DISCLOSURE OF EATING DISORDERS AND SUBSEQUENT HELP SEEKING

by

NICOLA JANE GILBERT

Volume 1

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Overall Abstract

Literature review: The severe consequences of having an eating disorder can be minimised by early treatment access. However, most individuals experience help seeking delays. Evidence regarding the barriers and facilitators that might influence these delays, for individuals with eating psychopathology was systematically reviewed. The evidence base is in its infancy. More complex studies could establish the directional influence of relationships. Future work could also focus on the factors that operate earlier in the help seeking process. This is likely to generate ideas and interventions to achieve a better prognosis for individuals with eating disorders.

Empirical paper: Following the recommendations of the review, the first disclosure of an eating problem and the impact of disclosure factors on subsequent help seeking were explored. Seventy one eating disorder service users were interviewed. Being older at first disclosure was linked with faster access to specialist services. Disclosure to mothers and friends were most common. Appraisals of ‘other-initiated’ and ‘volunteered’ disclosures did not differ. However, individuals involved in ‘other-initiated’ disclosures were younger and accessed help more quickly than those who ‘volunteered’ their disclosure. The more positively ‘other-initiated’ disclosures were appraised the quicker the subsequent help seeking. The findings suggest that people *should* mention eating.

Acknowledgements

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To my family and friends, I’m really looking forward to having more time to spend with you all now. Thanks for waiting for me!

Saving the most important people until last, I would like to thank all of the women who took the time to participate in this research. It made the world of difference to interview interested and friendly individuals.

Overview

The current thesis is partial fulfilment of the requirements for the degree of Doctorate in Clinical Psychology (Clin.Psy.D) awarded by the University of Birmingham. The contents include the research component, four clinical practice reports and one case presentation, outlining aspects of clinical work that was completed during the course.

Volume one contains three research papers. First, a systematic review of the literature regarding factors that inhibit or facilitate help seeking amongst individuals with eating disorders is provided. The intention is to submit this review to the journal, 'European Eating Disorders Review.' Next, the empirical paper explores the first disclosure and the impact of disclosure factors on subsequent help seeking for individuals with eating disorders. This paper will be submitted to the International Journal of Eating Disorders. Finally, a public domain briefing paper provides an overview of both the literature review and the empirical paper.

Volume two comprises four clinical practice reports and the abstract of a case presentation. The first report describes a 52-year-old man, with a learning disability, experiencing depressive symptoms and difficulties adjusting to a decline in his mobility. His case was formulated from a psychodynamic and a cognitive perspective. Next, a service evaluation is presented, that provides a qualitative exploration of experiences of being employed in a café from the perspective of workers with learning disabilities. The Day Hospital Well-being Project: Work to promote mutual understanding and facilitate well-being for stakeholders during a process of collaborative change, is outlined. Then, a single case experimental design approach used in work with a 26-year-old woman with a fear of thunder is delineated. Finally, an abstract is provided, of a presentation outlining work undertaken with an 8-year-old girl and her mother in a CAMHS setting.

Volume 1: Table of contents

<u>Literature review</u>

Factors that inhibit or facilitate help seeking amongst individuals with eating disorders: A systematic review

Empirical Paper

Should I mention eating? Disclosure of eating disorders and subsequent help seeking

Dissemination document

Disclosure of eating disorders and subsequent help seeking

List of Tables

Literature review

Empirical paper

Dissemination document

List of Figures

Literature review

Empirical paper

Dissemination document

Appendices

Literature review

Empirical paper

Volume 2: Table of contents

I. List of Tables

II. List of Figures

III. Appendices

Clinical Practice Report 1: Learning Disability Placement

A 52-year-old man with a learning disability experiencing depressive symptoms and difficulties adjusting to a decline in his mobility

Clinical Practice Report 2: Learning Disability Placement

A qualitative exploration of the experiences of being employed in a café: The perspectives of workers with learning disabilities.

Clinical Practice Report 3: Older Adult Placement

The Day Hospital Well-being Project: Work to promote mutual understanding and facilitate well-being for stakeholders during a process of collaborative change.

Clinical Practice Report 4: Adult Mental Health Placement

A single case experimental design approach used in work with Sophie, a 26-year-old woman with a fear of thunder.

Clinical Practice Report 5: Child and Adolescent Placement

My work with Ellie and her mum.

List of Tables

Clinical Practice Report 2

Clinical Practice Report 3

Clinical Practice Report 4

List of Figures

Clinical Practice Report 1

Clinical Practice Report 3

Clinical Practice Report 4

Appendices

Clinical Practice Report 1

Clinical Practice Report 2

Clinical Practice Report 4

Literature Review

Factors that inhibit or facilitate help seeking among individuals with eating disorders: A systematic review

Nicola Gilbert

Prepared for submission to the European Eating Disorders Review

Correspondence to: Dr Nicola Gilbert, Department of Clinical Psychology, School of Psychology, University of Birmingham, Edgbaston, Birmingham, B15 2TT, United Kingdom. Telephone: +44 (0)121 414915. E-mail: njg777@bham.ac.uk

Running head

HELP SEEKING AND EATING DISORDERS

Abstract

The severe consequences of having an eating disorder can be minimised by early treatment access. However, most individuals experience lengthy delays in accessing help. This review aimed to systematically evaluate the empirical literature relating to the barriers and facilitators that might influence these delays, for individuals with eating psychopathology. Twenty empirical studies were reviewed. Evidence for potential barriers included: 1) logistical difficulties, 2) ethnicity and acculturation, 3) poor mental health literacy, 4) self-reliance, and 5) social and interpersonal fears. Potential facilitators included: 1) problem recognition, 2) interventions to enhance recognition, 3) impairment of functioning and health, and 4) severity of eating disordered symptoms. More complex studies are required to establish the directional influence of these factors on help seeking. A shift in focus from resactive facilitators, such as symptom severity, towards the factors that might operate earlier on in the help seeking process, is more likely to generate ideas and interventions to achieve earlier treatment access.

Key words: eating disorders; help seeking; barriers; access to services.

Introduction

Eating disorders (such as bulimia nervosa and anorexia nervosa) can lead to irreparable physical damage such as dental erosion, infertility, cardiac complications and osteoporosis (e.g., Carney & Anderson, 2006; Golden, 2003; Little, 2002; Mehler, 2003). Women with bulimia nervosa frequently attempt suicide (Corcos, et al., 2002), and up to 20% of individuals with a diagnosis of anorexia nervosa are estimated to die as a result of their illness (Fairburn & Harrison, 2003; Tamburrino & McGinnis, 2002).

Such severe consequences can be minimised if individuals with eating disorders access treatment quickly. Indeed, if eating problems are detected early, the prognosis is favourable (e.g., Deter & Herzog, 1994; Howard, Evans, Quintero-Howard, Bowers & Andersen, 1999; Ratnasuriya, Eisler & Szmukler, 1991). However, there is evidence to suggest that treatment access for individuals with eating disorders is slow, and many are not accessing treatment at all (e.g., Cachelin, Rebeck, Veisel & Striegel-Moore, 2001; Cachelin, Striegel-Moore & Ragan, 2006). Among those who do access treatment, there is an average delay of 4 years from eating disordered symptom onset to first treatment contact (Cachelin, et al., 2001; de la Rie, Noordenbos, Donker & van Furth, 2006). This delay can extend to 10 years for some individuals (de la Rie et al. 2006).

The path between eating disorder symptom onset and treatment access is not necessarily direct and it is likely that individuals will move at various rates between several phases during the help seeking process. Figure 1 illustrates five phases that might be involved in help seeking. Following symptom onset (A) the individual might become aware of their symptoms and develop concern (B). Next they might disclose these concerns to another individual (C). This disclosure could either be voluntary, or initiated by another individual. For other-initiated disclosures the individual might not have developed concern regarding their symptoms and so have skipped from phase A to C. The G.P. is viewed as ‘the gate keeper’ to specialist mental health services, since most individuals need to meet with their

G.P before they can access specialist support (D). Some might do this without involving any other individuals (e.g., perhaps moving from phase B to D). The final link is between the G.P. and the specialist service (E).

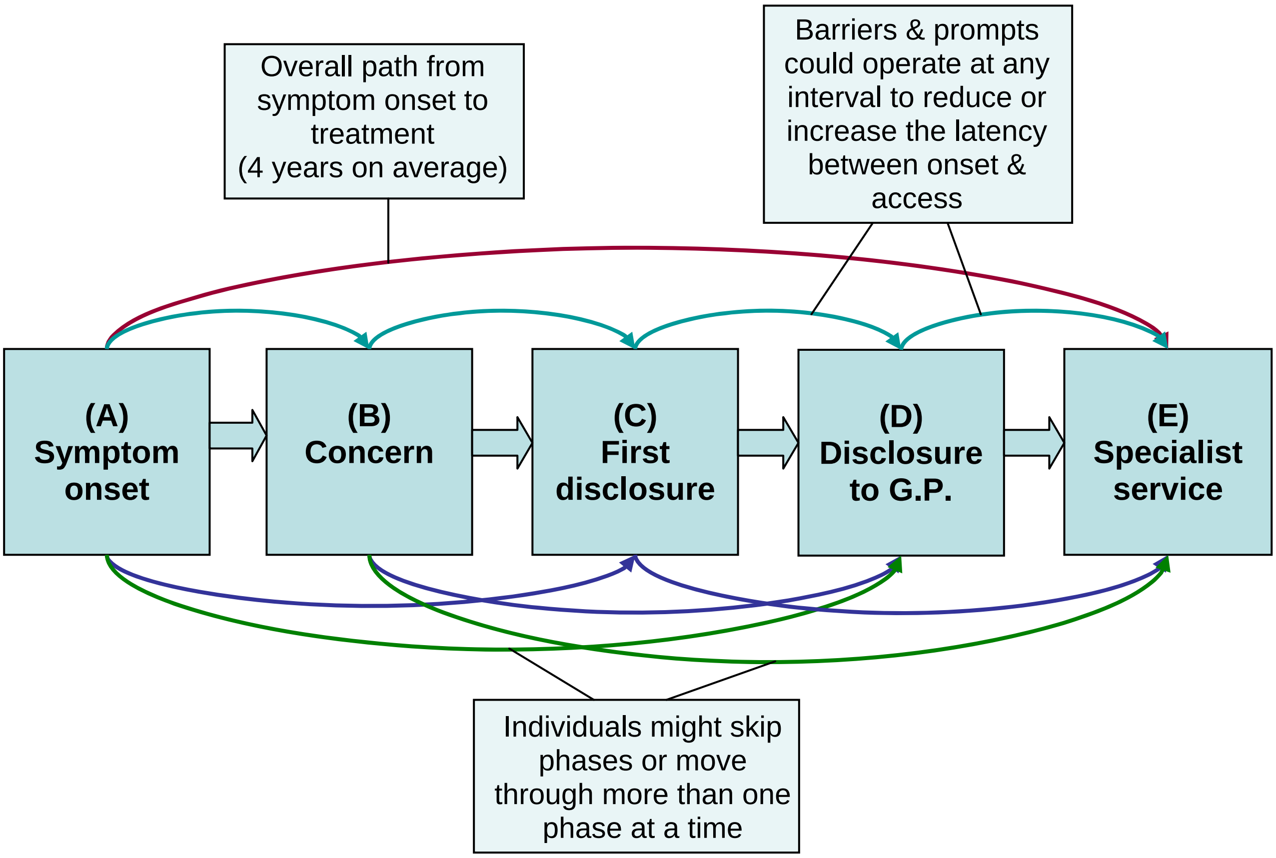

Figure 1 A model of the help seeking process from eating disorder symptom onset though to accessing specialist services

Several barriers exist that could operate at some or all of the intervals between the five phases of the help seeking process. Cachelin and Striegel-Moore (2006) list some of these barriers. At an inter-personal level, the authors implicate shame / stigma regarding having a mental health problem, a drive to minimize the severity of the problem, negative beliefs about the helpfulness of treatment, having low levels of acculturation, or a lack of familiarity with health services. At a systems level, proposed barriers include financial difficulties, lack of health insurance, inaccessible health care facilities, time conflicts and lack of transportation. Facilitators have also been identified that could improve access to treatment (e.g., Hepworth

& Paxton, 2007). Examples include high symptom severity, increased psychological distress, an interference with life roles, and a desire to get better.

Listing barriers and prompts to help seeking gives the illusion that each factor is supported by a similar level of empirical evidence, and that they all work to prolong or improve help seeking in the same way. In fact, the studies that have been conducted to explore proposed barriers and facilitators to help seeking amongst individuals with eating disorders vary in terms of the barriers and prompts on which they focused, the populations from which participants were drawn, and the methodological quality of the empirical work conducted.

There is a growing body of evidence regarding the factors that might inhibit or facilitate an individual’s ability to access treatment for their eating disorder. However, to date, a review has yet to be conducted that collates and systematically explores this literature, both in terms of the barriers and facilitators that have been studied, and the methodological quality of the evidence presented. Consequently, there is a need to address this omission.

Aim of the literature review

The aim of this review is to systematically evaluate the empirical literature relating to factors that might facilitate or inhibit help seeking amongst individuals with eating psychopathology. The studies will be described and subjected to a methodological evaluation in order to generate recommendations for future research and clinical practise. In addition, it is hoped that, through the provision of tentative recommendations, the review itself might provide a resource that professionals, individuals with eating psychopathology, and those who might suspect that someone they know has an eating disorder, could draw upon.

Method

Inclusion/ exclusion criteria

Original empirical work was included that investigated factors that might facilitate or inhibit help seeking and access to treatment amongst eating disordered populations. Studies using eating disordered populations, community and college-based populations were included. However, these studies must have included participants with full-syndrome or partial syndrome eating disorders or problems as at least part of their samples. Studies with a focus on obesity were excluded. The focus was on access to treatment, so those studies focusing solely on treatment outcome were also excluded.

Search Strategy

Three electronic databases, Web of Science, Pubmed, and Psych Info, were searched using the keywords ‘eating disorders’ and ‘help seeking’. Three journals were also searched: the European Eating Disorders Review, the International Journal of Eating Disorders, and Eating Behaviors, and forward searches and reference list searches were conducted on key articles. Taking account of duplications this initial search produced 175 potential articles. The abstracts of these articles were read and 135 articles were discarded because either they were not relevant to eating disorders, they did not include original empirical data, they focused on obesity or solely on treatment outcome, or they were written in a foreign language with no translation. The full versions of the 41 abstracts identified as potentially relevant were obtained. These articles were read and graded from 0, indicating high irrelevance, through to 4, indicating high relevance. Twenty-one articles scored 2 or less and were excluded from the current review. This left 20 relevant or highly relevant articles for inclusion. Table 1 provides the frequencies of the empirical papers coded according to relevance.

Table 1 - Frequency of articles coded according to relevance.

Score	Description	Frequency
0	Highly irrelevant	5
1	Irrelevant	7
2	Tenuously linked – exclude	9
3	Relevant	10
4	Highly Relevant	10

Methodological evaluation

The National Institute for Health and Clinical Excellence guidance (NICE guidelines manual, 2007) was used to classify the level of evidence provided by each study as: Class 1 (randomised controlled trials), Class 2 (case-control or cohort studies) or Class 3 (non-analytic studies such as case studies, case series or single case designs). Next, the methodological rigour of the studies was rated using the NICE checklists for cohort studies, case-control studies, and qualitative studies (see appendix). Currently, no checklist exists to evaluate the methodology for cross-sectional studies, so a checklist was developed from the other NICE checklists (see figure 2). The NICE rating system was then used to rate the studies in terms of their methodological quality from good quality (++), to reasonable quality (+) to poor quality (-) (see figure 3).

Study (*author, title, reference, year of publication)*

SECTION 1: INTERNAL VALIDITY			
In a well conducted cross-sectional or before-after design:			In this study the criterion is:
1.1	The study addresses an appropriate and clearly focused question.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
SELECTION OF SUBJECTS			
1.2	Recruitment is appropriate to the aims of the research.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.3	Representative cases from relevant population.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.4	The study indicates how many of the people asked to take part did so.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.5	Comparison is made between participants and non-participants to establish their similarities or differences.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.6	Inclusion criteria made explicit and sample characteristics sufficiently described	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.7	Were subjects recruited over the same period of time?	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
DATA COLLECTION			
1.8	Confidence in the quality of individual responses (e.g., tel. Questionnaires might produce better quality answers than postal).	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.9	Outcome is measured in an objective, standard, valid and reliable way.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.10	Reliance on current info rather than recall/ hypothetical scenarios.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
CONFOUNDING			
1.11	The main potential confounders are identified and taken into account in the design and analysis.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.12	Minimisation of bias – participant bias, observer bias, halo effects	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
STATISTICAL ANALYSIS			
1.13	Appropriate use of statistical analysis?		Appropriate Not appropriate Not clear

1.14	Actual P values reported (e.g., 0.037 rather than < 0.05) for the main outcome except when p value is < 0.001	Yes No
SECTION 2: OVERALL ASSESSMENT OF THE STUDY		
2.1	How well was the study done to minimise the risk of bias or confounding, and to meet its aims?	++ + -
2.2	Taking into account clinical considerations, your evaluation of the methodology used and the statistical power of the study are you certain that the findings could be replicated	Yes No

Figure 2 - Checklist developed for cross-sectional studies.

