and after the intervention, again mirroring findings by Plateau et al. (2018). Overall, a combination of a de-stigmatising psychological intervention with a thought-provoking and informative manual and sessions with guides that clients felt they could talk to openly, appeared to lead to an increase in self-awareness, confidence and the motivation to make positive changes. This interaction between guide and manual as co-existing facilitators has been reflected in previous evaluations of WOED, with young people describing guides bringing the content of the WOED manual *'to life'* (Winckley, 2019, p.68).

The third and final facilitator of positive changes was client specific: clients' willingness to be open and honest; clients' ability to accept they had a problem that they needed to change; and clients' ability to assume responsibility for making

changes outside of guide sessions. In considering Prochaska and DiClemente's (1983) change cycle, these clients would probably fall within the 'preparation' and/or 'action' phases. Interestingly, most clients contributing to this theme scored lower than their counterparts on the GAD-7, indicating that levels of anxiety may play a role in clients' positivity, motivation and ability to support themselves to make changes. Motivation to change, belief in one's ability to change and the ability to change perspective have been associated with better outcomes in similar low intensity programmes, with increased motivation at baseline associated with more positive outcomes (Amos et al., 2019; Steele, 2011). Similar themes of client motivation and hope as facilitators have been found within the common factors literature in psychotherapy research (Drisko, 2013; Fife et al., 2014; Rosenzweig, 1936) Conversely, a lack of these helpful client factors may prove a barrier to intervention effectiveness, particularly motivation, as this is crucial for any behaviour change (DiClemente & Velasquez, 2002). Due to the necessity of between session reading/engaging with materials, engaging in behavioural tasks and the increased expectations on clients in comparison to traditional psychotherapies more generally, client factors have been purported to be particularly important in the success of GSH programmes (Headley, 2021).

In this project clients displaying such helpful attributes also described wider help-seeking behaviours, such as engaging in therapy or mindfulness classes and seeking and receiving positive social support from friends/family/work. Positive social support in particular was considered key by the guides for the intervention's success. These behaviours indicate both a broader motivation to support themselves and access to the external resources to do so. Drisko (2013) notes that context must always be considered when investigating any measure of change, rather than assuming that any intervention is the *sole* cause of changes identified. The importance of access to positive social support in particular will be explored later.

In sum, results indicate that for some clients, the therapeutic alliance fostered by regular one-to-one contact and space to talk with the guide, within a psychologically informed intervention (including a helpful manual), increased clients' understanding of their relationship with food and eating, improved their problem-solving abilities and subsequently their confidence (i.e. self-efficacy) to do something differently. Important client factors, including willingness and ability to engage in the content and home tasks and access to positive social support and other sources of support, were considered key. Whilst explored in turn here for

ease of reading, facilitators of positive change should be considered interrelated rather than discrete (Fife et al., 2014).

WOED may not help everyone; potential barriers to be aware of.

As this project has focused on individual interviews concerning a specific intervention, the below section focuses predominantly on client factors that may be barriers to WOEDs success. However, all people exist within their own multifaceted context, and their behaviour is influenced by a wide range of experiences, both historical and ongoing. It is typical and simpler for research to focus on factors at the individual level, as wider contexual factors may be much harder to conceptualise and target for change (e.g. the impact of the current cost of living crisis on access to healthier foods, and the lasting mental health implications of living through Covid-19) (Davis et al., 2015). The importance of context must not be negated however. Kenny and Lewis (2023) recently used an ecological framework model to incorporate consideration for the influences of oppression, power and privilege, on the development, maintenance and recovery of eating disorders. They reflect on the fact that there are clear patterns with which demographics are prioritised within research, diagnoses and clinical services, and restricted outcome measures limit the possibility of individualised and linear definitions of personal recovery. This is not to undermine the importance of the current research but to situate it within its context – the barriers explored below cannot adequately account for these influences.

WOED, delivered within MoreLife as a precursor to WM, was very helpful for some, but may not have been suitable for all. Guides reflected difficulties with attendance and engagement, describing *'complex clients living complex lives'*. Difficulties with recruitment and retention were mirrored in MoreLife's initial pilot of WOED: 33 were eligible, 22 commenced the programme and 13 completed it (Edwards et al., 2023). Adherence and retention are understood as problematic across CBT-GSH interventions and factors associated with this warrant further exploration (Plateau et al., 2018). An exploration of client characteristics identified within this project for those that benefitted and struggled to benefit is of use, to determine any clinical recommendations for improving WOED's effectiveness and acceptability outside of mainstream ED services. Unfortunately, this project does not capture the voices of clients who disengaged from the programme, or chose not to commence it, so there are likely to be different barriers that are not identified by the clients interviewed. Finally, it must be noted that retention difficulties may be

due to factors completely external to the intervention, such as participants feeling better on their own or accessing other sources of support; aiming for a 100% recruitment and retention rate is not realistic or reflected within any treatment programme for any difficulty.

As already indicated, within this project, characteristics of clients who were thought to benefit most from WOED were: those who were willing and ready to explore their problems; those able to make behavioural changes and take responsibility for their difficulties (demonstrated by engaging in the ideas between sessions); and those with access to positive social support. These clients described feeling more positive towards themselves and their difficulties following WOED and more confident to continue to make changes to help themselves. They also exhibited a desire to help themselves more broadly, for example through engaging in therapy/mindfulness classes.

In contrast, other client factors presented potential barriers to engagement and positive change. Identified complexities included a lack of helpful social support, mental and physical ill health, a stuck focus on weight loss and external life events (e.g. financial difficulties, changing/losing jobs). Clients who described negative changes or fewer positive changes listed these problems and explored difficulties with motivation, low self-esteem and a reduced sense of personal agency for change. Interestingly, only the clients who described negative changes scored as ‘severe’ for both anxiety and depression and both had the lowest wellbeing scores, before starting the intervention. Mirroring their reduced emotional wellbeing, these clients found it harder to engage with the materials and ideas outside of guide sessions, harder to appreciate the positive changes that were made (including reductions in BE) and described feeling very isolated when the intervention finished.

These findings have important clinical implications for the screening and support of clients offered WOED in any clinical setting. Firstly, exploring the client’s social network is key. Guides were clear in their opinion that good social support was essential in facilitating all positive changes and lack of helpful social support was a barrier. The influence of social support has been reflected within the wider literature, with positive social support considered a facilitator of positive health-related behaviours in clients with type two diabetes and lack of social support as a barrier (Siopis et al., 2021). Moreover, within WOED specifically, support from family and friends was considered important for and by young people in facilitating the positive changes that they made (Winckley, 2019). Indeed, the importance of

relationships is thoroughly explored in session five of the WOED manual. Interestingly, within this project, an increase in social support was identified as both a positive change in and of itself and a facilitator of other positive changes. This may mirror Plateau et al.'s (2018) finding that talking about their difficulties with a guide, in a safe and non-judgmental space, subsequently enabled some clients to explore these topics with other people in their life.

If the client's current social circle is not considered supportive, there are alternatives that guides and services can consider. For example, BEAT (n.d.) run a free online support group 'Nightingale' for people self-diagnosed as struggling with BE. Services could also consider whether a peer support network or 'graduate programme' could be offered 'in-house', whilst clients undergo WOED and/or when they complete the intervention. This has been suggested as appropriate for clients accessing other GSH-CBT interventions for eating difficulties (Plateau et al., 2018) and graduate programmes are common practice within other therapy models such as DBT. Widening clients' access to appropriate social support may help with feelings of isolation that can occur following the ending of WOED, making the withdrawal of guide support easier to manage and hopefully increasing the motivation to continue to make positive changes. In addition, the follow-up 'check-in' with a guide after a period of time following the ending of WOED was greatly appreciated by clients in this project; this final one-to-one session may help to encourage engagement and provide guides with an opportunity to determine whether a possible dip in mood following the withdrawal of support requires signposting to more intensive support.

Secondly, clients' mental health needs must be considered. WOED and the input from the guide are not designed to resolve complex mental health difficulties. However, the research indicates that mental health difficulties should be expected within a BE and obesity sample (Blaine & Rodman, 2007; Matos et al., 2002). Complex mental health difficulties should not automatically be an exclusion criterion for participation, as this would ostracize a large proportion of people requiring support. Furthermore, the quantitative data from this project indicated that even those scoring as severe in their anxiety and depression can still reduce in their BE. This is particularly noteworthy as motivation, crucial for behaviour change, is often low when people are depressed (NHS, 2023). This understanding, that change can still occur even with the barriers of depression and/or anxiety, is reflected within recent commissioning of services local to the primary researcher. Leeds and York Partnership NHS Foundation Trust (n.d.) established the Link-ED service, open to

all adults with eating difficulties regardless of weight/BMI and offering peer support and GSH interventions to those under the care of a Community Mental Health Team (CMHT). This indicates the appreciation of the common mental health complexities associated with eating difficulties and the need for wrap-around support to manage this. It also infers that mental health difficulties need not be an automatic barrier to engaging in GSH, if those difficulties are being supported by appropriate services.

However, support such as West Yorkshire's Link-ED service may not be available nationally (and participants in this study were from the Essex area); appropriate screening and signposting for mental health difficulties outside of the remit of WOED, based on the provision of support in the local area, is essential. Perhaps if clients are scoring as 'severe' for anxiety and depression prior to engaging in WOED, an exploration of whether GSH is the most appropriate support for them at this moment in time (given the importance of client engagement) and whether any other support is indicated alongside or first, should be facilitated. If dissemination of GSH interventions for BE is to continue outside of mainstream ED or mental health services, protocols for recognising and responding to mental health difficulties are essential, to ensure that guides are not being asked to manage higher levels of risk or complexity than they are trained for. GSH is essentially self-help and guides should not be asked to assume the role of therapist or care-coordinator, due to the inequitable provision of and access to services.

Thirdly, the mismatch between client goal and intervention goal, with regards to weight loss, must be openly addressed (and indeed expected when WOED is offered within a WM service). It has already been explored above as a key task for guides. Shared goals and expectations are key for intervention retention, a positive therapeutic alliance and clinical outcomes (Bordin, 1979; Traviss et al., 2013; Voss et al., 2023), with unrealistic expectations presenting a barrier to positive change (Amos et al., 2019). Clients need to be supported to consider that their previous experience with attempting weight loss has not led to sustained changes and the goal of WOED is to address some of the maintaining difficulties, in order to help them with their goal of WM afterwards. Further quantitative research is required to substantiate the effectiveness of WOED in improving WM outcomes; this could then be explored with clients to build their motivation to engage and hope that it will be of benefit. Recognising this population's focus on weight loss will help guides be mindful and manage the

possibly demotivating/harmful content surrounding compensatory behaviours included in the manual.

In addition to an awareness of the potential barriers, the method of delivery should be considered, even though clients in this project described video/telephone contact as acceptable and at times preferable. Within in-person face-to-face GSH for BED/BN/OFSED delivered within mainstream ED services, 70% attended all sessions (Jenkins & Wake, 2024). This was in contrast to the 40% who completed remote GSH (email contact only), indicating that the method of guide session delivery impacted engagement from clients. This has been supported by qualitative research; the in-person face-to-face facilitation sessions within another CBT-GSH intervention were considered essential by the clients interviewed (Plateau et al., 2018). Clinical considerations for intervention delivery could determine whether offering at least some in-person face-to-face support could enhance engagement and motivation in future provision of WOED (Jenkins & Wake, 2024; Yim & Schmidt, 2019). This may be particularly pertinent for clients with added complexities/barriers to engaging, such as a reduced social circle. It would also ensure that services do not inadvertently create a barrier to accessing support due to issues of digital poverty. However, client choice of intervention delivery mode would always be most advisable where possible, as only offering face-to-face support could cause other problems through transport poverty or difficulties with clients getting time off work or balancing other responsibilities to attend in person.

The skill of the guide in screening for these potential barriers must be reflected in their training and ongoing supervision. Guides must be able to think holistically, consider where support may be offered to address some of these difficulties (e.g. signposting to peer support), but also recognise when and for whom GSH may not be appropriate (e.g. high levels of depression that are not being addressed and are leading to pervasive difficulties with motivation and forgetfulness). Whilst supervision is essential, this clinical skill appears to improve with experience of delivering the intervention to this client group. Examples within this project are of a guide supporting a client to pause WOED whilst they sought more appropriate mental health support and with another to reflect that with a new job and lengthy commute, now was not the right time to engage in GSH.

In sum, results from this project indicate that clients most likely to benefit from WOED are those whose mental health difficulties are being managed appropriately, those with good access to positive social support and those who are

motivated and ready to engage and make changes. None of these should be interpreted as concrete inclusion or exclusion criteria, but factors to be recognised by services and guides when exploring with clients whether GSH is the right fit at the current time for their problems. For those for whom GSH is not appropriate or does not lead to a relief in BE symptoms (or it is simply not the right time for them to address their BE) following a stepped care model, more intensive psychological treatments should be offered such as individual CBT-E (NICE, 2020) or CFT-E (Goss & Allen, 2010; Steindl et al., 2017).

Training for guides needs adapting.

There were areas for improvement identified by guides in the external training they received. Guides described wanting a more concrete/practical training approach, with more resources, a summary of key points for each section and to be explicitly told what to do in each session and how the intervention works. These requests indicate the zone of proximal development (Vygotsky, 1978, 1986) that a group of inexperienced guides could present with and the need to scaffold their development initially through concrete instructions to build their confidence. Such improvements may facilitate wider dissemination of WOED across non-ED services and support the transition in role from delivering group WM to facilitating individual GSH.

Research has demonstrated for over 25 years that GSH and similar interventions do not need to be delivered by specialist practitioners (e.g. Carter & Fairburn, 1998). Indeed, to enable wider dissemination of programme-led interventions, people from a range of backgrounds both working in and out of services need to be trained as guides (Wilson & Zandberg, 2012). The recent consensus statement for the improvement of ED programme-led interventions notes that this range could include carers (if their own needs are being addressed), support workers, charity workers and experts by experience (Davey et al., 2023). The result of this movement will be, like the guides in this project, a new wave of guides who are not ED or therapy specialists and who may not be experienced in offering one-to-one support. Accordingly, all must receive thorough training and supervision, to accommodate this shift in role (Traviss et al., 2017).