++	All or most of the criteria have been fulfilled. Where they have not been fulfilled the conclusions of the study or review are thought **very unlikely** to alter.
+	Some of the criteria have been fulfilled. Those criteria that have not been fulfilled or not adequately described are thought **unlikely** to alter the conclusions.
–	Few or no criteria fulfilled. The conclusions of the study are thought **likely or very likely** to alter

Figure 3 - NICE rating system for methodological quality of studies using methodological checklists (NICE guidelines manual, April 2007)

Factors that might inhibit or facilitate help seeking among individuals with eating disorders

The empirical literature relating to the factors that might inhibit or facilitate help seeking among individuals with eating disorders will be reviewed next. First, the studies will be described, then their methodological quality will be summarised, and finally, the results of the studies will be outlined according to evidence relating to barriers to help seeking, and that relating to facilitators of help seeking.

<u>Description of the studies</u>

The characteristics of the participants from the 20 studies varied. Seven studies recruited participants from large, college or school populations, from which sub-samples of participants with eating psychopathology were drawn. Nine studies specifically recruited participants with eating psychopathology from community populations. In 3 of these studies, participants had a range of eating psychopathology, one study only included individuals with Anorexia Nervosa (AN) and Bulimia Nervosa (BN), and 5 studies recruited participants with bulimic-type psychopathology. Three studies recruited participants from eating disorder services, the first included individuals with AN and BN, the second only included those with AN, and the third sample included users of an online eating disorder service with a range of eating psychopathology. The final study recruited their sample from a nation-wide twin study whose large population enabled the identification of a sub-sample of individuals with AN along with a non-clinical control group. Table 2 provides a summary of these details.

All studies used questionnaire or interview based methods. Five conducted telephone based structured interviews, many of which also incorporated standardised questionnaires. One questionnaire-based study was conducted by email. Thirteen studies involved face-to-face interviews or the supervised completion of standardised questionnaires. The final study drew upon data from both face-to-face interviews with self-report questionnaires and clinician assessed information. The main elements the 20 studies are summarised in table 2.

It is important to note that some studies utilized the same group of participants, or re-contacted individuals who were involved in a previous screening program or study. This appears to be the case for studies 1, 2 and 3, for studies 5 and 6, and for studies 15, 16 and 17 in table 2.

Methodological quality

Using the NICE guidelines manual (2007), 19 of the studies were class 2, the majority had cross-sectional designs, but 5 were cohort studies, and one was a case-control study. The additional study was class 3, with a qualitative design. In terms of the NICE ratings for methodological quality, only 2 studies were rated as (-) indicating that few or no methodological criteria from the checklist relating to their study design had been fulfilled. The other studies either received a rating of (+), indicating that some of the methodological criteria had been fulfilled (N = 7), or a rating of (++), indicating that all or most of the criteria had been fulfilled (N = 10). One study contained a cross sectional element and a cohort element and these received ratings of (++) and (+) respectively.

The sample sizes of the studies varied with 16 having total samples of over 100 participants, 2 having 50-100 participants and 2 with less than 50 participants. Regarding the group sizes for the statistical analyses, only 4 studies had samples of over 100 participants per group, 3 had 50-100 participants per group and 13 studies had less than 50 participants per group.

Table 2 - Summary of the studies included in the review

Authors & year	Study type & level of evidence	Sample	Sample size	Factors investigated	Comparisons made	Follow up & length	Measures used	Results relevant to review
1. Becker, Franko, Speck & Herzog (2003)	Cross-sectional & cohort Self-report & clinician-assessed Class 2++ for cross-sectional, and class 2+ for cohort	Non-clinical college population from NEDSP	Study 1: N = 9, 069, lowest N per group = 82 Study 2: N = 289, lowest n per group = 22	Impact of ethnic status on: eating disorder symptoms, treatment history, referral patterns, help-seeking & clinician response	Study 1: African American, Asian, Latino, Native American & Caucasian Study 2: Ethnic minority vs. non-ethnic minority	Study 1: None. Study 2: 1 ½ to 2 years	Demographic info, self-reported ethnicity, ED symptoms (not a standardised measure), history of accessing treatment, referral recommendation by counsellor.	- No sig. between-group differences in help seeking - After controlling for severity of ED symptoms, African-American & Latino participants sig. less likely to be referred for further evaluation than Caucasian - Ethnic minority subjects with self-identified weight concerns sig. less likely than non-minority to have been asked by a doctor about ED symptoms
2. Becker, Franko, Nussbaum & Herzog (2004)	Cohort study Structured telephone interviews Class 2+	Non-clinical college population from NEDSP	N = 289 males & females	Impact of screening program on knowledge & treatment-seeking for Eds	None	2 years	Baseline demographic & ED screening data; Questions re responses to the NEDSP & treatment seeking	- Enabled: disclosure of ED (32%), & help (28%) - 109 recommended for further evaluation: 51% somewhat to very willing to follow up, 42% neutral, & 8% unwilling - 47.7% who received an initial recommendation kept the 1st appointment - Barriers: can handle it on my own (36%), inconvenience (19%), problem isn't serious (15%), expense (13%), no problem (12%). - 35%/ 19.3% screening was very/ moderately important in seeking treatment

3. Becker, Thomas, Franko & Herzog (2005)	Cross-sectional Telephone questionnaire Class 2++	Eating or weight symptoms/ problems, college population from NEDSP	N = 216 males & females, lowest N per group = 5	Disclosure patterns regarding eating/ weight concerns	a) Disclosure vs. non-disclosure b) categories of confidant c) treatment seekers vs. non-treatment seekers	None	Demographic info & recall whether they had shared ED concerns with individuals; volunteered or other-initiated; denied information when queried	- 97.7% had disclosed but only 57% to a medic - Nearly 91% of those who did not volunteer disclosed information when asked - Those who shared eating concerns with a medical professional pre screening were sig. more likely to have sought treatment ≤ 2 yrs than those who did not
4. Cachelin, Rebeck, Veisel & Striegel-Moore (2001)	Cross-sectional Telephone interviews Class 2++	Community sample with BED, BN, AN & EDNOS	N = 61 ethnically diverse females, lowest N per group = 26	Diagnostic status (EDE) Treatment seeking history, barriers to treatment seeking, ethnic identity & acculturation	Treatment seekers vs. non-treatment seekers	None	Eating disorders (EDE); questions re treatment seeking history, yes/no responses to list of 9 reasons for treatment seeking; yes/no responses to list of 11 barriers to help-seeking; ethnic identity (MEIM)	- Treatment seekers: earlier onset of 1st symptoms; more binge eating-related distress; no difference for ethnic group, age, marital status, BMI, SES, insurance, type of ED - Not seeking treatment: financial difficulties, lack of insurance, others can't help, fear of label, not knowing about resources. - Seeking treatment: concern re body weight, depression/ anxiety, encouraged by friends, physically uncomfortable, concern re health
5. Cachelin & Striegel-Moore (2006)	Cross-sectional Telephone interview Class 2++	Community sample with AN, BN, BED & EDNOS	N = 145, 76 Mexican American (MA) & 69 European American (EA) women, lowest N per group = 21	Whether SES, insurance cover, access to services, type of ED & psychiatric co-morbidity are linked to treatment seeking	Treatment seeking vs. non-treatment seeking & MA vs. EA	None	Demographics: ethnicity, country of birth/ origin, age occupation, SES, Axis 1 disorders (SCID-IV-TR), acculturation (ARSMA-II), Reasons for treatment seeking (series of closed questions) Barriers to treatment seeking	- 74% knew they had problems, 69% would like help, only 27.6% had sought help - EA women with AN/ BN more likely diagnosed/ treated than BED/ EDNOS - EA women more likely than MA women to have sought specialist help & received medication - Help seeking: concern with overweight/ eating, encouragement from friends/ family, emotional distress, health concerns & initiated by parents - Not seeking help: shame, not knowing

							(19 possible reasons, 5 point scale)	where to go, should be strong enough to help oneself, minimization of seriousness, fear of label, financial concerns, unaware of treatments available - EA barrier = belief one did not had a problem - No relationship between acculturation & treatment seeking (although trend)
6. Cachelin, Striegel-Moore & Regan (2006)	Cross-sectional Telephone interviews Class 2++	Community sample with eating disorders	N = 190 Mexican American (MA) & European American (EA) women, lowest n per group = 39	Impact of symptom severity/ duration, socio-demographic factors, acculturation on treatment seeking/ receiving	Treatment seekers vs. non-treatment seekers & treatment receivers vs. non treatment receivers	None	Demographics: ethnicity, country of birth/ origin, SES, Axis 1 disorders (SCID-IV-TR), Eating disorders (EDE), depression (CES-D), acculturation (ARSMA-II)	- Treatment seeking associated with ethnicity (EA), having BN, more frequent purging, longer duration of ED, more co-morbidity, & greater acculturation for MA - Ethnicity = strongest predictor of seeking & receiving ED treatment - No association between AN & access to treatment
7. D'Souza, Forman & Austin (2005)	Cohort study Questionnaires Class 2+	Non-clinical school sample from NEDSP	N = 1027 males & females, lowest N per group = 435	Follow-up evaluation to assess the implementation & effectiveness of the NEDSP	Males vs. females & individuals with ≥ 20 EAT scores vs those scoring < 20	6 – 10 weeks post NEDSP	Demographic info: (age, ethnicity, father's educational status, current weight/ height); impressions of screening program (likert-scale); Eating disorders (recalled EAT-26).	- 44 females & 8 males were recommended to see a clinician about ED symptoms, but only 1 female & 5 males had - females felt more strongly than males that the program had helped them learn about EDs, change their thinking re EDs, body image & talk to friends re EDs - More individuals scoring ≥ 20 reported having talked to an adult or peer about their score than individuals scoring < 20 (65% vs. 50%) but difference was N.S. - Those scoring ≥ 20 were not more likely to report that referral was recommended

8. Goodwin & Fitzgibbon (2002)	Case-control study Questionnaires Class 2-	AN/ BN service-users	N = 28 females, lowest N per group = 8	Whether social anxiety influences treatment engagement for eating disorders	Patients who engaged with treatment post initial assessment vs. those who did not	No details	Demographic information; Eating disorders (EDI); Social anxiety (BORI)	- Individuals who did not engage had higher levels of social anxiety re being liked by others/ sensitivity to rejection - No differences in demographic characteristics, diagnoses or pathology
9. Grunwald & Wesemann (2006)	Cohort study e-mail questionnaire Class 2-	Probable EDs and relatives	N = 240 with ED & N = 85 relatives, males & females	Motives for using online service, changes due to the service & consequences of the consultation	Change or no-change since using the service	1 – 4 years after using online consulting service	17 closed ended items devised by the authors; eating disorders – describe themselves as suffering or clinical/ sub-clinical symptoms	- 55.4% of ED sample & 81.2% of relatives had not turned to professional help pre contact - 31.3% of ED sample gained insight re the need to seek further help - 22.5% of ED sample & 48.2% of relatives had improved knowledge of the disease - 27.9% of ED sample & 30.6% of relatives had more information of EDs - 32.1% of ED sample & 52.9% of relatives had more conversations re ED
10. Hepworth & Paxton (2007)	Qualitative Semi-structured interviews Class 3++	Community sample with past & current BN behaviours	N = 63 females	Exploration of problem recognition, barriers to help-seeking & prompts to help-seeking	N.A.	None	Demographic questions (age ethnic background, occupation, weight & height); Eating Disorders (EDE-Q); Barriers & prompts to help seeking (open-ended questions)	- Problem recognition: behaviour changes, life role interference, comments re changes & psychological problems - Barriers: fear of stigma & change, low MH literacy/ perception of need, shame & cost - Prompts: increased symptom severity, psychological distress, interference with life roles, health problems, desire to get better

11. Holliday, Wall, Treasure & Weinman (2005)	Cross-sectional Interviews Class 2++	AN service-users vs. students	N = 95 with ED vs. N = 80 students, males & females, lowest N per group = 36	Examine & compare representations of individuals with current AN & lay participants	AN vs. lay women vs. lay men	None	Demographic information (age, gender, ethnicity); EDs (EDE-Q) & info re onset & duration; Illness perceptions (IPQ-R & lay version)	- AN individuals who perceived their illness to have a more chronic course believed they had less control over their symptoms & their illness was less treatable - Lay participants were more optimistic re controllability/ curability than AN participants -
12. Keel, Dorer, Eddy, Delinsky, Franko, Blias, Keller & Herzog (2002)	Cohort Interviews Class 2+	Community sample with AN & BN	N = 228 females	Explored whether women who seek less treatment have less severe pathology	Level of treatment each year (over 5 years).	Follow-up interviews every 6 months	Eating & axis I pathology (schedule for Affective Disorders & Schizophrenia with DSM criteria for AN/ BN); structured interview for DSM-III personality disorders; global assessment of functioning scale	- Severity of eating disorder symptoms during each year significantly predicted treatment utilization during subsequent years - Presence of a personality disorder at intake was associated with greater treatment utilization - Lifetime history of mood disorder predicted greater use of individual therapy & medication
13. Meyer (2005)	Cross-sectional Questionnaires Class 2+	Non-clinical university sample	N = 294 females N = 188 non-clinical; N = 74 symptomatic; N = 32 ED, lowest N per group = 32	Examined relationship between fear of treatment, psychological defenses, endorsement of norms & treatment seeking for an ED	Non-clinical vs. symptomatic vs. ED & need for treatment vs. no need (amongst ED & symptomatic groups only)	None	Eating psychopathology (Q-EDD); fear of psychological services (TAPS); Endorsement of US societal values re thinness & attractiveness (BAA-R); Defense style (DSQ-40)	- ED Participants more likely to be in therapy than symptomatic participants - 44% of ED & 61% of symptomatic did not feel their behaviours warranted therapy - ED & symptomatic participants who felt they did not need treatment had higher levels of immature defenses & less endorsement of socio-cultural norms

14. Meyer (2001)	Cross-sectional Questionnaires Class 2+	Non-clinical high school population	N = 238 females then a focus on 116 symptomatic/ ED, lowest N per group = 38	Explored whether and why females are reluctant to seek counselling for their eating disorder	Symptomatic vs. eating disordered	None	Demographics (age, ethnicity); Eating psychopathology (Q-EDD); Attitudes towards seeking help (10-item ATSPPH-SF); past & current help-seeking, whether needed to & reasons for not	- Symptomatic more likely than ED individuals to deny their ED concerns merited counselling - 116 ED/ symptomatic but only 2 in counselling - ED more reluctant than symptomatic to tell - Barriers: 40% of ED & 21% of symptomatic ‘don’t want anyone to know’; 32% of ED & 50% symptomatic ‘problem not worrisome’, 24% ED & 35% symptomatic ‘don’t have a problem’
15. Mond, Hay, Rodgers & Owen (2007a)	Cross-sectional Interviews Class 2++	Community sample with BN, BED & EDNOS	N = 159 Females, lowest N per group = 31	Prior use of health services, types of treatment received & factors associated with help-seeking	AN, BN, BED, EDNOS; lifetime impairment (yes/ no); current impairment (yes/ no)	None	EDE – current & modified to assess past); experience of treatment for: eating & emotional problems. Yes/ no answers to lifestyle interventions; functional impairment (MCS scale of the SF-12)	- 40.3% had had treatment for an eating problem, 74.2% for general MH & all used self-help - High functional impairment & lifetime diagnosis of BED most strongly associated with basic treatment for an ED - High functional impairment & diagnosis of AN or BN purging strongly associated with treatment from a MH specialist
16. Mond, Hay, Rodgers & Owen (2007b)	Cross-sectional Face-to-face interview Class 2++	Community sample with BN, BED & EDNOS	N = 158 females	Examine the mental health literacy of BN amongst women with eating disorders	Perceived helpful vs. harmful treatments; responses of older (30 to 42 years) vs. younger (18 to 29 year) participants	None	Eating disorders (EDE); Mental health literacy (Vignette describing a 19 year old who met the criteria for BN followed questions her main problem and possible interventions).	- G.P., psychologists, counsellors & close friends = helpful - Lifestyle changes were highly regarded - Ambivalence about benefits of psychiatrists & alternative therapy - Inpatient treatment, weight-loss programs & medication = not helpful - Most thought it “might not be too bad” to have BN - Younger participants would approach a friend older participants would go to G.P.

17. Mond, Hay, Rodgers & Owen (2006)	Cross-sectional Interviews Class 2++	Community sample with BN, BED & EDNOS	N = 158 females, lowest N per group = 76	Examine self-recognition of EDs	Recognition vs. no recognition	None	Eating disorders (EDE-Q); health-related quality of life (SF-12); Psychological distress (K-10).	- Problem recognition linked to high: ED psychopathology, general distress, vomiting, BMI - Problem recognition = more chance of treatment from health professional. - Multivariate analysis: vomiting/ BMI were sig. associated with recognition
18. Mond, Marks, Hay, Rodgers, Kelly, Owen & Paxton (2007c)	Cross-sectional Questionnaires Class 2+	Non-clinical secondary school population	N = 537 females, lowest N per group = 18	Examined the mental health literacy of adolescent girls concerning BN	Probable ED cases vs. non-cases	None	Eating disorders (EDE); Mental health literacy (Vignette describing a 19 year old who met the criteria for BN followed questions her main problem and possible interventions).	- Primary care practitioners, mothers & close friends = highly regarded potential sources - Self-help interventions = highly regarded - Less positive re benefits of MH specialists - Amongst individuals with high levels of ED recognition of an eating problem was poor (50%)
19. Perkins, Klump, Lacono & McGue (2005)	Cohort Interviews Class 2++	Twin study population, threshold/ sub-threshold AN currently & not currently ill vs. non-ED control group	N = 27 ED vs. N = 273 control females, lowest N per group = 13	Explored associations between lifetime treatment seeking & personality disturbance	AN treatment & non-treatment seekers vs. control treatment & non-treatment seekers	None	Eating psychopathology (EDSCI); Personality characteristics (MPQ)	- Non-treatment seeking women in both groups had lower negative emotionality, stress reaction & alienation

20. Smalec & Storm Klingle (2000)	Cross-sectional Questionnaires Class 2+	Community sample with BN	N = 44 males and females	Investigated & empirically tested the effectiveness of interpersonal messages aimed at getting bulimic individuals to seek medical help	High threat vs. low threat messages; high efficacy vs. low efficacy messages	None	Questions/ beliefs re ED; most memorable message before receiving help & effectiveness of message, how close they were to the source; cognitive message acceptance (3 item 7-point scale); help seeking as a result? message rejection; threat perception scale; relational closeness	- Bulimics who believed they can easily & effectively search out & receive assistance will be more likely to do so than those who do not - Threat worked under conditions of high efficacy → bulimics who are alerted to the danger of their disorder and feel they can effectively search out assistance will do so - Threat also worked for low efficacy individuals (perhaps because they were forced to get help?)

Note: NEDSP = national eating disorder screening program; sig. = significant; ED = eating disorder; BED = binge eating disorder; BN = bulimia nervosa; AN = anorexia nervosa; EDNOS = eating disorder not otherwise specified; EDE = eating disorder examination; MEIM = the multigroup ethnic identity measure ; BMI = body mass index; SES = socio economic status; SCID-IV-TR = the structured clinical interview for DSM-IV-TR; ARSMA-II = the acculturation rating scale for Mexican Americans-II; CES-D = center for epidemiologic studies depression scale; EAT-26 = eating attitudes test-26; N.S. = non significant; BORI = bell object relations inventory; EDI = eating disorders inventory; MH = mental health; EDE-Q = eating disorder examination questionnaire; IPQ-R = illness perception questionnaire-revised; Q-EDD = questionnaire for eating disorder diagnosis; TAPS = thoughts about psychotherapy scale; BAA-R = beliefs about attractiveness scale-revised; DSQ-40 = defense style questionnaire-40; ATSPPH-SF = attitudes towards seeking professional psychological help-short form; MCS = mental component summary; SF-12 = the medical outcomes study short form; K-10 = Kessler psychological distress scale, EDSCI = eating disorders structured clinical interview; MPQ = multidimensional personality questionnaire.

Barriers to help seeking

Five factors emerged as potential barriers to help seeking for individuals with eating psychopathology: 1) Logistical barriers, 2) ethnicity and acculturation, 3) poor mental health literacy, 4) self-reliance, and 5) social and interpersonal fears. These will be discussed next.

1) Logistical barriers

Evidence regarding logistical barriers came from 4 studies. Three were class 2, and one was a class 3 study. All had quality ratings of (+) or (++) (studies 1, 4, 5 and 10 in table 2).

Following an eating disorder screening program, 109 college students had received a recommendation for further clinical evaluation, and 2 years later Becker, Franko, Nussbaum & Herzog (2004) found that 59 individuals had not followed it up. Reported reasons were: inconvenience (19%), expense (13%), and unavailability of professional treatment (2%). In Cachelin, et al.'s (2001) ethnically diverse sample of non-treatment seeking women with eating disorders (N = 29), 58.6% endorsed financial difficulties as a barrier. Lack of insurance (48.3%), not knowing about resources (34.5%), and a lack of transportation (10.3%) were also endorsed.

Amongst their sample of women with eating disorders who were not seeking treatment, Cachelin & Striegel-Moore (2006) found 'not knowing where to go', 'finances' and 'unaware of treatments' were reported barriers. Conversely, most of the women did not highlight 'childcare', 'transportation' and 'language barrier' as barriers to treatment. Hepworth & Paxton (2007) identified 'cost' as a theme linked with non treatment seeking from the semi-structured interview responses of 63 women with past or present bulimic behaviour. However, it was less popular than barriers linked to social and interpersonal fears and poor mental health literacy.

2) Ethnicity and acculturation

Four studies focused on ethnicity and acculturation as barriers to treatment (studies 1, 4, 5 & 6 in table 2). They were all class 2 studies with methodological ratings of (++) or (+).

Drawing upon both cross-sectional and prospective data and controlling for severity of self-reported eating disorder symptoms, Becker, Franko, Speck & Herzog (2003) found that their Latino and Native American participants were significantly less likely than their White participants to be recommended or referred for further professional support following a national eating disorder screening program. In addition, amongst participants with self-identified eating concerns, ethnic minority participants were significantly less likely than non-minority participants to have been asked by a doctor about eating disorder symptoms. In contrast, Cachelin et al. (2001) found no significant differences for treatment seeking amongst individuals with eating psychopathology from different ethnic groups, and no effect of ethnic identity strength or acculturation. However, their sample size was small. In addition, the white sample might not have been representative, since it contained women of Armenian or Middle Eastern origin, and the ability to speak English was a requirement for participation in the study, thus potentially creating a ceiling effect for acculturation.

Cachelin & Striegel-Moore (2006) found that European American (EA) women were more likely to have sought help from specialists and to have received medication than Mexican American (MA) women. MA women were more likely to have sought help from their G.P., to have received diet pills, and not to have been diagnosed with or treated for their eating disorder. Using the same sample, Cachelin, et al. (2006) found a significant association between treatment seeking and ethnicity (being EA). Amongst the MA group, they also found a significant relationship between a higher degree of acculturation and an increased likelihood of seeking help.

3) Poor mental health literacy/ perception of need

The term “mental health literacy” was introduced by Jorm, Korten, Jacomb, Christensen, Rodgers, & Pollitt, (1997), to describe “knowledge and beliefs about mental disorders that aid their recognition, management and prevention.” Eight class 2, and one class 3 studies, examined poor mental health literacy and perception of need as potential barriers to help seeking. Four of the studies received methodological quality ratings of (+) and five of (++) (studies 2, 5, 10, 11, 13, 14, 16 and 18 in table 2).

Amongst individuals who had received a recommendation to seek specialist help, but had not pursued it (N = 57 out of 107), Becker et al. (2004) found that ‘feeling the problem was not serious’ (15%), and ‘feeling there was no problem’ (12%) were reasons reported for not pursuing the recommendation. Similarly, Cachelin and Striegel-Moore’s (2006) participants endorsed the belief that the ‘problem was not serious enough’ as a barrier to accessing treatment.

The ‘problem was not worrisome enough’ was selected as a reason for not seeking professional treatment by 50% of Meyer’s (2001) symptomatic individuals and by 32% of the eating disordered participants. In addition, 35% of the symptomatic, and 24% of the eating disordered participants indicated that they did not ‘have a problem at all.’ Symptomatic individuals were more likely than eating disordered individuals to endorse the belief that their eating concerns were not ‘worrisome enough to merit counselling.’ Meyer (2005) found that amongst women with full or partial eating disorders, the belief that their behaviours ‘did not warrant therapy’ was common (44% (N = 14) of the ED group and 61% (N = 45) of the symptomatic group). Furthermore, women with eating psychopathology holding this belief had significantly higher levels of immature defenses (such as denial), than those women who believed that they needed treatment.

For Hepworth and Paxton (2007), ‘low mental health literacy/ perception of need’ emerged as the second most prominent theme relating to barriers to help seeking for women with past or present bulimic behaviours. Regarding more specific mental health beliefs, Holliday, Wall, Treasure & Weinman (2005) found that lay participants were more optimistic about the controllability and curability of AN than were individuals with the illness. The authors suggested that these beliefs might contribute to the stigmatisation of AN, and make it harder for individuals who might have AN to share their concerns and gain support from their social network.

Mond, Hay, Rodgers & Owen (2007b) found that 71% of women with bulimic eating disorders had at some point though that ‘it might not be too bad’ to have the condition. They also found that certain types of treatments, and treatment providers, were not perceived as helpful. Most participants were ambivalent about whether psychiatrists or alternative therapy would be helpful or harmful, and many felt that inpatient treatment, commercial weight-loss programs and prescription medication would be more harmful than helpful (82.4%, 56.3% & 46.2% respectively). Similarly, Mond, Marks, Hay & Rodgers (2007c) found that their non-clinical participants were less positive about the benefits of mental health specialists and ambivalent about the use of antidepressant medication.

Becker, Thomas, Franko & Herzog (2005) provided evidence to suggest that participants’ mental health beliefs regarding the competency of health professionals might influence their actions. In their sample of 216 individuals with eating concerns or symptoms, they found that although 97.7% had disclosed these concerns to someone, only 57% had disclosed them to a health care professional. Disclosure to health care professionals was significantly associated with access to treatment within 2 years, but disclosure to other sources was not.

4) Self-reliance

A drive towards self-reliance in the treatment and management of eating disorders was a barrier that was identified by 4 studies. All were level 2 studies with methodological quality ratings of (+) or (++) (studies 2, 4, 5, and 14 in table 2).

Following an eating disorder screening program, 109 college students received a recommendation for further clinical evaluation. Two years later, Becker et al. (2004) found that, for the 59 individuals who had not pursued the recommendation, the most popularly endorsed reason was the belief that ‘I can handle it on my own’ (36%), and 8% selected ‘not wanting others to know.’ Cachelin et al. (2001), found that the belief that ‘others can’t help’ was the third most popular reason for not seeking help, endorsed by 37.9% of women with eating disorders who were not seeking treatment (N = 29). In addition, Cachelin and Striegel-Moore (2006) found that, for women with eating disorders who were not seeking treatment, the belief that they ‘should help themselves’ was a popularly endorsed barrier.

Meyer (2001) found that ‘not wanting others to know’ was endorsed as a barrier by 40% of the 38 individuals with eating disorders, and by 21% of the 78 symptomatic individuals. In addition, participants with eating disorders were significantly more reluctant than symptomatic participants to let others know about their problem.

5) Social and interpersonal fears

Four studies highlighted social and interpersonal fears as potential barriers. Three were class 2 studies and one was class 3. Methodological quality ratings were high (++) for 3 studies, but one of the class 2 studies received a rating of (-) (studies 4, 5, 8 and 10 in table 1.2).

Cachelin et al. (2001) found a ‘fear of being labelled’ was endorsed by 37.9% of the 29 women in their sample who had not sought help, 31% cited ‘feelings of shame,’ and 20.7% indicated a ‘fear of discrimination’ as reasons for this. Cachelin & Striegel-Moore (2006) found that shame was a commonly endorsed reason amongst their sub-sample of women with eating psychopathology who had not sought help. Fear of labelling also arose as a prominent factor, and a fear of discrimination and a fear of separation from family were less strongly endorsed.

In Hepworth and Paxton's (2007) study, stigma emerged as the most commonly occurring theme relating to barriers to help seeking amongst women with bulimic symptoms. Shame and fear of change were also prominent themes. A pilot study by Goodwin & Fitzgibbon (2002) explored social anxiety as a barrier to treatment for eating disorders. It received a methodological quality rating of (–) mainly due to its small sample (N = 28) and comparison group sizes. When compared with the rest of the sample, the 8 individuals who did not complete treatment were found to have significantly higher scores on the subscale of the Bell Object Relations Inventory that relates to anxiety about being liked by others and sensitivity to rejection.

Facilitators of help seeking

Evidence relating to four categories of potential facilitators of help seeking for individuals with eating disorders emerged: 1) problem recognition and a motivation to get better, 2) interventions to enhance recognition and improve access to help, 3) impairment in terms of functioning and health, and 4) type and severity of eating disorder. They will be discussed in turn.

1) Problem recognition and a motivation to get better

Regarding problem recognition and a motivation to get better, four level 2, and one level 3 studies provide evidence to suggest that these factors might play a role in facilitating help seeking. All five studies received methodological quality ratings of (+) or (++) (studies 10, 11, 17, 18 and 20 in table 2).

Amongst individuals with bulimic eating disorders, Mond, Hay, Rodgers & Owen (2006) found that those who recognised they had an eating problem (51.9% of the total sample) were significantly more likely to have sought treatment from a health professional, than those who did not recognise that they had a problem. Mond et al. (2007c) found low recognition rates (50%) amongst a sub-group of adolescent girls who were identified by screening questionnaires as probable cases of clinically significant eating disorders (N = 36).

Hepworth & Paxton (2007) identified ‘an increased desire to get better’ as a prompt to help seeking from semi structured interviews with individuals with bulimic-type behaviours. However, interviewees mentioned concepts relating to increased symptom severity, psychological distress, life-role interference, and health problems with a greater frequency. Holliday et al. (2005) found that individuals with AN, who held beliefs that their illness was less chronic, and that they had more control over their symptoms, perceived their illness to be more treatable, than those who held more pessimistic beliefs regarding their illness.

In line with the idea that holding more optimistic beliefs might facilitate treatment access, Smalec & Storm Klingle (2000) found that amongst a community sample of 44 individuals with bulimia, those who believed they could easily and effectively search out & receive help were significantly more likely to do so, than those with low levels of efficacy. Contrary to the prediction that high levels of both threat and efficacy would achieve maximal persuasive power in convincing bulimics to seek help, high levels of threat was found to be linked to receiving help at both high and low levels of efficacy. They suggested that this might have been because individuals with low levels of efficacy were forced to get help by those around them.

2) Interventions to enhance recognition and increase access to help

Interventions to enhance the recognition eating disordered symptoms, and increase access to help fell into two categories: 1) formal interventions aimed at enhancing awareness, identification and enhanced access to treatment, and 2) less formal interventions targeted at a particular individual and initiated by concerned friends and family members. Evidence came from 5 level 2 studies and one level 3 study. Three studies had methodological ratings of (++), 2 had ratings of (+) and one had a (-) rating (studies 2, 3, 5, 7, 9 and 10 in table 2).

Regarding formal interventions, two studies have explored the impact of USA-based national eating disorder screening programs on subsequent treatment seeking amongst high school students. These programs were rolled out in 1996 and in 2000. First, Becker et al. (2004) contacted a random sub-set of individuals (N = 289) 2 years after they had participated in the screening program. Of the 109 individuals who were identified as having high levels of eating psychopathology and who were recommended for further exploration of their disordered eating, 47.7% pursued this recommendation and kept at least a first appointment for further evaluation, and 39.4% reported seeking treatment subsequent to the screening program. The authors took this as an indication that the screening program had facilitated treatment access for many students. The program reportedly enabled 28% of this treatment seeking sub-group to receive help for their eating problem. However, the extent to which the screening program facilitated treatment access cannot be determined because there was no control group to confirm that more individuals pursued treatment than they would have without the program.

In the second screening program evaluation, 592 girls and 435 boys who took part in the screening and evaluation, and the EAT-26 scores of 71 girls and 5 boys indicated that further investigation of their eating psychopathology was warranted. D’Souza, Forman & Austin (2005) found that half of the girls and a third of the boys reported speaking to a peer or adult about their screening score, and the program also reportedly enhanced their awareness of eating disorders. However, only one girl and five boys said that they had met with a healthcare professional since the screening program. There was only 1 to 2 months between the implementation of the screening program and the post-screen evaluation, so this might have been too short a time frame for individuals to follow the recommendations of the screen.

Grunwald and Wesemann (2006) evaluated a different kind of intervention to enhance recognition of eating disordered symptoms and increase access to treatment. The study received a methodological rating of (-), but it is useful for considering the ways in which online consulting service for individuals with eating disorders and their relatives might operate as an intervention to enhance access to treatment. Of the 240 respondents who had contacted the service with concerns about eating problems, 55.4% had not turned to professional help pre contact. The same was true for 81.2% of the 85 of relatives who contacted the service. The service reportedly enabled 31.3% of individuals with eating concerns to gain insight into the need to seek professional help. It also improved knowledge of the disease for 22.5% of the eating disordered sample and 48.2% of their relatives, and it provided 27.9% of ED sample and 30.6% of relatives with more information about eating disorders. Finally, for some, the service helped them have more conversations about eating disorders (32.1% of ED sample and 52.9% of relatives).

Three studies highlighted a role for friends and family members in terms of facilitating access to treatment for those individuals with eating disorders. Becker et al. (2001) found that ‘being encouraged by friends or family’ was endorsed as a facilitator by 22.9% of the 35 treatment seeking women in their sample. Similarly, Cachelin and Striegel-Moore’s (2006) found that ‘encouragement by friends’ was a popular reason for seeking treatment amongst the treatment-seeking women with eating disorders in their sample, and they also endorsed ‘initiated by parents.’ In addition, ‘comments about changes in appearance and behaviour’ was a theme that emerged from Hepworth and Paxton’s (2007) interviews in connection with enhancing problem recognition.