Davey et al. (2023) provide clear recommendations for guide training. Training needs to involve exploration of: the role – guides are not there to provide therapy but to support clients to engage in the materials and ideas themselves; knowledge-based competencies concerning intervention content (taking account of

guides' previous knowledge and competencies and then altering accordingly); how to individualise the support based on client need (whilst adhering to the standardised framework); when and why GSH may not be appropriate for an individual (considering factors explored in the previous section); and, the importance of sessional outcome measures in order to monitor and adapt support. Supporting resources such as recorded training sessions and 'what if?' documents were also advised. Indeed, 'Frequently Asked Questions' documents have been used in previous guide training for WOED to good effect, according to one of the project supervisors (A.H.).

These recommendations, particularly that of knowledge-based competencies concerning intervention content, reflect the initial anxieties and concerns of the MoreLife guides and what they felt would be helpful within the training. Moving forward it may be pertinent, before offering group training, to obtain information on guides' experience of offering one-to-one support, working with BE, working with mental health difficulties (reflecting an understanding of the broader nature of participants' difficulties) and any concerns they have about working in this new way. Specifically in relation to supporting people living with BE and obesity, findings from this project indicate that exploration of client expectations, particularly with regards to weight loss and managing the potentially harmful/difficult manual content on compensatory behaviours, would be highly beneficial. Tailoring training according to service context and guide background may help improve its accessibility and usefulness. Changes should be monitored to assess adherence to the model and support further and wider iterations of the training.

Strengths and Limitations

Strengths:

This is the first project to explore in detail the perspectives of guides and clients using a GSH intervention (WOED) to target BE as a precursor to WM, in a Tier three WM service. The design followed research recommendations directly informed by previous work (Traviss-Turner et al., 2018) and aligned with how care should be designing and delivered, through capturing the voices of those using and delivering the service (NHS England, 2017; Omeni et al., 2014). As research into BE has lagged behind research into other EDs, capturing the voices of those living with obesity and BE is even more pivotal.

Use of an adapted version of the CCI elicited qualitative data centered on change but provided the space for participants to explore other relevant topics. In

addition, for some clients the interview provided a space for them to uncover positive changes they were not aware of, aligning with Elliott et al.'s (2001) perspective that the CCI can be a useful therapeutic tool alongside a research instrument. Client participants thanked the researcher for the opportunity to give recommendations and felt like they were 'giving something back' in supporting future clients, indicating an acceptable and ethical research design.

This project captures the voices of male clients (2/9) and clients from other ethnic backgrounds than white British (2/9). Whilst still a small proportion of those interviewed, previous qualitative research into WOED with adults has included solely white British and female voices (e.g. Traviss et al., 2013). As BE has been demonstrated across ethnicities and genders, capturing a range of perspectives is essential. Research to date often captures only a very homogenous group and men in particular are not often participants within such research (Davis et al., 2020; Striegel et al., 2012). It was important to the researcher to understand whether the sample interviewed demographically represented the sample that received WOED from MoreLife, however this was not possible as the data was not provided as requested.

The project's design enabled the researcher to obtain quantitative data already collected by MoreLife, to situate the qualitative findings and add context, without adding an additional burden on the research participants. This enabled exploration of the outcome measures MoreLife used and consideration for whether they captured the nuances or 'felt sense' of the positive changes for clients. At times, the quantitative data did not reflect what clients reported in interview, highlighting the utility of mixed methods research and involving participant voices in the evaluation of services. Using quantitative methods alone to explore efficacy and acceptability may inadvertently misrepresent the real felt experiences of the end user.

Whilst it was not possible to co-design this project due to time constraints, following the initial draft of themes an additional meeting was held with a client and a guide. This space was used to explore the development of themes, to determine whether the primary researcher's interpretation of the data was being unduly influenced by their own assumptions about what was most important to capture. The sense of the intervention being 'new' for both parties was particularly salient within these discussions and problems with the training were re-emphasised. It also gave the primary researcher the opportunity to clarify their language use. They had

some reservations concerning the term ‘complex clients living complex lives’ and was reassured by the client participant that they felt this was an appropriate phrasing.

Finally, it was important to the primary researcher that this thesis did not accidentally perpetuate any harmful societal narratives surrounding obesity and its maintenance. The researcher’s interest and previous research into weight stigma highlighted this as a possible problem. In recognition of this, an experienced Clinical Psychologist working in Bariatric services with a keen interest in weight stigma was asked to read a late draft of the thesis to offer any reflections on areas that could be potentially harmful from a weight stigma standpoint. Certain reflections throughout the thesis were updated accordingly.

Limitations:

At its conception, one of the possible research aims for this project was to determine whether engaging in WOED increased clients’ subsequent engagement with and outcomes following the later WM intervention. It was not possible to answer this question due to the time constraints of a DClin thesis and the commissioning of MoreLife interventions. Clients were interviewed between WOED and WM and it was not possible to wait until all the client participants completed the WM intervention to receive the relevant data from MoreLife. A larger quantitative study comparing outcomes in WM between participants who do/do not complete WOED beforehand is required to determine whether GSH for BE increases the subsequent effectiveness of WM interventions (see research recommendations).

As it was not possible to include any guides/clients in the project's design, early decisions may have negatively impacted recruitment. For example, in the initial recruitment materials the label ‘patients’ is used instead of MoreLife’s term ‘client’. If possible participants did not identify themselves as ‘patients’ this could have negatively impacted whether they felt they wanted to proceed with the project. This word choice was later rectified with an amendment.

In addition, this project used an indirect method of recruiting client participants; guides were responsible for disseminating recruitment materials after two sessions of WOED. Whilst this method was used to minimise the unnecessary transfer of confidential data, this means that the primary researcher cannot be assured that all possible participants received the recruitment materials. It also means that this research is unable to comment on the number of people approached to interview and whether their demographics/quantitative outcome

measures reflect those who interviewed. This represents the challenges of recruiting through a third party. Next time, the primary researcher would endeavour to make stronger links with those supporting recruitment (i.e. guides), in order to make sure they were aware of any barriers or queries pertaining to recruitment as they arose.

The inclusion criteria used did not enable the researcher to capture the perspectives of those who did not choose to commence WOED, or who disengaged early. Only those who completed or had nearly completed WOED were recruited. This means that the barriers to success/engagement have not been informed by clients who could not or did not engage. This therefore limits the results, particularly within a small sample of 9 client participants. Potentially, a more thorough method of investigating further barriers may be for MoreLife clinicians to capture, either qualitatively or quantitatively, responses from clients when they are offered WOED but neglect to participate, or when they disengage early. An internal service evaluation project could shed further light on barriers not captured within this research.

As this study involved interviewing people undergoing an intervention in a clinical setting, and not as part of a randomised control trial (RCT), it did not control for people accessing other sources of support. For example, one client was undergoing a wellbeing / mindfulness course concurrently with WOED and others had recently had private counselling and hypnotherapy. Any positive changes described could have been influenced by factors other than WOED. This is not necessarily a limitation but a caveat: identified positive changes cannot be completely causally attributed to WOED due to lack of control over confounding variables.