3) Functional and health impairment

Seven level 2 and one level 3 studies, implicate psychological distress, other forms of health impairment, and an interference with everyday function as potential prompts to help seeking. Seven of these studies have methodological ratings of (++) and one has a rating of (+) (studies 4, 5, 6, 10, 12, 15, 17 and 19 in table 2).

The second most popular reason for having sought treatment was ‘feelings of anxiety and depression,’ reported by 31.4% of the 35 women in Cachelin et al.’s (2001) sub-sample of women with eating disorders who had sought treatment. ‘Concerns relating to physical health,’ ‘feeling physically uncomfortable’ and being ‘concerned about health problems’ were also reported as reasons, but to a lesser extent. Cachelin and Striegel-Moore (2006) found that ‘emotional distress’ and ‘health concerns’ were endorsed as reasons for help seeking, by their help seeking sample. However, other factors such as, ‘initiation by parents’, ‘encouragement by friends’ or ‘concerns about eating and weight’ emerged as more popular reasons for help seeking for this sample. ‘Psychological distress and a lack of control’ emerged as a theme linked with prompts to help seeking in Hepworth and Paxton’s (2007) study, as did ‘interference with life roles’ and ‘health-related problems’ but to a lesser extent. ‘Psychological problems’ and ‘interference with life roles’ also emerged as themes linked with problem recognition.

Keel et al. (2002) found that individuals who had a personality disorder at the start of their study, and those who reported poorer general functioning and a lifetime history of a mood disorder, were significantly more likely to have accessed treatment over the five years that their study was conducted than those who did not. Perkins, Klump, Cacono & McGue (2005) found that the 27 treatment seeking women with AN in their sample had higher levels of negative emotionality, stress reaction and alienation than the 13 non-treatment seeking women with AN. Mond, Hay, Rodgers & Owen (2007a) found that for a community sample of women with bulimic-type eating disorders, high levels of functional impairment was one of two variables that were most strongly associated with receiving general treatment for an eating problem, and one of three variables that were most strongly associated with being treated for an eating problem by a mental health professional.

Cachelin et al. (2006) revealed that psychiatric co-morbidity differentiated women who had sought treatment for their eating disordered symptoms from those who had not. However, when the predictive power of psychiatric co-morbidity was tested alongside six other factors, it no longer predicted treatment engagement. Amongst 158 individuals with bulimic eating disorders, Mond et al. (2006) found that problem recognition was associated with significantly higher levels of general psychological distress than non recognition, and problem recognition was significantly linked with an increased likelihood of receiving treatment. However, when a logistic regression was used to explore the relative predictive powers of several factors on recognition, psychological distress was no longer linked. Self-induced vomiting and BMI were the only variables that were significantly associated with recognition.

4) Type and severity of eating disorder

The type and severity of eating disorder symptoms have been explored as potential facilitators of help seeking by seven level 2 studies, and one level 3 study, five of which received methodological ratings of (++) and 3 of (+) (studies 5, 6, 10, 12, 13, 14, 15 & 17 in table 2).

Cachelin and Striegel-Moore (2006) found that concerns relating to weight and eating were endorsed by more than 50% of their treatment-seeking sample. For Hepworth and Paxton (2007), increased symptom severity regarding eating and weight was the most prominent theme that emerged from interviews with 63 women with past or present bulimic psychopathology. In addition, Meyer (2005) found that participants with more severe levels of eating psychopathology were more likely to be in psychotherapy than those with less severe eating psychopathology.

Keel et al. (2002) found that the severity of eating disorder symptoms significantly predicted treatment utilization during subsequent years. They also found that women with AN spent significantly longer in in-patient and group treatment than did individuals with BN. However, this difference was no longer significant when they controlled for in-patient treatment.

Meyer (2001) found that individuals who met the criteria for an eating disorder were more likely to agree that their eating concerns merited counselling than were individuals who met sub-threshold criteria for an eating disorder. Similarly, Mond et al. (2006) found that problem recognition was significantly linked with higher levels of eating psychopathology, a larger body mass index and more self-induced vomiting, and problem recognition was significantly linked with treatment seeking. In addition, self-induced vomiting and higher BMI were the variables that best predicted problem recognition when compared with other variables such as eating concern, age, and psychological distress.

Mond et al. (2007a) found that a lifetime diagnosis of binge eating disorder was one of two variables most strongly associated with seeking treatment for an eating problem in a community sample of women with bulimic-type eating disorders. Alongside high levels of functional impairment, a lifetime diagnosis of anorexia nervosa or bulimia nervosa (purging sub-type), were the variables most strongly associated with treatment for an eating problem by a mental health professional. Cachelin et al. (2006) found that alongside ethnicity and heightened psychiatric co-morbidity, treatment seeking for women with eating psychopathology was associated with suffering from bulimia nervosa, engaging in more frequent purging and having a longer duration of disorder.

Discussion

This review aimed to systematically evaluate the empirical literature relating to the barriers and facilitators of help seeking, amongst individuals with eating psychopathology, in order to generate ideas for future research to further develop the evidence base. In addition, tentative recommendations that are generated from the review could provide a resource for professionals and stake holders to draw upon for ideas and interventions.

The current evidence will be critiqued by generating two models. The first model will represent the potential barriers, and the second, the potential facilitators, of help seeking for individuals with eating psychopathology. Directions for future research will also be considered and the clinical implications of the current findings will be provided. Finally, recommendations stemming from the current review will be outlined.

Modelling the barriers of, and the facilitators to, help seeking

The examination of the literature regarding the potential barriers and facilitators of help seeking amongst individuals with eating psychopathology has revealed that the evidence base is in its infancy. Most of the studies included in the current review were cross-sectional in design, despite the fact that the best studies for mapping temporal precedence are those employing prospective and experimental methodology, where independent variables predict a subsequent change in dependent variables (Stice & Shaw, 2002). Nevertheless, the collation of the current evidence offers a starting point from which to develop two models that consider help seeking as a sequential process. Using these models, hypotheses will be generated regarding the points along the help seeking process at which particular barriers and facilitators are likely to operate. Future studies with more complex designs could then test these hypotheses.

1) Developing a model of the barriers to help seeking

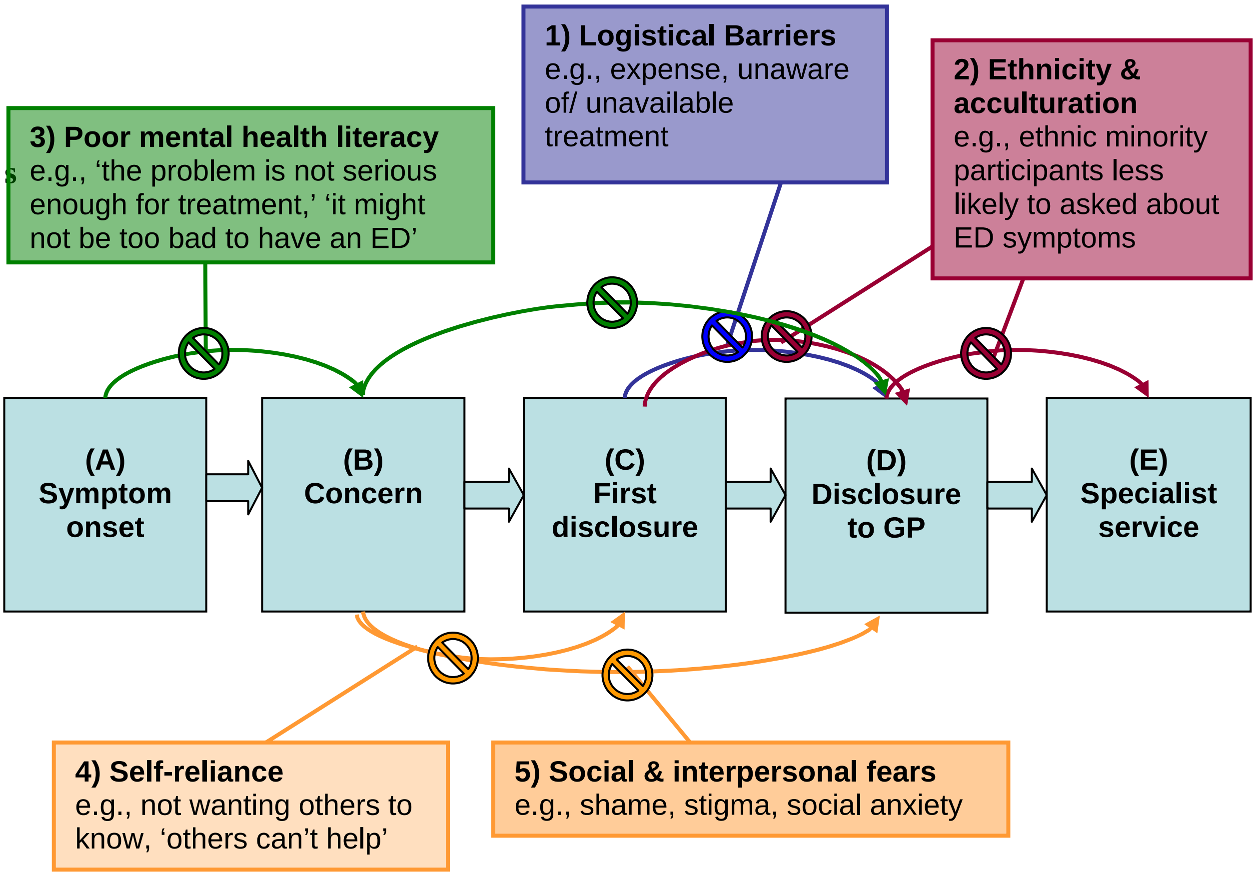

Figure 4 - The points along the help seeking path at which potential barriers might operate

‘Expense’ was a commonly reported logistical barrier (box 1 of figure 1.4). Less prominent barriers included ‘not knowing about resources’ or ‘unavailability of professional treatment,’ ‘inconvenience’ and a ‘lack of transportation.’ Future work could develop consensus regarding the factors that constitute logistical barriers, and determine their relative importance. Logistical barriers are proposed to operate later in the help seeking process (see figure 1.4), most likely, by impeding access to the G.P. and specialist services.

Ethnic minority status emerged as a barrier to accessing treatment (box 2 of figure 1.4). Indeed, one prospective study showed this relationship even after controlling for eating disorder severity. The null relationship found by one study, was likely to have been due to methodological difficulties. Future large-scale and prospective research is required to corroborate this proposal. Nevertheless, the current evidence suggests that ethnic minority individuals are less likely to have sought help from their G.P., and to have been asked by a medical professional about their eating psychopathology. Therefore, as figure 1.4 illustrates, it is proposed that ethnicity and acculturation might prevent access to the G.P., and service-related factors might also cause help seeking delays for individuals with ethnic minority status. Future work could test these proposals.

Regarding mental health literacy (box 3 of figure 4), evidence implicated beliefs relating to the ‘problem not being serious enough,’ or that ‘there was no problem,’ as barriers to help seeking. In addition, some evidence suggested that individuals might hold unhelpful beliefs about the usefulness of treatment and professionals. However, professionals seemed more likely to enable access to treatment than other individuals in the person’s social network. Regarding figure 4, the evidence for mental health literacy seems to have focused upon it operating as a barrier at the earliest stages of the help seeking process. However, beliefs, for example, regarding the efficacy of treatment, could also be operating at a later stage of the help seeking process, and future work could explore this.

Self-reliance factors, i.e., beliefs such as ‘I can handle it on my own’ or ‘I don’t want others to know’ were implicated as barriers (box 4 of figure 4). Development of the evidence base relating to self-reliance factors would benefit from clarifying its definition, and testing its relative impact by comparing it with other barriers. Considering figure 4, self-reliance factors are hypothesised to work as barriers mainly between developing concern and disclosing to others.

Shame and stigma were more commonly endorsed than other barriers (box 5 of figure 4). As figure 4 shows, social and interpersonal fears are proposed to exacerbate the delay between developing concern and disclosing to other individuals including the G.P. Future prospective research could test the impact of shame and stigma on impeding access to services.

In summary, addressing barriers relating to logistics and ethnicitys is likely to require service level interventions. These might involve improving the access and availability of eating disorder services, and raising awareness at a primary care level that disparities might exist regarding the identification of eating disorders amongst individuals with ethnic minority status. Barriers relating to poor mental health literacy might more usefully be addressed by targeting the whole population regarding the seriousness of eating psychopathology, how to handle a disclosure, or where to go if you have eating-related concerns. The barriers of self-reliance and social and interpersonal fears might be overcome by intervening at the level of families and friends, perhaps by encouraging them to raise concerns, and enabling them to support the person with eating psychopathology to access more specialist help. It is also important to remember that the evidence suggests that lay people (including family and friends) seem to play a role in normalising disordered eating attitudes and impeding the help seeking process and it will be important to consider this in any intervention work.

2) Developing a model of the facilitators of help seeking

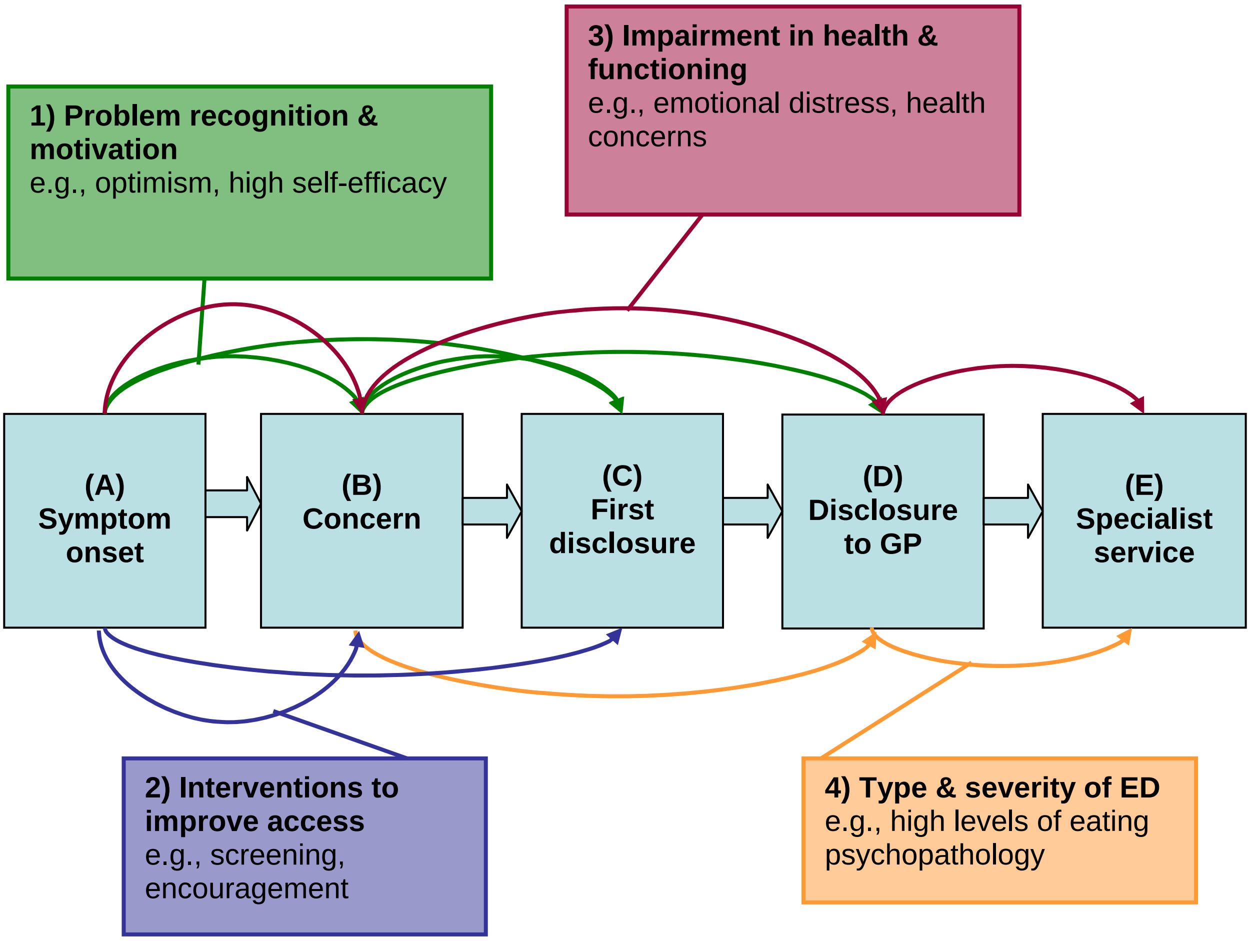

Figure 5 - The points along the help seeking path at which potential facilitators might operate

Problem recognition was associated with receiving treatment (box 1 of figure 5). The directional nature of this relationship needs to be determined. However, recognition rates amongst individuals with eating psychopathology who are not receiving treatment are around 50%, leaving scope to develop interventions to improve recognition and speed the help seeking process. In addition, preliminary evidence suggests that optimistic beliefs and enhanced self-efficacy might facilitate an individual's access to treatment. Further work is required to consolidate these findings, but interventions to enhance self-efficacy amongst individuals with high levels of eating psychopathology could improve the speed of their help seeking. Figure 4 illustrates that problem recognition and a motivation to get better are hypothesised to operate at the early stages of the help seeking process, but they may also be important later on in the process, and future work could test this.