Finally, this project does not directly consider or address the wider contextual factors at play that may facilitate/prevent client engagement and success in WOED. The role of weight stigma and the poorer treatment by society of those living with BE and obesity, is likely to play a substantial role in clients' experience of shame, mental health problems and lack of capacity or opportunity to seek/receive support for this difficulty. Outside of issues associated specifically with BE and obesity, other factors that could impact any client's capacity to engage and benefit from WOED (or any other intervention) include pressures such as the cost of living crisis, financial difficulties and balancing caring responsibilities. A thorough investigation of the wider systemic issues that may impact client engagement and

success was beyond the scope of this project's research aims. However, results/recommendations should not be interpreted as blaming individual clients if they have found it difficult to benefit from WOED.

Research and Clinical implications

Research:

Three out of four guide participants had only worked with one or two clients to completion of WOED. This may explain why the intervention felt so new, why they felt so anxious delivering it and why their perspectives on the training were so strong. All consented to be contacted for future research. It would be pertinent to re-interview them after they have gained more experience, to determine whether and how their own practice and confidence has changed and whether they have recognised any other client changes and facilitators/barriers to change. It may also provide an opportunity to further explore whether guide training and facilitation experience truly upskills their confidence/competence within other clinical roles. The biopsychosocial content of WOED is likely to be relevant to many clients seen by MoreLife for WM or other healthy lifestyle interventions; investigating the 'wider impact' of WOED for clinicians of a variety of backgrounds may provide useful insights.

There is a clear need for a larger quantitative or mixed methods pre-post study with individuals living with obesity and BE to determine the clinical effectiveness of WOED in a) reducing BE and b) leading to increased weight loss (and weight loss maintenance) following a subsequent WM intervention. This will add to the literature exploring whether WOED is statistically an effective precursor treatment within this context. If so, this information could be utilised to encourage future participants with a goal of weight loss to engage in WOED first, or alongside WM support if appropriate. It may be pertinent to include a validated measure of self-efficacy, to explore whether an improvement in (or high baseline levels of) self-efficacy is demonstrated to be related to improvements in ED psychopathology including internalisation symptoms following WOED and whether this impacts the subsequent effectiveness of a WM intervention (e.g. Eating Disorder Recovery Self-Efficacy Questionnaire, Pinto et al., 2006, and/or the Self-Efficacy for Self-Help Scale, Tomczyk et al., 2023). Similarly, the use of validated measures of hope should also be considered, such as the Adult Hope Scale (Snyder et al., 1991). Finally, as improvements for the clients in this project were thought to be continuing

after the intervention ended, the timing of any follow-up measures should be considered in order to capture this.

Clinical:

Offering individual GSH before group WM. Reported improvements in eating behaviours indicate that, aligning with NICE (2020) guidance and a stepped-care model of support, WOED should be offered before WM interventions. Within this project, some clients did not know they binge ate and were not seeking support for it. The highlights the utility of offering GSH interventions within WM services, to capture a broader audience that may benefit from such support. However, WOED may not be suitable for all clients and guides/services must assess this.

Recruitment and retention. Guides noted that some clients were offered WOED but declined it. This aligns with Edwards et al.'s (2023) finding that only 22/33 commenced WOED in MoreLife's original pilot. One recommendation was that it may be helpful to have testimonials from clients who have completed WOED made available to potential WOED participants, perhaps through short videos, to encourage engagement and remind clients that they are not alone in their difficulties. Another recommendation was that all sessions could be organised at the start of the client's journey with WOED, to try and help aid retention and reduce cancellations/rearrangements. A final recommendation may be to consider whether to offer face-to-face support for those clients with whom there may be more barriers to engage and change (e.g. mental/physical health complications and a lack of social support), particularly as face-to-face support has been associated with improvements in participants' motivation levels (Yim & Schmidt, 2019).

***Starting well* (Davey et al., 2023).** Plateau et al. (2018) note that the start of CBT-GSH may hold some vulnerabilities for clients, in hesitancies/skepticism surrounding the effectiveness of the intervention and subsequent low motivation to engage. This may be particularly pertinent with the recruitment methods used here, as clients were unlikely to be seeking BE support. To mitigate this, setting clear expectations will be essential. This should include a discussion of the following: WOED is a client-led intervention so change cannot happen unless the client is able to take responsibility for addressing their difficulties and has the capacity to engage with the manual and ideas between sessions; weight loss is not an aim or expected outcome (but the hope is that WOED will help clients engage/succeed with the WM intervention afterwards); WOED is designed to be delivered transdiagnostically across ED presentations so not all of the manual will be relevant (and be aware that

there may be some information that clients in this context may find particularly unhelpful/challenging if they associate it with weight loss); clients are not expected to make changes based on everything in the manual; and change is not expected to only occur within the seven sessions but can continue to occur after the intervention if clients continue engaging with the material. Part of 'starting well' will be assessing when WOED is not suitable, if a client cannot align with these intervention expectations, or if they are particularly high risk and the service cannot hold such risk (see Davey et al., 2023 for a discussion). Holistic assessment discussions should include an exploration of clients' mental/physical health needs that may impact engagement if not supported appropriately and their access to appropriate social support.

Ending well **(Davey et al., 2023).** Some clients will feel alone once support has ended, potentially resulting in less motivation to continue with their changes. Guides/services could consider whether a follow-up 'check in' is something the service is able to offer routinely to clients who express they would value it (for equity of provision). If not/in addition, clear signposting to other sources of support such as BEAT (n.d.) may be beneficial (e.g. the 'Nightingale' support group), as may be setting up a peer support space for 'graduates' of the programme to support each other in-house. Instilling hope that change can continue to occur and reiterating any progress they have made so far will be important for clients' sense of self-efficacy.

Future development of WOED; addressing training needs. To enable a broader group of guides, without a therapy/psychology background, or experience in offering one-to-one support, to assimilate to the new role, changes to the training are required. Results from this study indicate that training should include: a clear overview of the intervention, CBT framework and what should be included in each support session; what is and is not expected of a guide; the importance of setting expectations (especially around weight loss); and how to assess when GSH may not be appropriate (and signpost accordingly). A concrete, practical approach with key summaries and the opportunity to practise the skills required of a guide may be particularly helpful. Training should be limited in its psychological jargon and there should be space to explore guides' concerns about facilitating GSH. If WOED is being offered within a WM service, training should include a discussion for sections of manual content that might prove unhelpful/challenging for clients with a focus on weight loss (e.g. compensatory behaviours) and how to explore this with clients and monitor any potential impact. Such improvements/alterations to standardised

training packages may be beneficial more broadly following movements for an even wider pool of guides to deliver programme-led interventions in ED. Ideally, for flexibility purposes, all training should take into account the individual experience of the trainees present and be adjusted accordingly. The result of making changes to training will need to be monitored using robust qualitative and quantitative outcome measures.

Future development of WOED; the manual. When the manual is next updated, incorporating feedback for its development from clients will be key. In particular, the addition of personal narratives (e.g. through videos) of previous clients may reduce feelings of isolation, increase normalisation of BE difficulties and hope/motivation to engage and increase the accessibility of the intervention for those who struggle with understanding/retaining information in the written form. The National Institute for Health and Care Research (2022, no page number) reports that 'In the UK 7.1 million adults read and write at or below the level of a nine-year-old' and 'More than 4 in 10 adults struggle to understand health content written for the public'. Videos are one way that this intervention could become more inclusive concerning health illiteracy, hopefully increasing the diverse populations that could be supported from such low-intensity programmes (Davey et al., 2023). However, this does not account for the fact that most activities prescribed within the manual involve clients writing. To fully address health illiteracy and increase programme dissemination, this will require further consideration. Other ideas for the manual's development generated by clients in this project included more notes pages, coping skills, clear signposting to crisis information and emailing digital chapters. Guides expressed the desire for more information on healthy eating, however this is outside of the aims of WOED and could be easily accessed/provided elsewhere.