Evidence regarding interventions to enhance recognition and facilitate help seeking was weak. However, the interventions that were investigated aimed to address some of the barriers to help seeking. The lack of strong findings might be because such interventions are hypothesised to operate during the early stages of the help seeking process (see box 2, figure 5), and they tend to be prospective in design. Consequently, even if they were effective in terms of raising an individual’s level of concern regarding their eating behaviours, we have seen that barriers later on in the help seeking process could then impede access to services. Furthermore, the average latency between the development of eating disordered symptoms and accessing services is approximately 4 years (Cachelin et al., 2001; de la Rie et al., 2006). The studies evaluating screening programs had much shorter follow-up periods, so it is unlikely that individuals would have moved through the different phases of help seeking when the studies were conducted. Future work would benefit from breaking the help seeking process into phases and exploring the impact of interventions on reducing the latency between each phase.

There was considerable evidence linking heightened psychological distress, health impairment and an interference of everyday functioning with help seeking. Some individuals reported that concerns regarding the impact of physical and psychological health had prompted them to seek help. In addition, the association between psychiatric co-morbidity and treatment utilization could indicate that co-morbid psychopathology, such as mood disorders, are easier to detect in primary care settings. Consequently, this might facilitate treatment access even without eating psychopathology detection. Figure 5 illustrates these two possibilities. It will be important to generate evidence to support or refute these proposals, and develop interventions accordingly.

There was strong support for eating disorder symptom severity (box 4 of figure 5) as a facilitator of help seeking. Perhaps this is a reflection of the high levels of demand many services face, which means that only those individuals with the most severe levels of eating psychopathology are able to access treatment. However, it could also be linked with misguided health beliefs held by society, that a degree of eating psychopathology is normal (Polivy & Herman, 1987). Future work could explore the interplay between the barrier of mental health literacy and the facilitator of heightened eating psychopathology in prolonging or shortening help seeking. A small body of evidence suggested that certain presentations such as having a diagnosis of either anorexia nervosa (AN) or bulimia nervosa (BN) were linked with help seeking. This is concerning because diagnoses of AN, and BN, are far less common than of eating disorder not otherwise specified (EDNOS) (e.g., Machado, Machado, Goncalves & Hoek, 2007). This finding might reflect a lack of knowledge on the part of primary care providers, and if this is true an important intervention will be improve this.

In summary, it seems that evidence regarding facilitators of help seeking has focused on reactive indicators, such as high levels of co-morbid psychopathology, health concerns and more severe eating disordered symptoms. It seems that individuals need to get to the point where they are causing physical damage to themselves, and their life has been severely impacted before they, society, and healthcare providers recognise that they need help. Preliminary work has focused on the barriers and facilitators that might operate at a much earlier point in the help seeking journey, and there is room to consolidate and expand this work to generate further proactive interventions.

Recommendations

The current evidence base, regarding barriers and facilitators of the help seeking process for individuals with eating psychopathology, requires consolidating and expanding with more complex study designs. Nevertheless through the collation of the existing literature several recommendations could be made:

- Future research and intervention work could conceptualise help seeking as a process, and consider the intervals during this process at which barriers and facilitators are most likely to operate. This would enable stronger support to be generated for factors that might exert an influence earlier on in the help seeking process.
- Future research could explore the relative strengths of barriers and facilitators of help seeking, to determine which are more important at each stage of the help seeking process
- In terms of facilitators, a shift in focus is needed from reactive factors, such as heightened eating psychopathology, towards more proactive facilitators, such as interventions to improve recognition and enhance self-efficacy.

Conclusions

The current evidence base requires consolidation and development. In addition, some barriers and facilitators have been thoroughly explored, whereas others have received less attention. For example, there is a great deal of evidence to support more reactive facilitators of help seeking. This evidence suggests that individuals need to get to the point where they are causing physical damage to themselves, and their life has been severely impacted before they, society, and healthcare providers recognise they need help. However, fewer studies have focused on the more proactive facilitators of help seeking. These include facilitators that a centred within the individual themselves, such as a motivation to get better, or those initiated by services and other individuals to facilitate the help seeking process. A focus on the factors that might operate earlier on in the help seeking process is more likely to generate ideas and interventions to achieve earlier access to treatment and a better prognosis for individuals with eating disorders.

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Empirical Paper

Should I mention eating? Disclosure of eating disorders and subsequent help seeking

Nicola Gilbert

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Correspondence to: Dr Nicola Gilbert, Department of Clinical Psychology, School of Psychology, University of Birmingham, Edgbaston, Birmingham, B15 2TT, United Kingdom. Telephone: +44 (0)121 414915. E-mail: njg777@bham.ac.uk

Running head

DISCLOSURE OF EATING DISORDERS

Abstract

Objective: To retrospectively explore the first disclosure of an eating problem and the impact of specific disclosure factors on subsequent help seeking, amongst women with eating disorders. **Method:** Seventy one eating disorder service users completed a structured Eating Disorder Disclosure Interview (EDDI), the Eating Disorders Examination Questionnaire (EDE-Q), the Rosenberg Self Esteem scale (RSE) and the Hospital Anxiety and Depression Questionnaire (HADS). **Results:** Being older at first disclosure was linked with faster access to specialist services. First disclosures to mothers and friends were more common than to other categories of confidants. Appraisals of ‘other-initiated’ and ‘volunteered’ disclosures did not differ. However, individuals involved in ‘other-initiated’ disclosures were younger and accessed help more quickly than those who ‘volunteered’ their disclosure. The more positively ‘other-initiated’ disclosures were appraised the quicker the subsequent help seeking. **Conclusion:** Since instigated disclosures are experienced as positively as volunteered disclosures, but linked with faster help seeking, people *should* mention eating.

Key words: eating disorders; help seeking; disclosure; access to services.

Should I mention eating? Disclosure of eating disorders and subsequent help seeking

If eating disorders are detected early, prognosis is favourable (Deter & Herzog, 1994; Howard, Evans, Quintero-Howard, Bowers & Andersen, 1999). However, evidence suggests an average delay of approximately 4 years between eating disordered symptom onset and first treatment contact (Cachelin, Rebeck, Veisel & Striegel-Moore, 2001; de la Rie, Noordenbos, Donker & van Furth, 2006), and this delay can extend to 10 years for some individuals (de la Rie, et al., 2006). Longer delays are related to a poor long-term outcome (Reas, Williamson, Martin & Zucker, 2000).

One difficulty is that eating behaviours are covert and difficult to detect (Becker, Thomas, Franko & Herzog, 2005), resulting in a reliance on the individual first to <u>acknowledge</u> their eating concerns and then to <u>disclose</u> them to another individual. However, individuals with eating concerns are reluctant to disclose them (Becker, Grinspoon, Klibanski & Herzog, 1999). Potential barriers include social and interpersonal fears, self-reliance, and a belief that eating disorders are not serious (e.g., Becker, Franko, Nussbaum & Herzog, 2004; Cachelin et al., 2001; Meyer 2001). Following disclosure, practical difficulties and service-related factors, such as the unavailability of professional treatment (e.g., Becker et al., 2004; Cachelin et al., 2001), could account for additional delay between symptom onset and treatment access (de la Rie et al., 2006). Nevertheless, for individuals with eating psychopathology, the disclosure of eating concerns represents an important first step towards seeking help. Consequently, exploring this first disclosure interaction could generate ways to speed the help seeking process.

To date, only one study has looked at the disclosure process amongst individuals with eating disorders (Becker et al., 2005). This study found differences in disclosure patterns of eating concerns to different groups of people (e.g., friend, parent, teacher, healthcare professional etc). A limitation of the study was that they did not focus specifically on the first disclosure. In addition, disclosure was treated as a discreet event (i.e., a yes/ no response for whether individuals had disclosed). This is despite evidence to suggest that disclosing information is a complex social interaction (Antaki, Barnes & Leudar, 2005).

Whilst research regarding disclosure factors and eating concerns is limited, there is a growing evidence-base relating to the disclosure of other forms of sensitive information (e.g., secrets - Afifi & Caughlin, 2006, and sexual abuse - Goodman, Jones & Gordon, 2003). Drawing on this literature, and combining it with evidence from eating disorder research, several factors could influence the nature of the disclosure interaction and the speed of help seeking. Key factors include: 1) age at first disclosure, 2) the individual’s appraisal of the disclosure process, 3) the identity of the confidant, and 4) the method of the disclosure.

First, amongst individuals with eating disorders, older individuals are more likely to have more entrenched symptoms. For individuals who first disclosed when they were older, there would have been more time for symptoms to develop and possibly escalate pre disclosure, compared with individuals who first disclosed at a younger age. Consequently, such individuals might be more ready to acknowledge their symptoms and seek help, and the people and services around them might be more likely to provide it. Indeed, treatment access for individuals with eating psychopathology is associated with having a longer duration of disorder and greater levels of eating-related distress (Cachelin, Striegel-Moore & Regan, 2006; Cachelin, et al., 2001), reflecting the reactive nature of most eating disorder services. It will be important to explore whether individuals who disclosed when they were older, subsequently accessed help more quickly than those who disclosed when they were younger.

Second, an individual’s *appraisal* of the disclosure process is likely to impact on their subsequent help seeking. In particular, disclosing sensitive information is not always beneficial (e.g., Strobe, Schut & Strobe, 2005). For example, Afifi and Caughlin (2006) found that secret revelation led to decreased rumination and improved self-esteem, but only for individuals who experienced positive reactions from the person with whom they shared their secret. Such links between more positive appraisals of the disclosure experience and positive outcomes such as increased speed of help seeking have not been tested amongst individuals with eating psychopathology.

Third, the identity of the confidant might influence the disclosure interaction. Whilst friends, partners and parents are the most popular confidant to be involved in disclosures amongst individuals with eating psychopathology (e.g., Becker et al., 2005; Hepworth & Paxton, 2007), there is evidence to suggest that poor mental health literacy regarding eating disorders might exist amongst some of these individuals (e.g., Holliday, Wall, Treasure & Weinman, 2005; Mond & Marks, 2007). Mond and Marks (2007) found that lay individuals held beliefs such as *"it would not be too bad to have an eating disorder."* Such beliefs could impair both their ability to support an individual during the disclosure process, and their ability tos facilitate subsequent help seeking. In line with this, Becker at al. (2005) found that disclosure to friends, partners and parents was not associated with access to treatment, whereas disclosure to the G.P. or to healthcare professionals was linked with accessing treatment. It will be important to examine the impact of confidant identity on help seeking, and test whether Becker et al.'s (2005) findings are replicable.

Fourth, amongst people with a broad range of mental health concerns, Vogel, Wade, Wester, Larson and Hackler (2007) found that being prompted to seek help was related to more positive attitudes towards help seeking. Such attitudes have been linked with a greater chance of actual help-seeking behaviour (Bayer & Peay, 1997; Carlton & Deane, 2000; Cramer, 1999). It is also possible that by instigating a disclosure, a confidant might facilitate problem recognition. This could then speed up subsequent help seeking since enhanced problem recognition has been linked with greater access to treatment (e.g., Mond, Hay, Rogers & Owen, 2006). Links between 'other-initiated' disclosures and subsequent help seeking have yet to be tested, but Becker et al. (2005) found that the majority of individuals with eating disorders (90.3%) who had not yet disclosed their eating concerns were willing to disclose them if asked, and parents were involved in the most ‘other-initiated’ disclosures (44.2%). They concluded that individuals were amenable to disclosing symptoms if asked, but included no measure of the appraisal of the disclosure interaction. It will be important to test whether parents are the most likely confidants to initiate disclosures, and whether ‘other-initiated’ disclosures are appraised as favourably as ‘volunteered’ disclosures. ‘Other-initiated’ disclosures are hypothesised to happen more quickly than ‘volunteered’ disclosures. They are also predicted to lead to faster help seeking than ‘volunteered’ disclosures. These hypotheses, along with the impact of the appraisal of these two methods of disclosure on subsequent help seeking, require testing amongst individuals with eating disorders.

In summary, knowing more about the first disclose interaction could provide ways to speed the help seeking process for individuals with eating psychopathology. However, to date, only one study has been conducted with a focus on disclosure amongst individuals with eating disorders (Becker et al., 2005). Evidence from the disclosure of other forms of sensitive information, and from existing eating disorder research, suggests that factors such as age at first disclosure, the appraisal of the disclosure event, the role of the confidant, and the initiation method of the disclosure, might impact on the first disclosure and the speed of help seeking. However, these hypotheses require testing amongst individuals with eating disorders.

This clinical study of women with eating disorders is an extension of Becker et al.’s (2005) study, with a focus on the first disclosure interaction and subsequent help seeking. It has three aims. The first aim is to determine the impact of specific disclosure factors on the subsequent speed of help seeking. The second aim is to determine the identity of disclosure confidants for this group, and then to explore the impact of confidant identity on the speed with which help was accessed. The third aim is to examine the method of first disclosing (‘volunteered’ versus ‘other-initiated’) and determine its links with the speed of help seeking.

In line with the first aim, it is hypothesised that, women who were older at first disclosure, will seek help significantly more quickly than those who were younger. In addition, more positive disclosure experiences are predicted to be significantly associated with earlier help seeking. Linked to the second aim, it is predicted that participants will report more first disclosures to friends, partners and parents than to other individuals. However, first disclosures to healthcare professionals are predicted to be associated with earlier subsequent treatment access compared with disclosures to other confidants. For the third aim, parents are predicted to be involved in more 'other-initiated' disclosures compared with other types of confidant. In addition, in keeping with the findings of Vogel et al. (2007), it is hypothesised that 'other-initiated' disclosures will be appraised as favourably as 'volunteered' disclosures and that 'other-initiated' disclosures will happen significantly earlier, and lead to earlier help seeking than 'volunteered' disclosures. Finally, it is predicted that 'other-initiated' first disclosures that are positively appraised will be linked to faster subsequent help seeking than those that received negative appraisals.

Method

Participants

The participants were 71 women with a broad range of eating problems, at various stages of treatment and recovery. All were volunteers, and received no payment for participating. They were recruited from two secondary eating disorder services. One is a voluntary organisation taking both primary care and self-referrals for individuals with eating problems, and the other is a specialist NHS eating disorder service taking referrals from primary care and other secondary services. The mean age of the women was 28 years, 9 months (SD: 9.98, range: 15 years, 8 months – 62 years, 2 months). The first disclosure of an eating problem to another individual occurred on average 6 years, 2 months prior to this study (SD: 5.60, range: 1 month – 24 years, 2 months).

Measures and Procedure

Following ethical clearance and informed consent, participants were interviewed and completed a series of questionnaires. This took approximately 40 minutes.

The Eating Disorder Disclosure Interview (EDDI): A structured interview schedule, the EDDI, was developed to explore the first disclosure interaction. The EDDI consisted of questions to obtain the characteristics of, and appraisals regarding the disclosure experience. The Session Evaluation Questionnaire, (SEQ; Stiles & Snow, 1984), a measure to assess psychotherapy and counselling sessions, formed the basis of the EDDI. It was adapted slightly for the current purposes, through consultation with service-users and professionals.

First, a series of tick-box questions captured demographic information and recorded whether the disclosure was ‘volunteered’ or ‘other-initiated.’ In addition, respondents were required to provide the age (in years and months) at which they: a) became concerned about their eating, b) first disclosed their concerns to another person, c) first disclosed their concerns to their General Practitioner (G.P.), and d) accessed specialist eating disorder services. In addition, participants identified the category to which the person to whom they first disclosed their eating concerns belonged (from a list of 21 options). This list was derived from categories used by Becker et al. (2005) and expanded by drawing on other help-seeking studies (Kelly, Klusas, von Weiss, & Kenny, 2001; Wilson, Deane, Ciarochi & Rickwood, 2005). Twenty six potential confidants were refined to 21 by amalgamating some categories, e.g., ‘spouse,’ ‘boyfriend’ and ‘girlfriend’ became a ‘partner’ category, and by omitting categories that were specific to American participants e.g., ‘resident assistant.’

For the next phase of the EDDI, the Session Evaluation Questionnaire (SEQ) was adapted to create a Disclosure Evaluation Tool (DET), which captured participants’ appraisals of the disclosure interaction. The original SEQ has 11 bi-polar adjectives to describe a therapy session and 10 bi-polar adjectives to describe the way the client felt after this therapy session, and participants’ respond to adjective pairs such as happy-sad on a 7-point likert-scale. The instructions for the measure and the bi-polar adjectives were not changed. However, the wording that preceded each of the two sets of adjective pairs was amended slightly. Set one was proceeded by "*the disclosure was*:" and set two was proceeded by "*after sharing my concerns with this person I felt*:" Kelly, et al. (2001) adapted the measure in a similar way to assess participant's recollections of how they felt after sharing their secrets with confidants, and obtained an alpha co-efficient of 0.91 for the scale. The alpha for the DET was 0.75 for the current sample.