Conclusion

Results from this project suggest that GSH interventions such as WOED may be helpful and acceptable to clients within broader settings outside of traditional ED services, such as in WM services. Feedback from the small sample interviewed in this project indicates that GSH interventions should be considered before WM interventions, particularly if previous attempts at WM have not been helpful. GSH offers a new, alternative, focused and programme-led approach which, in addition to supporting with BE, can improve confidence, wellbeing and the wider lifestyle of individuals. It is important to recognise that GSH is likely to be most appropriate for a sub-set of individuals and that guides/services are trained in identifying who is most likely to benefit from WOED (e.g. those with appropriate

social support and those who are ready and able to commit to the ethos of a client-led intervention) and those who may require more support or an alternative method of care. It may be that further work around identifying and decreasing individual barriers to access is needed before WOED can be beneficial for some clients, particularly as there will be other barriers not identified within this project. To increase the dissemination of WOED, improvements in guide training are required.

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List of Abbreviations

AN..... Anorexia Nervosa

BE..... Binge Eating

BED..... Binge Eating Disorder

BES.....Binge Eating Scale

BN..... Bulimia Nervosa

BMI.....Body Mass Index

CAMHS.....Child and Adolescent Mental Health Service

CBT..... Cognitive Behavioural Therapy

CCI.....Client Change Interview

CFT.....Compassion Focused Therapy

COPD.....Chronic Obstructive Pulmonary Disease

DBT..... Dialectical Behaviour Therapy

DSM-IV/V.....Diagnostic and Statistical Manual of Mental Disorders 4th / 5th edition

ED..... Eating Disorder

EDNOS..... Eating Disorder Not Otherwise Specified

GAD-7.....Generalised Anxiety Disorder-7 scale

GSH..... Guided Self Help

HRA.....Health Research Authority

IPT.....Interpersonal Psychotherapy

IMD.....Index of Multiple Deprivation

MI..... Motivational Interviewing

NICE..... National Institute for Health and Care Excellence

PHQ-9.....Patient Health Questionnaire-9 scale

RCT.....Randomised Controlled Trial

RQ.....Research Question

RTA.....Reflexive Thematic Analysis

SWEMWBS..... Short Warwick-Edinburgh Mental-Wellbeing Scale

WHO.....World Health Organisation

WOED..... Working to Overcome Eating Difficulties

WM..... Weight Management

Appendix

Appendix A: Ethical approval letter

NHS
Health Research Authority

East of England - Cambridge East Research Ethics Committee

The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 02071048181

06 February 2023

Ms Ella Upton
Psychologist in Clinical Training
The Leeds Teaching Hospitals NHS Trust
Clinical Psychology Training Programme
Leeds Institute of Health Sciences
University of Leeds
Clarendon Way
Leeds
LS2 9LJ

Dear Ms Upton

Study title:	**Managing binge eating prior to weight management using guided self-help**
REC reference:	**23/EE/0053**
Protocol number:	**N/A**
IRAS project ID:	**319705**

The Proportionate Review Sub-committee of the East of England - Cambridge East Research Ethics Committee reviewed the above application.

Ethical opinion

On behalf of the Research Ethics Committee (REC), the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

1. registering research studies
2. reporting results
3. informing participants
4. sharing study data and tissue

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Recommendations

- As the study will not be registered on a public database, the PR Sub-Committee would recommend that details are made available on a suitable platform, such as the University of Leeds website
- The PR Sub-Committee recommend that at the beginning of the interview, the interviewer reminds the participant that they may withdraw at any time, and they have the right to refuse any questions as well as the fact that the interview will be recorded
- The PR Sub-Committee would recommend that the CI ensures they have up to data research training, such as GCP training

Appendix B: Guide and Client Participant Interview Schedules

B1. Guide Schedule V.03 06.01.23

A) Initial checks

- Greet Guide and re-introduce self.
- Clarify audio and sound are working adequately.
- Check they are in a quiet private space, highlight that you are in a private home office.
- Explain confidentiality: "As it says in the participant information sheet, whilst your data will be treated confidentially, if I hear anything today that raises a concern for me, such as a risk to you or somebody else, I am duty bound to pass that information back to MoreLife. Ideally this will be done with your knowledge and we will have a conversation about it first, but sometimes researchers have to break confidentiality if we have immediate concerns. Do you have any questions about this? Does that make sense to you?"
- 27.02. ADDED FOLLOWING REC APPROVAL ADVICE – remind participant that they may withdraw at any time and they have the right to refuse any questions.
- Explain that the interview will now be transcribed and recorded, and will last approximately an hour.

Start interview:

A) Demographics

"Let's start by gathering some basic information. What is your age/identified gender/job role/professional training/years in practice?"

B) Intervention information

"I need to understand where you're at with delivering the guided self-help intervention. How many participants have you supported? Were they all to completion?"

C) Client Change Interview

1. "What has been your experience of delivering the guided self-help intervention?

1a. How have you found it?"

2. Changes [about 10 min]

2a. "Are there any general changes that you've noticed in the participants you've been working with?"
(Reflect back change to interviewee and write down brief versions of the changes for later. If it is helpful, you can use some of these follow-up questions: For example, are clients doing, feeling, or thinking differently from the way they described before? What specific ideas, if any, have they taken from the intervention so far, including ideas about themselves or other people? Have any changes been brought to their attention by other people?)

2b. "Have you noticed any changes for the worse in any of your participants?
2c. Is there anything that you thought the GSH intervention would address that it does not address?"
3. Change Ratings: [about 10 min] *(Go through each change and rate it on the following two scales)*

SCREENSHARE RATINGS AND LIST IF HELPFUL

3a. "For each change, please rate how much you expected it vs were surprised by it?"

1. Very much expected it
2. Somewhat expected it
3. Neither expected nor surprised by the change
4. Somewhat surprised by it
5. Very much surprised by it.

3c. "How important or significant do you consider this change to be for your clients?"

1. Not at all important
2. Slightly important
3. Moderately important
4. Very important
5. Extremely important.

4. Attributions [about 5 min].
"In general, what do you think has caused the changes in participants that you've described? In other words, what do you think might have brought them about?" (Including things both outside of the intervention and in the intervention)

5. Resources [about 5 min]
5a. "What personal strengths do you think have helped you to be an effective Guide?" (what you're good at, personal qualities)
5b. "What practical resources do you have that have enabled this?" (e.g. access to equipment, supervision)

6. Limitations [about 5 mins]
6a. "What things about you do you think have made it harder for you to be an effective Guide?" (things about you as a person)
6b. "What things in your life, work situation or job role have made it harder for you to be an effective guide?" (family, job, resources, relationships, living arrangements)

7. Helpful aspects [about 10 min].
"Can you sum up what you think is helpful about the role of the Guide in this intervention? Please give examples."

8 Problematic aspects [about 5 minutes]
8a. "What kinds of things about the GSH intervention have been hindering, unhelpful, negative or disappointing for your clients?" (for example, general aspects, specific events)
8b. "Were there things in the GSH intervention which you found difficult or painful to deliver, but were still OK or perhaps helpful? What were they?"
8c. "Is there anything missing from the GSH intervention?" (What would make/have made it more effective or helpful?)

9. The research [about 10 min]
9a. "What has it been like to be involved in this research?" (Initial screening, research interviews, completing questionnaires etc)
9b. "Can you sum up what has been helpful about the research so far?" Please give examples.
9c. "What kinds of things about the research have been hindering, unhelpful, negative or have got in the way of the GSH intervention?" Please give examples.

10. Suggestions [about 5 min]. "Do you have any suggestions for us regarding the research or the GSH intervention? Do you have anything else that you want to tell me?"

D) Wrap up

- Thank Guides for their time.
- Ask if they would like to know the results of the study, and discuss how best to access them.

B2. Client Schedule V.04 06.01.23

A) Initial checks

- Greet participant and re-introduce self.
- Clarify audio and sound are working adequately.
- Check they are in a quiet private space, highlight that you are in a private home office.
- Explain confidentiality: "As it says in the participant information sheet and consent form, whilst your data will be treated confidentially, if I hear anything today that raises a concern for me, such as a risk to you or somebody else, I am duty bound to pass that information back to MoreLife. Ideally this will be done with your knowledge and we will have a conversation about it first, but sometimes researchers have to break confidentiality if we have immediate concerns. Do you have any questions about this? Does that make sense to you?"
- 27.02. ADDED FOLLOWING REC APPROVAL ADVICE – remind participant that they may withdraw at any time and they have the right to refuse any questions.
- Explain that the interview will now be transcribed and recorded, and will last approximately an hour.

Start interview:

A) Demographics

"So that I can match your interview with information that we will gather from MoreLife, please could I take your DOB?"

B) Intervention information

"I need to understand where you're at with the guided self-help intervention. How many sessions have you completed? Have/did you miss any sessions? Why? *[if completed]* When did you finish the intervention?"

C) Client Change Interview

1. "What has been your experience of participating in the guided self-help intervention?

1a. How have you found it?

1b. How are you doing now in general?"

2. Changes [about 10 min]

2a. "What changes, if any, have you noticed in yourself since starting the guided self-help intervention?"

(Reflect back change to interviewee and write down brief versions of the changes for later. If it is helpful, you can use some of these follow-up questions: For example, are you doing, feeling, or thinking differently from the way you did before? What specific ideas, if any, have you gotten from the GSH intervention so far, including ideas about yourself or other people? Have any changes been brought to your attention by other people?)

2b) "Has anything changed for the worse for you since the GSH intervention started?

2c) Is there anything that you wanted to change that hasn't since the GSH intervention started?"

3. Change Ratings: [about 10 min] *(Go through each change and rate it on the following three scales)*

SCREENSHARE RATINGS AND LIST IF HELPFUL

3a. "For each change, please rate how much you expected it vs were surprised by it?"

1. Very much expected it
2. Somewhat expected it
3. Neither expected nor surprised by the change
4. Somewhat surprised by it
5. Very much surprised by it.

3b. "For each change, please rate how likely you think it would been if you hadn't been in the GSH intervention?

1. Very unlikely without the GSH intervention (clearly would not have happened)
2. Somewhat unlikely without the GSH intervention (probably would not have happened)
3. Neither likely nor unlikely (no way of telling)
4. Somewhat likely without GSH intervention (probably would have happened)
5. Very likely without the GSH intervention (clearly would have happened anyway)

3c. "How important or significant to you personally do you consider this change to be?"

1. Not at all important
2. Slightly important
3. Moderately important
4. Very important
5. Extremely important.

4. Attributions [about 5 min].
"In general, what do you think has caused the various changed you described? In other words, what do you think might have brought them about?" (Including things both outside of the intervention and in the intervention)

5. Resources [about 5 min]
5a. "What personal strengths do you think have helped you make use of the GSH intervention to deal with your problems?" (what you're good at, personal qualities)
5b. "What things in your current life situation have helped you make use of the GSH intervention to deal with your problems?" (family, job, relationships, living arrangements)

6. Limitations [about 5 mins]
6a. "What things about you do you think have made it harder for you to use the intervention to deal with your problems?" (things about you as a person)
6b. "What things in your life situation have made it harder for you to use the GSH intervention to deal with your problems?" (family, job, relationships, living arrangements)

7. Helpful aspects [about 10 min].
"Can you sum up what has been helpful about the GSH intervention so far? Please give examples." (For example, general aspects, specific events)

8. Problematic aspects [about 5 minutes]
8a. "What kinds of things about the GSH intervention have been hindering, unhelpful, negative or disappointing for you?" (for example, general aspects, specific events)
8b. "Were there things in the GSH intervention which were difficult or painful but still OK or perhaps helpful? What were they?"
8c. "Has anything been missing from the GSH intervention?" (What would make/have made it more effective or helpful?)

9. The research [about 10 min]
9a. "What has it been like to be involved in this research?" (Initial screening, research interviews, completing questionnaires etc)
9b. "Can you sum up what has been helpful about the research so far?" Please give examples.
9c. "What kinds of things about the research have been hindering, unhelpful, negative or have got in the way of the GSH intervention?" Please give examples.

10. Suggestions [about 5 min]. "Do you have any suggestions for us regarding the research or the GSH intervention? Do you have anything else that you want to tell me?"

D) Wrap up

- Thank participants for their time.
- Explain how they will receive their £10 Amazon/Love2shop voucher
- Ask if they would like to know the results of the study, and discuss how best to access them.

Appendix C: Recruitment materials for Clients

C1. Client Participant Information Sheet V.07 22.05.2023

Participant Information Sheet - Client version 0.7 22.05.23

Managing binge eating prior to weight management using guided self-help

We would like to invite you to take part in our research study investigating your experiences of receiving the guided self-help intervention for binge eating difficulties. Joining the study is entirely up to you; before you decide, we would like you to understand why the research is being done and what it would involve for you. Once you've read this sheet, if you have any questions please contact the chief investigator on the contact details below, who will be happy to talk this through with you.

The study is being conducted and sponsored by the University of Leeds as part of a Doctoral Thesis in Clinical Psychology. Any reference to 'we' in this document refers to the University of Leeds.

What is the purpose of the research?

We do not currently know much about what participants with binge eating difficulties think of the guided self-help intervention that you took/are taking part in. The aim of this research is therefore to learn more about what participants think of 'Working to Overcome Eating Difficulties', and the impact it may have on people's binge eating behaviours and wellbeing.

This may help us inform future interventions in this area, by helping us to learn more about what is helpful about the intervention, and what could be better. This is an educational study as we want to learn more.

Who can take part?

Anyone who has had at least 2 sessions of the guided self-help intervention 'Working to Overcome Eating Difficulties', provided by MoreLife. We will be interviewing up to 12 participants, and 4 of the guides.

What would taking part involve?

You will be asked to consent to take part in a remote interview at a time that suits you. You can participate remotely from your home, or somewhere else you feel comfortable. Interviews will last approximately an hour and it will involve discussing your experience of the intervention.