Following the EDDI, participants completed a series of questionnaires that captured their current eating attitudes, self-esteem, anxiety and depression in the order outlined below.

The Eating Disorder Examination Questionnaire (EDE-Q). The EDE-Q (Fairburn & Beglin, 1994) is a 36-item questionnaire version of the Eating Disorders Examination interview. This provides 4 subscale scores relating to restraint, eating-, shape- and weight-concerns, a global score, and diagnostic information such as frequency of binge episodes. Each item is rated on a scale from 0 to 6, apart from frequency items for which respondents provide an overall frequency for the previous month. High scores indicate greater psychopathology. The EDE-Q has been shown to be a reliable and valid measure amongst both clinical and non-clinical populations, with an overall Chronbach's alpha of 0.90, and alphas for the four sub-scales ranging from 0.70 to 0.83 (Peterson, Crosby, Wonderlich et al. 2007). The overall alpha was 0.85 for the current sample, and the alphas for the sub-scales ranged from 0.74 to 0.90.

The Hospital Anxiety and Depression scale HADS. The HADS (Zigmond & Snaith, 1983) is a 14-item self-report measure developed to detect current levels of anxiety and depression. Each item is answered on a four point likert scale. High scores reflect greater psychopathology. The HADS has been shown to be both a reliable and a valid measure (e.g., Crawford, Henry, Crombie & Taylor, 2001). In the current sample the alpha co-efficient for the HADS total scale was 0.89.

Rosenberg Self-Esteem scale (RSE). The RSE (Rosenberg, 1965) is a self-report measure of general self-esteem. Respondents indicate whether they strongly agree, agree, disagree, or strongly disagree with ten statements. Half of the statements are positive and half are negative. An example of a negative item is ‘I feel I do not have much to be proud of.’ High scores indicate low levels of self-esteem. Within non-clinical populations, the RSE has a Cronbach’s alpha of 0.88 and one-week test re-test reliability of 0.82 (Fleming & Courtney, 1984). For the current sample the scale had an alpha of 0.89.

Data analysis

Kolmogorov-Smirnov Z tests indicated that the data were not normally distributed so non-parametric tests were adopted throughout. For the descriptive statistics, Mann-Whitney tests were used to test for differences between the characteristics of the samples drawn from the two eating disorder services. In addition, Friedman and post-hoc Wilcoxon tests were used to explore differences in disclosure and help seeking latencies.

To test the hypotheses linked with the first aim, Spearman’s rho correlations were used to ascertain the impact of age and disclosure experience on the speed of subsequent treatment seeking. For the hypotheses linked with the second aim, Chi-square tests were used to test differences between categorical variables, such as the differences in frequency amongst categories of first disclosure confidant. Kruskal Wallis and post-hoc Mann-Whitney tests were then used to compare the women’s ages across different groups of confidants and investigate the impact of confidant identity on the subsequent speed of treatment seeking. To test the three predictions linked to the third aim, first, Mann-Whitney tests were used to compare ‘volunteered’ versus ‘other-initiated’ disclosures in terms of sample characteristics, aspects of pathology, age at each stage of the disclosure process and disclosure latencies. Then Chi-square tests were used to test the relationship between ‘volunteered’ and ‘other-initiated’ disclosures and the category of first confidant. Finally, Spearman’s rho correlations were used to compare 'volunteered' and 'other-initiated' disclosures in terms of associations between the appraisal of the disclosure and the speed of subsequent help seeking.

Results

Characteristics of the sample

Table 1 shows the mean age, DET, EDE-Q, HADS and RSE scores for the total sample (N = 71), and for participants from service one (N = 35) and those recruited from service two (N = 36).

Table 1 - Characteristics (age, DET, EDE-Q, RSE and HADS scores) of the sample.

	Total sample (N = 71)		Service one (N = 35)		Service two (N = 36)	
	Mean	(SD)	Mean	(SD)	Mean	(SD)
Current age	28.9	(9.98)	28.8	(9.84)	29.0	(10.3)
Disclosure experience						
DET	69.9	(13.1)	68.3	(14.9)	71.5	(11.0)
EDE-Q scales						
Restraint	3.23	(1.84)	3.60	(1.65)	2.86	(1.97)
Eating concern	3.40	(1.41)	3.37	(1.42)	3.45	(1.44)
Shape concern	4.52	(1.46)	4.40	(1.55)	4.66	(1.37)
Weight concern	3.95	(1.59)	4.01	(1.56)	3.90	(1.64)
Global	3.79	(1.32)	3.84	(1.33)	3.73	(1.32)
HADS & RSE Scale						
Anxiety	13.2	(4.13)	13.5	(4.09)	12.9	(4.20)
Depression	8.78	(4.40)	9.00	(4.20)	8.56	(4.63)
Self esteem	19.9	(5.65)	19.0	(5.69)	20.8	(5.56)

Note: DET = Disclosure Evaluation Tool; HADS = Hospital Anxiety and Depression Scale; RSE = Rosenberg Self Esteem.

For the sample as a whole, scores for the EDE-Q sub-scales and the RSE were slightly lower than those reported in clinical populations (e.g., Hughes, Hamill, van Gerko, Lockwood & Waller, 2006; Rockert, Kaplan & Olmsted, 2007) reflecting the fact that the current sample consisted of individuals at various stages of treatment and recovery for an eating disorder. In a more comparable sample of 47 women with current and past eating disorders, the current sample had slightly more pathological scores on the HADS (Holliday, Tchanturia, Landau, Collier & Treasure, 2005).

Participants recruited from the two different services seemed to have similar characteristics. Mann-Whitney tests confirmed that there were no significant differences between the groups for any of the characteristics.

The speed of the disclosure and help seeking processes

The mean ages of participants at the four stages of the disclosure and help seeking process are presented in figure 1. These scores indicate that the majority of individuals developed concern first (A), followed by the first disclosure (B), the G.P. disclosure (C) and access to eating disorder services (D). It is worth noting that 27 individuals (38%) reported that their concern developed either at the same time as, or just after, their first disclosure. In addition, for 10 individuals (14.1%), the G.P. was the person to whom they first disclosed.

Figure 1 also provides disclosure and help seeking latencies (in months) between the stages of the disclosure and help seeking process: (A) concern, (B) first disclosure, (C) disclosing to the G.P., and (D) access to eating disorder services. Latencies were calculated by converting respondents' ages, at each stage of the process, from years into months. These converted scores were used to create disclosure and help seeking latency scores. Latencies were the gap (in months) between the stages. Age (in months) at the later stage was subtracted from the age (in months) at the earlier stage to create a latency score. This process was repeated six times to create the six latencies presented in figure 1.

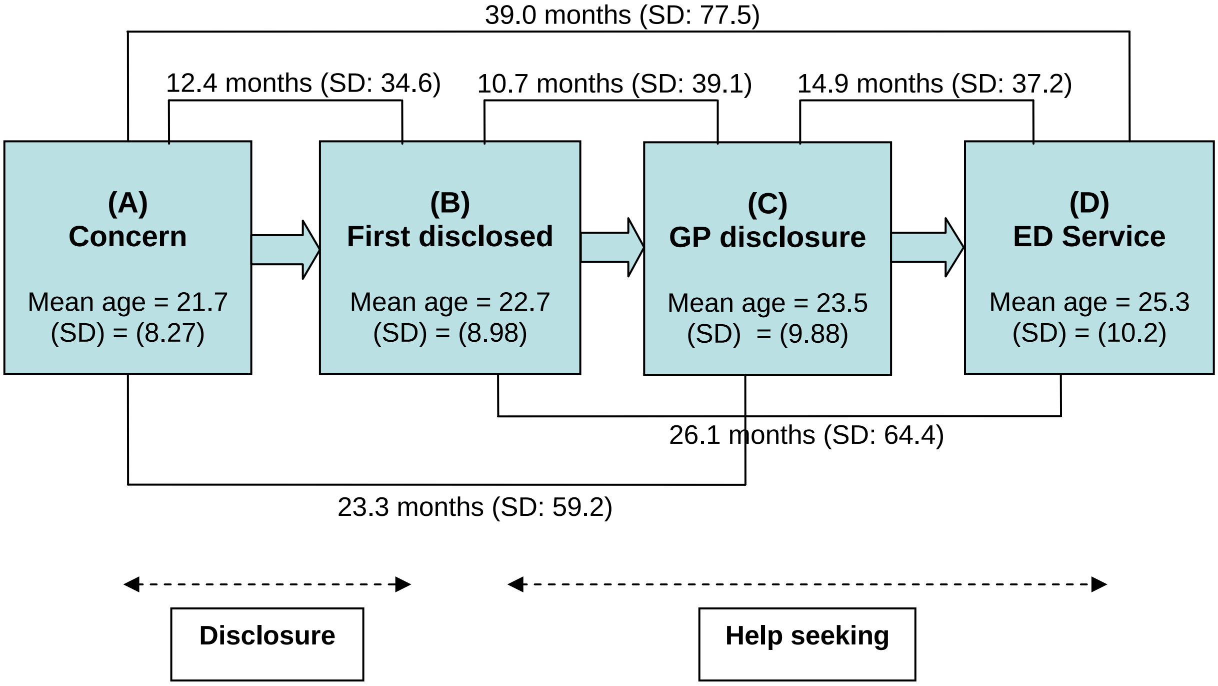


Figure 1 - Model outlining the mean age (in years) and the mean latencies (in months) of participants (N = 71) during the disclosure and help seeking process.

As figure 1 demonstrates, there were delays at each stage of the disclosure and help seeking process. Overall, the mean delay between developing concern and accessing specialist services (A to D) was 39 months (SD = 77.5). The average latency between developing concern and first disclosing (A to B) was 12.4 months (SD = 34.6), it was 10.7 months (39.1) from first disclosing to disclosing to the G.P. (B to C), and it was 14.9 months (SD = 37.2) from disclosing to the G.P. and accessing specialist services (C to D). A Friedman test revealed that these three latencies differed significantly (F(2) = 14.3, p = 0.001). Post-hoc Wilcoxon tests revealed that the latency between seeing the G.P. and accessing specialist services, and that between first disclosing and disclosing to the G.P., accounted for this significant difference (z = -2.32, p = 0.02), indicating that the delay between first disclosing and disclosing to the G.P. was significantly shorter than the delay between disclosing to the G.P. and accessing eating disorder services.

Impact of disclosure factors on the speed of help seeking

The latencies between first disclosing and disclosing to the G.P. (B to C), and between first disclosing and accessing specialist eating disorder services (B to D), provided an indication of the speed with which individuals accessed help following the initial disclosure. These ‘help seeking’ latencies were correlated (one-tailed Spearman’s rho) with disclosure factors, and table 1.2 provides the results of these analyses. Age at first disclosure was significantly and negatively correlated with the latency between the first disclosure and accessing eating disorder services, indicating that the older participants were at first disclosure, the faster their subsequent access to specialist services. All other correlations were non-significant.

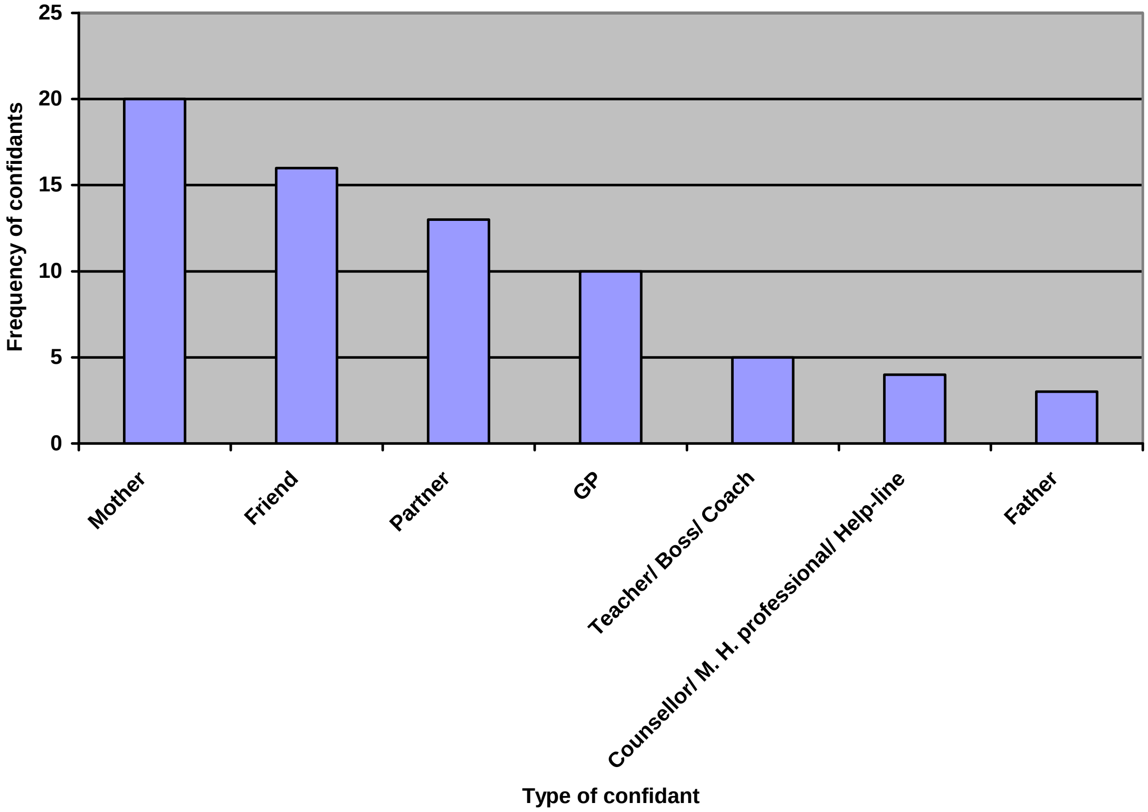
Table 2 - Associations (one-tailed Spearman’s rho) between the speed of help seeking with age at, and experience of, first disclosure, for the total sample (N = 71).

	Help seeking latencies	
	1st disclosure to G.P. (B to C)	1st disclosure to ED service (B to D)
Disclosure factors		
Age at first disclosure	.01	-.26*
Disclosure Experience Tool	-.13	-.02

* $p < 0.02$ (1-tailed)

Identity of the first disclosure targets

Figure 2 provides an indication of the numbers of each type of confidant who were involved in first disclosure interactions for the whole sample (N = 71).



<u>Figure 2</u> - Frequency of confidants involved in the first disclosure interaction

Figure 2 illustrates that mothers (28.1%) and friends (22.5%) were involved in the majority of first disclosure interactions. Additional confidasnts, in order of decreasing popularity, were: partners (18.3%), G.P. (14.1%), teacher, boss, coach (7%), counsellor, mental health professional, telephone help-line (5.6%), and fathers (4.2%).

A chi-square test revealed that these differences in frequency were significant ($X^2(6) = 25.13$; $p < 0.001$). An examination of the residuals revealed that the categories of mother, father, counsellor/ mental health professional/ telephone help-line, and friend varied the most from the expected cell value of 10.1, and contributed to this significant result. Suggesting that mothers and friends were significantly more popular than the other categories of confidants, and counsellor/ mental health professional/ telephone help-line, and fathers were significantly less popular than the other categories of confidants.

The identity of the first disclosure target and the speed of subsequent help seeking

For each type of confidant, table 3 shows respondent's mean ages and corresponding standard deviations at first disclosure. The youngest respondents were those who disclosed to their mothers, followed by teacher/ boss/ coach, partner, friend and father. Respondents who first disclosed to their G.P. were, on average, nearly 10 years older than those who first disclosed to their mothers, and those who disclosed to a counsellor, mental health professional or help-line were older still. A Kruskal-Wallis test of these differences was significant ($X^2(6) = 14.8$; $p < 0.01$ (1-tailed)). Post-hoc Mann-Whitney tests (with significance levels set at 0.01 to compensate for multiple tests) revealed that the difference between mother and friend contributed to this significant relationship ($z = -2.78$; $p < 0.01$). Individuals who disclosed to their mothers were significantly younger at first disclosure than those who disclosed to their friends.

Table 3 - Relationship between age at first disclosure and help seeking latencies (in months) with the type of confidant involved (N = 71).

		Age at first disclosure		Help seeking latencies (in months)			
				B to C		B to D	
Type of confidant	(N)	Mean	(SD)	Mean	(SD)	Mean	(SD)
(1) Mother	(20)	17.7	(4.46)	1.7	(3.79)	7.92	(14.2)
(2) Friend	(16)	25.1	(10.3)	34.4	(66.6)	68.3	(15.4)
(3) Partner	(13)	23.2	(5.32)	1.0	(64.8)	7.31	(17.1)
(4) G.P.	(10)	27.0	(13.4)	0	(0)	8.08	(21.1)
(5) Teacher/ Boss/ Coach	(5)	19.8	(4.44)	3.5	(5.69)	43.8	(30.9)
(6) Counsellor/ MHP/ help-line	(4)	29.0	(11.7)	3.25	(3.86)	12.1	(35.7)
(7) Father	(3)	23.3	(10.4)	41.3	(62.3)	45.0	(35.7)

For each category of confidant, table 3 shows the mean help seeking latencies (in months) between first disclosing and disclosing to the G.P. (B to C), and between first disclosing and accessing specialist services (B to D). The longest mean latencies were for individuals who first disclosed to fathers and to friends. Clearly, those who first disclosed to G.P.'s had no interval between first disclosing and disclosing to their G.P. Those who disclosed to partners and to mothers had the next shortest latencies. Similarly, individuals who disclosed to their partners and their parents had short B to D help seeking latencies, as did those who disclosed to their G.P. Two Kruskal-Wallis tests, with individuals who first disclosed to the G.P. excluded in the first analysis, revealed that these differences were not significant ($X^2(5) = 6.13$; $p = 0.15$; 1-tailed; and $X^2(6) = 1.39$; $p = 0.48$; 1-tailed).

Method of first disclosure

Table 4 displays the mean age and scores on the EDE-Q, RSE, and HADS for those women who 'volunteered' their disclosure versus those where the disclosure was 'other-initiated'. Mann Whitney tests revealed that the groups did not differ on any characteristic.

Table 4 - Characteristics (age, DET, EDE-Q, RSE and HADS scores) of the women with 'volunteered' versus 'other-initiated' disclosures.

	Method of first disclosure					
	Volunteered (N = 30)		Other-initiated (N = 41)		Mann-Whitney test	
	Mean	(SD)	Mean	(SD)	Z	P
Current age	31.2	(10.6)	27.3	(9.32)	-1.46	N.S.
Disclosure experience						
DET	70.4	(11.4)	69.5	(14.4)	-0.24	N.S.
EDE-Q scales						
Restraint	3.32	(1.84)	3.17	(1.86)	-0.23	N.S.
Eating concern	3.50	(1.33)	3.34	(1.49)	-0.34	N.S.
Shape concern	4.70	(1.13)	4.41	(1.66)	-0.02	N.S.
Weight concern	4.32	(1.40)	3.70	(1.68)	-1.50	N.S.
Global	3.96	(1.20)	3.67	(1.40)	-0.95	N.S.
HAD & RSE Scales						
Anxiety	12.8	(3.79)	13.5	(4.38)	-0.91	N.S.
Depression	9.37	(4.47)	8.34	(4.34)	-1.30	N.S.
Self esteem	20.6	(5.01)	19.4	(6.09)	-0.95	N.S.

Note: DET = Disclosure Evaluation Tool; HADS = Hospital Anxiety and Depression Scale; RSE = Rosenberg Self Esteem.

Method of first disclosure and the identity of disclosure targets

Figure 3 presents the frequency of confidants involved in 'volunteered' and 'other-initiated' first disclosures for the whole sample (N = 71).

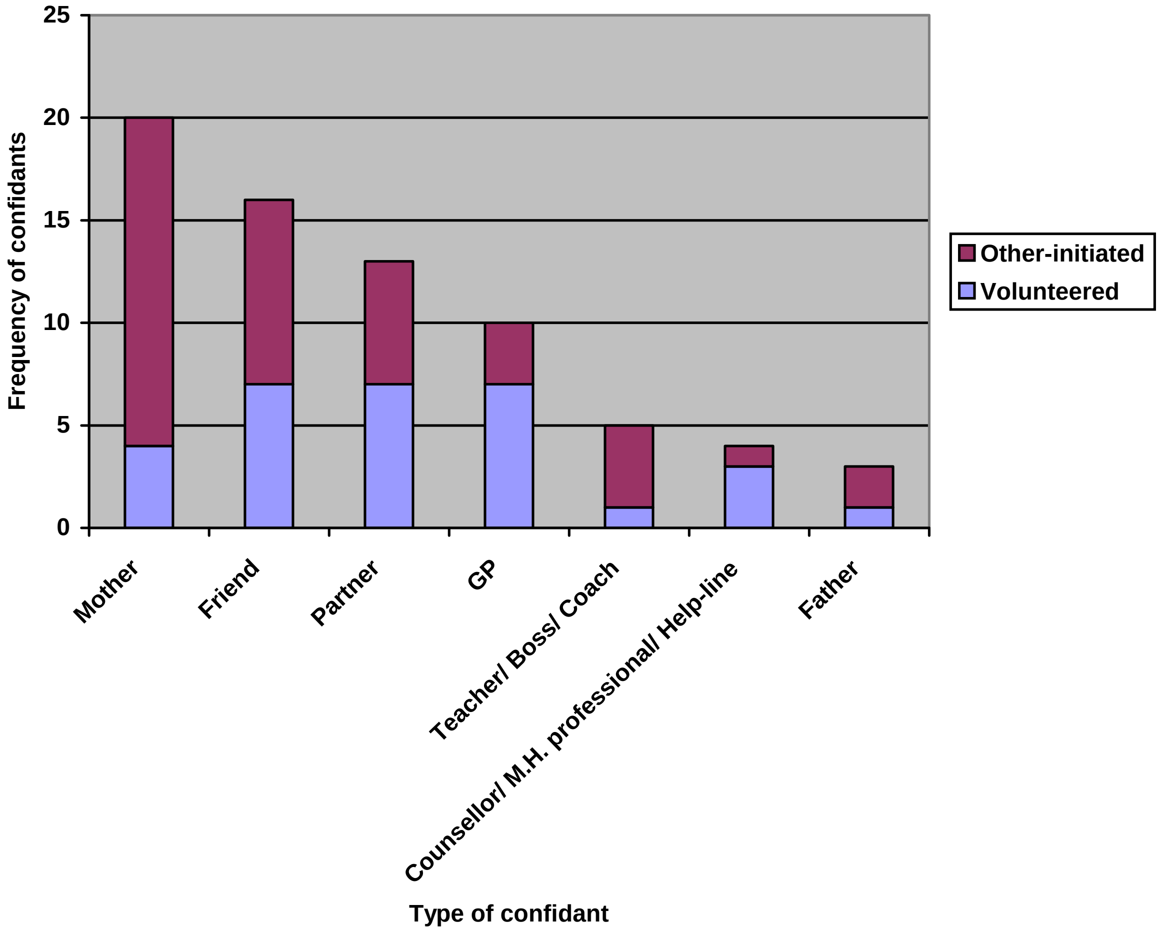


Figure 3 - Frequency of confidants involved in ‘volunteered’ and ‘other-initiated’ first disclosures

Visual inspection of the data indicates that mothers, friends, teacher/ boss/ coach, and fathers were involved in a greater number of ‘other-initiated’ disclosures than ‘volunteered’ disclosures. There were an equal number of both types of disclosures amongst partners. Medical professionals (including G.P., counsellors, mental health professionals and telephone help-lines) were involved in more ‘volunteered’ than ‘other-initiated’ disclosures.

Patterns of ‘volunteered’ versus ‘other-initiated’ disclosures amongst different types of confidants were explored using a chi-square test (table 5). In order to minimize the number of cells with expected counts of less than 5, categories were grouped, and the teacher/ boss/ coach category was excluded from the analysis. Consequently N = 66 for this analysis.

Table 5 - Relationship between the method of first disclosure and the type of confidant.

	Method of first disclosure					
	Volunteered (N = 29)		Other-initiated (N = 37)		Post-hoc cell contributions	
Type of confidant	N	(% of total)	N	(% of total)	Adjusted residuals	p
Partner/ friend	14	(21.2%)	15	(22.7)	0.6 & -0.6	N.S.
Parent	5	(7.6%)	18	(27.3%)	-2.7 & 2.7	0.01
Medical professionals	10	(15.2%)	4	(6.1%)	2.3 & -2.3	0.05

The overall chi-square was significant ($X^2(2) = 9.12$; $p = .005$ (1-tailed)) and post-hoc analyses based on adjusted residuals indicated that the cells that contributed to this were parent and medical professional (i.e., G.P., counsellor etc). When the confidant was a parent there was a high chance that the first disclosure would have been ‘other-initiated’. However, when the first disclosure involved a G.P., counsellor, mental health professional or telephone help-line it was likely to have been ‘volunteered’.

Method of first disclosure and speed of subsequent help seeking

For individuals in ‘volunteered’ versus ‘other-initiated’ disclosures, table 6 shows their mean ages (in years), and corresponding standard deviations, for each phase of the disclosure and help seeking process.

At every stage of the disclosure and help seeking process, individuals involved in ‘other-initiated’ disclosures were younger than those where the disclosure was ‘volunteered,’ as indicated by lower mean ages for the ‘other-initiated’ group. Mann-Whitney tests revealed that these differences were significant for first disclosure and disclosure to the G.P.

Table 6 - Mean age (in years) of participants at each stage of the disclosure and help seeking process for 'volunteered' versus 'other-initiated' disclosures.

	Method of first disclosure					
	Volunteered (N = 30)		Other-initiated (N = 41)		Mann-Whitney test (1-tailed)	
Age (in years) at each stage	Mean	(SD)	Mean	(SD)	Z	p
(A) Concern	22.9	(9.08)	20.8	(7.62)	-1.10	N.S.
(B) First disclosed	24.9	(10.1)	21.1	(7.79)	-1.92	0.03
(C) Disclosed to the GP	26.9	(11.7)	21.1	(7.63)	-2.23	0.01
(D) Access to ED service	28.2	(12.5)	22.9	(7.55)	-1.62	N.S.

Table 7 shows the mean disclosure and help seeking latencies (in months) and standard deviations for 'volunteered' versus 'other-initiated' disclosures.

Table 7 - 'Volunteered' versus 'other-initiated' disclosures compared in terms of mean disclosure and help seeking latencies (in months).

	Method of first disclosure					
	Volunteered		Other-initiated		Mann-Whitney test	
Disclosure latencies (in months)	(N = 30)		(N = 41)		z	p (1-tailed)
Concern to 1st disclosure (A to B)	24.7	(46.5)	3.44	(18.2)	-2.12	0.02
Concern to GP (A to C)	48.4	(81.1)	5.53	(25.7)	-2.53	0.01
Concern to ED service (A to D)	60.6	(102.9)	22.9	(46.4)	-1.90	0.03
Help seeking latencies (in months)						
1st disclosure to GP (B to C)	22.8	(52.7)	2.10	(22.6)	-0.86	N.S.
1st disclosure to ED service (B to D)	35.0	(85.2)	19.4	(43.2)	-0.13	N.S.
GP to ED service (C to D)	12.0	(39.1)	17.3	(35.6)	-0.62	N.S.

Across all latencies ‘other-initiated’ disclosures took less time than those disclosures that were ‘volunteered,’ as indicated by lower mean latencies for the ‘other-initiated’ group. These differences were significant for the lag between developing concern and first disclosing (A to B), developing concern and disclosing to the G.P. (A to C) and developing concern and accessing specialist services (A to D). Figure 4 provides a summary of these differences.

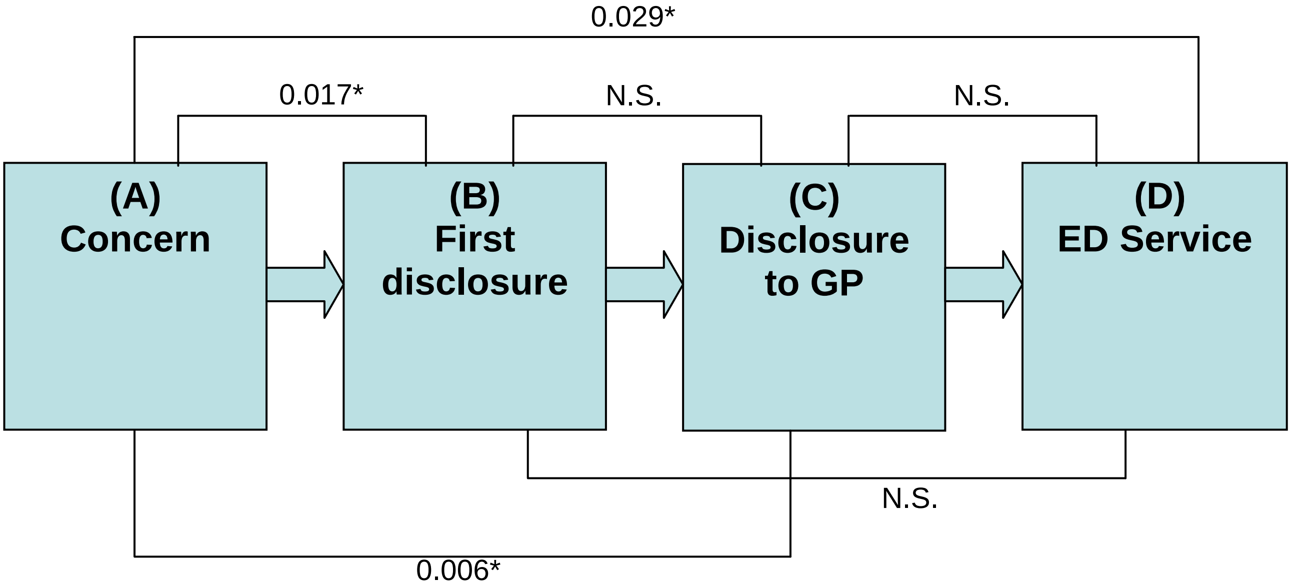


Figure 4 - Model outlining the disclosure and help seeking latencies for which ‘volunteered’ disclosure took significantly longer than ‘other-initiated’ disclosure according to Mann-Whitney U tests (1-tailed).

For ‘volunteered’ versus ‘other-initiated’ first disclosures, table 8 shows associations between the appraisal of the disclosure experience with the speed of help seeking.

Table 8 - Spearman's rho correlations of the appraisals of the first disclosure with help seeking latencies, for 'volunteered' and 'other-initiated' first disclosures.

	Nature of first disclosure	
	'Volunteered' (N = 30)	'Other-initiated' (N = 41)
Speed of help seeking	Disclosure Rating Form	Disclosure Rating Form
1st disclosure to GP disclosure	.12	-0.33*
1st disclosure to ED service	.13	-.09

*p < 0.05; **p < 0.01

For 'other-initiated' disclosures, there was a significant correlation between the way in which the disclosure was appraised and the speed with which an individual then sought help from their G.P. This relationship was negative suggesting that more positive appraisals were linked with speedier help seeking from the G.P. For 'other-initiated' disclosures the association between the appraisal of the disclosure and subsequent access to specialist treatment was not significant. For 'volunteered' first disclosures, no significant relationships were found between the appraisal of the first disclosure and the speed of help seeking.

Discussion

This study aimed to extend the work of Becker et al. (2005) and examine the impact of: 1) specific disclosure factors, 2) the identity of disclosure confidants, and 3) the initiation method of disclosure, on the speed of help seeking amongst individuals with eating disorders. In keeping with the first aim and hypothesis, an older age at first disclosure was significantly associated with faster help seeking than a younger age. However, more positive appraisals of the first disclosure were not linked with faster help seeking. In line with the second aim and hypothesis, the most popular categories of disclosure confidants were mothers and friends. In addition to the G.P., the shortest help seeking latencies were for first disclosures to partners and to mothers, and the longest help seeking latencies were for disclosures to fathers and to friends. However, these help seeking latencies did not differ significantly from each other. Regarding the third aim and hypotheses, parents were involved in significantly more ‘other-initiated’ first disclosures whereas health professionals were involved in significantly more ‘volunteered’ disclosures. No differences were found between ‘volunteered’ versus ‘other-initiated’ disclosures regarding disclosure appraisal. However, throughout the disclosure and help seeking process, individuals whose disclosures were ‘other-initiated’ were younger and accessed help more quickly than those who ‘volunteered’ their disclosure. The more positively ‘other-initiated’ disclosures were appraised, the faster the subsequent help seeking.

The contribution of the present findings in consolidating and advancing the literature can be summarised in five key themes. First, the finding of an average delay of 3 years and 3 months, between developing concern about symptoms and accessing specialist services, is in line with existing evidence to suggest substantial delays between the onset of eating disorder symptoms and first treatment contact (e.g., Cachelin et al., 2001; de la Rie, et al., 2006). The longest latency was from disclosing to the G.P., to accessing eating disorder services. This finding highlights the need for services and professionals to consider the ways in which they might contribute to help seeking delays, and potential interventions to improve them.

Second, the finding of a significant association between being older at first disclosure, and faster access to eating disorder services is in line with existing evidence indicating that access to treatment for eating disorders is linked with having a longer duration of disorder and greater levels of eating-related distress (Cachelin et al., 2006; Cachelin et al., 2001). It is possible that the drive to seek help amongst the older individuals could have been linked to greater levels of eating-related distress. However, this possibility could not be tested, since the retrospective design of this study meant that only data regarding current levels of eating distress could be collected. The finding might also reflect the fact that services have tended to be reactive, responding only when individuals have been experiencing severe levels of eating psychopathology for a considerable time frame. It is also possible that older individuals might disclose to confidants who are better able to facilitate the help seeking process. Indeed, individuals who disclosed to health care professionals were considerably older than individuals who disclosed to other types of confidants.