To thank you for your time in the study, we will provide you with a £10 Amazon/love2shop voucher. This will be sent to you as either an email or in the post. If you withdraw from the study, you will still receive this voucher.

What are the advantages of taking part?

There may be no advantage to you taking part in this study. However, the interview provides you

with an opportunity to honestly share what you found helpful or not, and what we can do better. This information may help us to understand how to support people with binge eating difficulties better.

What are the disadvantages or risks of taking part?

There is a small chance that you might feel uncomfortable talking about some of the issues relating to eating and mood. The chief investigator has experience in managing distress should it arise.

Whilst your data will be treated confidentially, if any participant reports something that raises a concern for the chief investigator (i.e. risk to self, risk to other, possible others at risk of harm), as appropriate the chief investigator will provide some information about where to get help and contact MoreLife (who have direct contact with your GP). Ideally this will be done with your knowledge, but there are times researchers have to break confidentiality if they have immediate concerns.

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

Taking part in the research is entirely voluntary and will not affect your standard NHS care. You can stop being part of the study, up until the point that the data is analysed, without giving a reason. Due to the nature of the data, you cannot withdraw your data after this stage, but all information will be anonymised. We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

You can withdraw by contacting the chief investigator using the contact details below.

How will we use information about you?

We will need to use information from you and from MoreLife for this research project. The information from you will include your name, date of birth and contact details. From MoreLife we will ask for information on your: date of birth (to clarify your identity), gender, ethnicity, other health conditions; scores for the binge eating and mental health questionnaires; weight and BMI (taken at different time points); information about the area you live in; and start date for your GSH intervention. We collect this data to add context to our interviews in terms of change that is made over the course of the intervention. *As we collect data from MoreLife, this means that MoreLife will know you are involved in this research.* People will use this information to do the research or to check your records to make sure that the research is being done properly.

All interviews will be audio and video recorded, transcribed (written up) by the chief investigator, anonymised and stored securely. The recordings will be deleted after we have used them to check the accuracy of the transcripts. Other than this, all information that we gather, from you and MoreLife, including your contact details, will be held for 3 years (in line with University guidance, which currently allows for storage on University of Leeds secure computer servers) and then deleted. All data will be stored in line with the University of Leeds policy, and will only be accessible by the research team. All investigators will follow the GDPR rules and Data Protection Act 2018, and all information will be given an ID number. We will keep all information about you safe and secure.

The information generated by this project will be analysed using thematic analysis, and published as part of the chief investigator's doctorate of clinical psychology. The results may be used in academic publications but all data will be non-identifiable, including any quotes used. We will write our reports in a way that no-one can work out that you took part in the study. The findings may also be

used in other ways such as a presentation to commissioning bodies. The results of the study will also be shared with MoreLife in a way that is helpful to them (e.g. research poster/summary of findings/full thesis). If you would like to know the outcome of the study when it is completed, please let us know.

If you have a concern about any aspect of this study, you should ask to speak to the chief investigator or her academic supervisors (see contact details below) who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this by contacting the Patient Advice and Liaison Service (PALS), for confidential advice. Your local office can be found at https://www.nhs.uk/nhs-services/hospitals/what-is-pals-patient-advice-and-liaison-service/

You can also contact the sponsor representative at the University of Leeds as an independent contact for complaints on governance-ethics@leeds.ac.uk

You can find out more about how we use your information at www.hra.nhs.uk/information-about-patients/.

Please follow this link for the Leeds University Research Participant Privacy Notice - https://dataprotection.leeds.ac.uk/wp-content/uploads/sites/48/2019/02/Research-Privacy-Notice.pdf

Please follow this link for the Health and Research Authority Generic Patient Data and Research Leaflet - https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/data-protection-and-information-governance/gdpr-guidance/templates/template-wording-for-generic-information-document/

If you agree to take part in this study, you will have the option to take part in future research using your data saved from this study.

What happens now?

By providing your consent to be contacted, you are agreeing for a researcher from the University of Leeds to contact you about this project. You can provide your consent by:

1. Scanning the QR code at the top of this form with your mobile device
2. Completing and return the paper copy to: FAO Ella Upton, Level 10, Clinical Psychology Training Programme, Worsley Building, Leeds Institute of Health Sciences, University of Leeds, Clarendon Way, Leeds, LS2 9NL
3. Completing the online survey with your Guide
4. Following the link in the email/letter you were sent accompanying this document, which will direct you to the online survey.

Contact details

Chief Investigator - Ella Upton, Psychologist in Clinical Training (umeu@leeds.ac.uk)

Chief Investigator's Academic Supervisors - Professor Andrew Hill (A.J.Hill@leeds.ac.uk) & Dr Gemma Traviss-Turner (G.Traviss@leeds.ac.uk).

University of Leeds Data Protection Officer - dpo@leeds.ac.uk.

Ethical approval has been granted from the NHS Research Ethics Committee.

C2. Covering and reminder emails for Clients V.03 06.01.23

Instruction for Guides - Please send the following email and attachments to individuals that you are working with after a minimum of 2 sessions of the intervention. The following email and two attachments can be sent as letters if needed if participants do not have internet access. The word 'attached' in the body of this email should be replaced with 'included' if this happens.

Please keep a log of the participants you send this information to, as anonymous information about them may be required by the chief investigator to explore who does/does not opt in.

...

Covering email for client participants

Good morning/afternoon [insert name here],

My name is Ella Upton and I'm the chief investigator on a research project that is seeking to learn more about people's experiences of the guided self-help intervention that you've been involved in.

I've made a short video of myself introducing the study:

https://dclinpsych.leeds.ac.uk/take-part-in-research/

Please see the attached participant information sheet that will tell you more about this study and how you could be involved. The participant information sheet contains a QR code which will direct you to an online consent to be contacted form. The online consent form can also be accessed here:

https://leeds.onlinesurveys.ac.uk/consent-to-be-contacted-form-v02-07102022

Please see the attached consent to be contacted form should you wish to post it to me instead. You only need to complete the paper OR online version, you do not need to complete both.

Kind regards,

Ella Upton

Chief Investigator

Trainee Clinical Psychologist

University of Leeds

Instruction for Guides - Please send the following reminder as an email/letter a week after you've sent the first email/letter.

...

Reminder email for client participants

Good morning/afternoon [insert name here],

You have recently been provided with the participant information sheet and a consent to be contacted form for a research project that is seeking to learn more about people's experiences of the guided-self help intervention that you have been involved in.

I've made a short video of myself introducing the study:

https://dclinpsych.leeds.ac.uk/take-part-in-research/

If you'd like to be involved, please complete the consent to be contacted form, either the paper copy or online. The online consent form can be accessed here: https://leeds.onlinesurveys.ac.uk/consent-to-be-contacted-form-v02-07102022

Kind regards,

Ella Upton

Chief Investigator

Trainee Clinical Psychologist

University of Leeds

C3. Client participant informed consent form

Patient Informed Consent Form V.04 06.01.23

Page 1: Page 1

Study Title: Managing binge eating prior to weight management using guided self-help

Name of researcher: Ella Upton

IRAS ID: 319705

Version number 0.3 06.01.2023

1. 1. I confirm that I have read the participant information sheet dated 25.01.23 (version 0.6) for this study. I have had the opportunity to consider the information, ask questions, and have had these answered satisfactorily. * *Required*

- Please tick box if you agree

2. 2. I understand that my participation is voluntary and that I am free to withdraw, up until the point of data analysis, by contacting the Chief Investigator by phone or email, without giving any reason, without my medical care or legal rights being affected, but that data up until that point may still be used anonymously. * *Required*

- Please tick box if you agree

3. 3. I understand that data collected during the study, may be looked at by individuals from University of Leeds, from regulatory authorities or from the NHS Trust, where it is

relevant to my taking part in this research. However, if quotations are used, anonymity will be preserved. I give permission for these individuals to have access to my data. * *Required*

- Please tick box if you agree

4. 4. I understand that interviews will be recorded and transcribed. I understand that the recording will be deleted once it has been used to verify the accuracy of the transcript. I understand that the transcripts will be stored securely and will not be accessed by people outside of the research team. * *Required*

- Please tick box if you agree

5. 5. I understand that as part of this project the research team need to collect some information about me that MoreLife have gathered (this is listed on the participant information sheet). This means that MoreLife will know that I am involved in this study. I consent for this to happen, and understand that data gathered will not be accessed by people outside of the research team. * *Required*

- Please tick box if you agree

6. 6. I understand that should any concerns arise for the Chief Investigator during the interview, she is duty bound to pass this information back to MoreLife. I consent for this to happen. * *Required*

- Please tick box if you agree

7. 7. I agree to be contacted using the contact details I have provided to participate in

this study. ✱ *Required*

- ○ Please tick box if you agree

8. 8. I agree to be contacted using the contact details I have provided to participate in future associated studies. ✱ *Required*

- ○ Please tick box if you agree
- ○ Please tick box if you DO NOT agree

9. 9. I consent that the data generated in this study will be anonymised and may be used in future research and understand that this may be shared with other researchers. ✱ *Required*

- ○ Please tick box if you agree
- ○ Please tick box if you DO NOT agree

10. 10. I agree to take part in the above study. ✱ *Required*

- ○ Please tick box if you agree

Appendix D: Method – extra detail

D1. Excerpt from reflexive log (written 01.02.23 - prior to recruitment)

Through my understanding of the poorer treatment of those with obesity, I am very hopeful that WOED is an effective and acceptable intervention, and that my interview data reflects this. I will therefore have to be careful not to bias my interpretation positively, but aim to create a balanced view which captures both the positive and negative aspects of the intervention. Holding in mind that this will not work for everyone, and that people will interpret different components of the intervention through the lens of their own understanding and experience, and that it is my role to try and understand this to the best of my ability, will be imperative. A desire to help will become unhelpful if it biases my interpretation of the data. Additionally, due to previous research, I am expecting the guide to be a helpful part of this intervention, and will endeavour to ensure that all voices on this are captured. Through supervision and personal reflection I will ensure continued reflexivity during the analytic process, to adhere to the values of RTA.

I will also endeavour to be mindful that I live with thin privilege, and have not faced many of the barriers/difficulties my research participants will have. However, I have experienced internal and external weight stigma throughout my life and feel an acute sense of injustice surrounding this. Remaining curious about ***their*** *experience, trying not to make any assumptions, and not stepping into the 'saviour' position, will be vital.*

D2. Reflexive statement on researcher positioning post-research (written 07.08.24 - post VIVA)

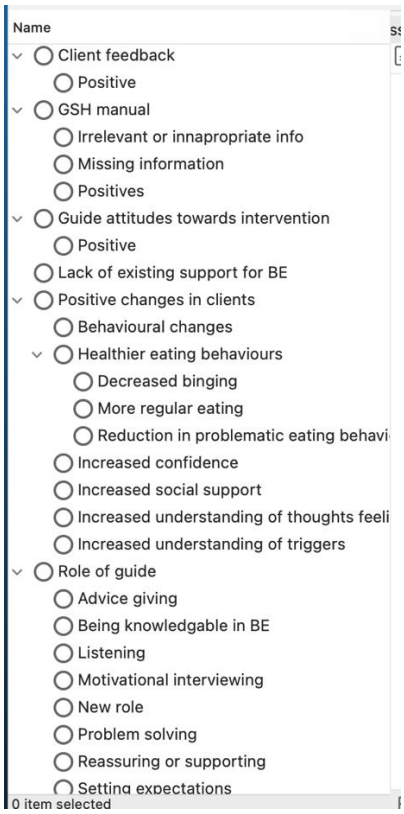
I found conducting this research interesting and challenging. I am used to building therapeutic relationships with clients over several sessions, and it felt very different to be offering one-off interview sessions instead, in which my role wasn't as therapist but as researcher. This became particularly challenging when clients were upset, as I felt pulled to listen and support them, and at times found it tricky to reorientate the conversation back to the interview schedule.

In addition, in writing the discussion and considering clinical recommendations, I am well versed in the complexities surrounding health services through my clinical work. I felt a strong sense of advocacy both for the clients who aren't accessing the support that they need, and for services that aren't currently equipped to provide an increase in support.

Following several internal battles, I accepted that it was not possible to separate my clinical hat from my research hat. My hope is that the former has complemented the latter. I believe my clinical experience through working with people in distress therapeutically can only enhance my ability to advocate for better services through such research.

My moral positioning did not change through the research. I continue to believe that this population deserves better, both in terms of access to services, representation within research, and treatment at a societal level.

D3. Step 2; Example of initial codes following the re-reading of two Guide transcripts



D4. Step 3; Early venn diagram of codes

D5. Ensuring quality; reflexive log entries following conversations with a Guide and Client concerning the RTA.

Excerpt from reflexive log (15.01.24 - written after speaking to a guide)

Discussing my initial themes with a guide participant gave me some more background and clarity as to why this intervention felt so new to guides. It also enabled me to hold in mind this guides' particular views on the most important themes – namely that the WOED training could be improved, and the most important element of this programme to them was that it offered clients the space to talk about something they may not have been able to before. It was a helpful exercise in enabling me to re-establish links between themes that I had put to one side. I felt slightly frustrated that they were bringing more helpful content to this conversation, to add context to my themes, and I was unsure whether I would be able to include it in my analysis. It made me reflect on whether I had missed a useful question in my interviews, or whether sending the questions in advance to participants would have yielded even more useful information. I planned to take this back to research supervision.

Excerpt from reflexive log (22.01.24 - written after speaking to a client)

I was nervous to discuss my initial themes with a client – I didn't want to accidentally misrepresent what they had told me or cause offense in any way. However – it was really enjoyable! It was a helpful exercise to discuss my use of language – I was unsure whether the theme 'complex clients living complex lives' would sound pejorative/reductionist but they really liked it, and felt it captured what I wanted it too.

This client reiterated how helpful WOED had been (compared to other WM interventions). They also gave me a brilliant metaphor about follow up support – they said that without any follow up support it would feel like 'you'd had an operation and then never had an appointment with the consultant'.

They agreed with the themes I felt clear on, that they represented their experience, and noted where themes felt a bit more unclear and needed further refinement. Again, they gave more helpful information that would have been good to know during the interview. It made me wonder again whether next time I interview participants whether I would send the questions in advance.