Third, more positive appraisals of the first disclosure experience were predicted to be linked with faster subsequent help seeking. However, a null effect was found. This does not mean that appraisal of the disclosure has no bearing on subsequent help seeking. Taking the sample as a whole might have masked its impact. Indeed, when ‘volunteered’ and ‘other-initiated’ disclosures were compared, more positive ‘other-initiated’ appraisals were associated with significantly faster help seeking.

Forth, consistent with previous research (e.g., Hepworth & Paxton), first disclosures involving mothers and friends were found to be significantly more popular than those involving other types of confidants, particularly counsellors, mental health professionals, telephone help-lines and fathers. In contrast to Becker et al. (2005), in addition to first disclosures to the G.P., short help seeking latencies were found for disclosures to parents and to partners. Disclosures to healthcare professionals were not linked with significantly shorter help seeking latencies. The finding that disclosures to friends were popular, and yet such disclosures were not linked to fast help seeking, highlights friends as an important target for intervention work aimed at improving the ability of confidants to support individuals during the disclosure process and facilitate help seeking. Future research could explore whether this finding is due to poor mental health literacy amongst friends as has been previously implicated (e.g., Holliday, et al., 2005; Mond & Marks, 2007).

Finally, in line with Becker et al. (2005), parents were found to be involved in significantly more ‘other-initiated’ disclosures, whereas healthcare professionals were found to be involved in significantly more ‘volunteered’ disclosures. ‘Other-initiated’ disclosures were appraised as favourably as ‘volunteered’ disclosures. However, at every stage of the disclosure and help seeking process, individuals whose disclosures were ‘other-initiated’ were younger and accessed help more quickly than those who ‘volunteered’ their disclosure. ‘Other-initiated’ disclosures that were more positively appraised were linked with faster subsequent help seeking. Taken together, these findings suggest that asking about an eating disorder may facilitate help seeking. Mothers were the most pro-active confidants whereas surprisingly few professionals were involved in initiating such disclosures. Further research is required to ascertain the best ways to initiate a disclosure. However, it seems that instigated disclosures are experienced as positively as volunteered disclosures, but they seem to be linked with earlier access to treatment and hence, a better prognosis for individuals with eating psychopathology.

The study has several limitations. First, its cross-sectional design meant that causal relationships could not be inferred. In addition, participants were required to retrospectively recall their disclosure experience. For some women this was recent, but one participant first disclosed 24 years and 2 months before their interview. Individuals who disclosed longer ago might have had more difficulty accurately recalling their experience than those who disclosed more recently. Furthermore, the socio-cultural understanding of, and treatment approaches to, the eating disorders have changed over the past 20 years (Treasure, Schmidt & Van Firth, 2003). Such changes might have influenced individuals to a lesser or greater extent depending on the era in which their disclosure took place. A larger sample would have enabled this possibility to be explored by comparing the experiences of individuals who disclosed more recently with those of individuals whose disclosure was longer ago. Finally, no information was obtained regarding the severity and nature of the eating distress at the time of disclosure and whether the participants had co-morbid conditions. Evidence suggests that eating disorder symptom severity and heightened psychological distress are linked with faster help seeking (Cachelin et al., 2006; Keel et al., 2002; Mond, Hay, Rodgers & Owen, 2007). Consequently the extent to which co-morbid conditions and heightened eating disordered symptom severity influenced the current findings could not be ascertained.

In summary, the current findings support previous evidence suggesting substantial help seeking delays for individuals with eating psychopathology (e.g., Cachelin et al., 2001; de la Rie, et al., 2006), and linking an older age at first disclosure with faster subsequent help seeking (e.g., Cachelin et al., 2006; Cachelin et al., 2001). These findings could reflect the reactive nature of current eating disorder services, and highlight the role of service providers in contributing to and therefore, potentially improving the help seeking process. The current findings also expand existing evidence (Becker et al., 2005) to suggest that initiating a disclosure could be a way to facilitate early access to treatment, and hence, better outcomes for individuals with eating psychopathology. The current study is limited by its cross-sectional and retrospective design. Future prospective work is needed to corroborate and build upon these findings. Nevertheless, the disclosure process has been highlighted as an important area for future exploration, particularly regarding the factors that might predict more positive ‘other-initiated’ disclosure outcomes. Lay people and professionals alike should know that, compared with voluntary disclosures, other-initiated disclosures are associated with faster help seeking for individuals with eating psychopathology.

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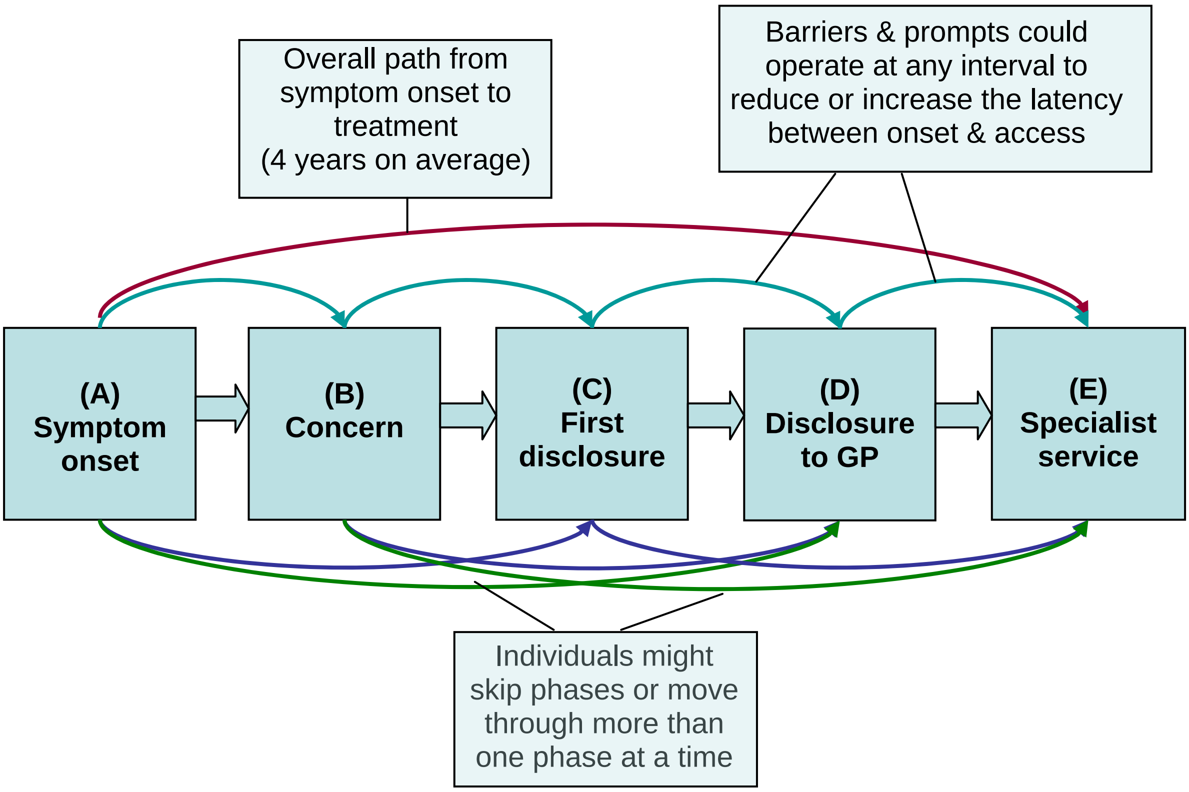
Dissemination Document

Disclosure of eating disorders and subsequent help seeking

Why focus on help seeking amongst individuals with eating disorders?

The severe physical and psychological consequences of having an eating disorder can be minimised by early treatment access. Unfortunately, most people with eating disorders experience lengthy delays in accessing help. Researchers have explored both the barriers to, and the facilitators of, the help seeking process. An improved understanding of these barriers and facilitators could provide ideas for achieving earlier help seeking and better outcomes for individuals with eating disorders. This review aimed to provide this understanding, by organising and evaluating the current evidence.

<u>Model of the help seeking process</u>



<u>Figure 1</u> - The help seeking journey

It was helpful to consider the process of help seeking as a journey (see figure 1). An individual might pass through several phases before they access help. By breaking help seeking down into its constituent parts it can be seen that potential barriers and prompts could operate at any point along the journey, to reduce or increase the speed of help seeking.

Evidence focusing on help seeking and eating disorders

Twenty studies were identified that focused on help seeking and eating disorders. All had simple designs, but most were well conducted.

Barriers to help seeking

Table 1 summarises the 5 categories of evidence relating to barriers, along with the main intervals on the help seeking journey at which each barrier is thought to operate.

Table 1 – Barriers to help seeking

	Barrier	**Example**	**Main point of operation on the help seeking journey**
1.	Logistical difficulties	*Treatment was too expensive*	C to D
2.	Ethnicity & acculturation	*Ethnic minority status linked to impaired access*	C to D, D to E
3.	Poor mental health literacy	*Having an eating disorder is not a serious problem*	A to B
4.	Self-reliance	*Others must not know*	B to C and D
5.	Social and interpersonal fears	*Fear of the stigma of mental illness*	B to C and D

Facilitators of help seeking

Evidence for 4 categories of potential facilitators is outlined in table 2, along with the main points along the help seeking journey at which these facilitators are thought to operate.

Table 2 – Facilitators of help seeking

	Facilitator	**Example**	**Main point of operation on the help seeking journey**
1.	Problem recognition & motivation	*Self efficacy linked to help seeking*	A to B, A to C
2.	Interventions to enhance recognition	*Screening for eating disorders*	A to B, A to C
3.	Impairment of health and functioning	*Emotional distress & health concerns linked to improved access*	B to D, D to E
4.	Severity of symptoms	*More severe eating attitudes linked to improved access*	B to D

Recommendations

The current evidence base needs to be built upon. Studies with more complex designs are required, to test, for example, whether some of the proposed barriers actually cause a delay in help seeking. Some barriers and facilitators have been thoroughly explored, whereas others have received less attention. For example, there is a great deal of evidence to support more reactive facilitators of help seeking. Suggesting that individuals need to get to the point where they are causing physical damage to themselves, and their life has been severely impacted before they, society, and healthcare providers recognise they need help. Fewer studies have focused on the factors that might operate earlier on in the help seeking process. A shift in focus to more proactive facilitators of help seeking is more likely to generate ideas and interventions to achieve earlier access to treatment.

The disclosure of eating disorders: An important step towards help seeking

One outcome of the review was the recommendation for future research to focus on the barriers and facilitators that might operate earlier on in the help seeking process. In line with this, the point at which an individual first discloses their eating concerns to another individual (labelled C on figure 1.1) represents an early step towards help seeking. Consequently, knowing more about the factors that might be important during this first disclosure interaction could generate ways to speed the help seeking process.

Disclosure amongst individuals with eating disorders

In line with the findings of the review, evidence regarding the factors that might operate earlier in the help seeking process for individuals with eating disorders was limited. Not surprisingly, to date, only one study had focused specifically on the disclosure of eating concerns to other individuals. Consequently, it was necessary to take evidence from similar areas of research, for example, from studies that have examined what happens when people reveal secrets, and combine it with what was known from eating disorder research. This evidence suggested that factors such as age at first disclosure, the individual’s impression of the way the disclosure went, the identity of the person they disclosed to, and how the disclosure happened (either volunteered or initiated by the other person) might be important during the process of disclosing eating disordered attitudes, and possibly related to the speed with which individuals then accessed help. However, these were just ideas, and they needed to be tested. This became to aim of the study.

Should I mention eating? Exploring the disclosure of eating disorders

The process of disclosing eating concerns to another individual was explored. This involved asking 71 women with a broad range of eating problems questions about: 1) their age when they first told someone they had eating problems; 2) what it was like to share these concerns; 3) who they chose to disclose to; and 4) how the disclosure happened (either volunteered or initiated by the other person). The women also provided information about how quickly following this disclosure they accessed help from the G.P., and from eating disorder services.

The findings

Individuals, who were older when they first disclosed their eating problems, accessed help faster than those who were younger. First disclosure to mothers and friends were more common than to other categories of confidants. Individuals whose disclosure was initiated by another person rated the experience of this to be the same as those who volunteered their first disclosure. However, the individuals whose disclosures were initiated by another person were younger and accessed help more quickly than those who volunteered their first disclosure. For those whose disclosure was initiated by another person, the more positively they rated their disclosure, the quicker their subsequent help seeking.

Conclusion

Since disclosures that are initiated by another individual are experienced as positively as volunteered disclosures, but linked with faster help seeking, people *should* mention eating.

Appendices

Literature review

Appendix 1 - Instructions for authors: EEDR
Appendix 2 - Nice checklists for cohort studies, case-control studies and qualitative studies

Empirical paper

Appendix 3 - Instructions for authors: IJED
Appendix 4 - Letter of ethical approval
Appendix 5 - Information sheet and consent form
Appendix 6 - Eating Disorder Disclosure Interview (EDDI)
Appendix 7 - Eating Disorder Examination Questionnaire
Appendix 8 - Hospital Anxiety and Depression Scale
Appendix 9 - Rosenberg Self Esteem Scale

APPENDIX 2

Nice checklists for cohort studies, case-control studies and qualitative studies

Methodology checklist: cohort studies **Study identification** *Include author, title, reference, year of publication*			
Guideline topic		**Key question no:**	
Checklist completed by:			
SECTION 1: INTERNAL VALIDITY			
In a well conducted cohort study:		**In this study the criterion is:** **(*Circle one option for each question)***	
1.1	The study addresses an appropriate and clearly focused question.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
SELECTION OF SUBJECTS			
1.2	The two groups being studied are selected from source populations that are comparable in all respects other than the factor under investigation.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.3	The study indicates how many of the people asked to take part did so, in each of the groups being studied.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.4	The likelihood that some eligible subjects might have the outcome at the time of enrolment is assessed and taken into account in the analysis.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.5	What percentage of individuals or clusters recruited into each arm of the study dropped out before the study was completed?		
1.6	Comparison is made between full participants and those lost to follow-up, by exposure status.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
ASSESSMENT			
1.7	The outcomes are clearly defined.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.8	The assessment of outcome is made blind to exposure status.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.9	Where blinding was not possible, there is some recognition that knowledge of exposure status could have influenced the assessment of outcome.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable

1.10	The measure of assessment of exposure is reliable.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.11	Evidence from other sources is used to demonstrate that the method of outcome assessment is valid and reliable.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.12	Exposure level or prognostic factor is assessed more than once.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
CONFOUNDING			
1.13	The main potential confounders are identified and taken into account in the design and analysis.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
STATISTICAL ANALYSIS			
1.14	Have confidence intervals been provided?		

SECTION 2: OVERALL ASSESSMENT OF THE STUDY	
2.1	How well was the study done to minimise the risk of bias or confounding, and to establish a causal relationship between exposure and effect? *Code ++, + or –*
2.2	Taking into account clinical considerations, your evaluation of the methodology used and the statistical power of the study, are you certain that the overall effect is due to the exposure being investigated?
2.3	Are the results of this study directly applicable to the patient group targeted in this guideline?

Methodology checklist: case–control studies Study identification *Include author, title, reference, year of publication*			
Guideline topic		**Key question no:**	
Checklist completed by:			
SECTION 1: INTERNAL VALIDITY			
In a well conducted case–control study:		**In this study the criterion is: (*Circle one option for each question)***	
1.1	The study addresses an appropriate and clearly focused question.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
SELECTION OF SUBJECTS			
1.2	The cases and controls are taken from comparable populations.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.3	The same exclusion criteria are used for both cases and controls.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.4	What percentage of each group (cases and controls) participated in the study?	Cases: Controls:	
1.5	Comparison is made between participants and non-participants to establish their similarities or differences.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.6	Cases are clearly defined and differentiated from controls.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.7	Is it clearly established that controls are non-cases?	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
ASSESSMENT			
1.8	Measures have been taken to prevent knowledge of primary exposure influencing case ascertainment.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
1.9	Exposure status is measured in a standard, valid and reliable way.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable
CONFOUNDING			
1.10	The main potential confounders are identified and taken into account in the design and analysis.	Well covered Adequately addressed Poorly addressed	Not addressed Not reported Not applicable

STATISTICAL ANALYSIS	
1.11	Have confidence intervals been provided?

SECTION 2: OVERALL ASSESSMENT OF THE STUDY	
2.1	How well was the study done to minimise the risk of bias or confounding? *Code ++, + or –*
2.2	Taking into account clinical considerations, your evaluation of the methodology used and the statistical power of the study, are you certain that the overall effect is due to the exposure being investigated?
2.3	Are the results of this study directly applicable to the patient group targeted by this guideline?

Methodology checklist: qualitative studies

Study identification *Include author, title, reference, year of publication*			
Checklist completed by:			
Guideline topic:		**Key question no:**	
Criteria:		**How well is this criterion addressed? (*Circle one option for each question*)**	
1 Aims of the research			
1.1	Are the aims and objectives of the research clearly stated?	Clearly described Unclear Not reported	Comments
1.2	Is a qualitative approach appropriate?	Appropriate Unclear Not appropriate	Comments
2 Study design			
2.1	Is (are) the research question(s) clearly defined and focused?	Clearly defined and focused Unclear Not focused Not defined	Comments
2.2	Are the methods used appropriate to the research question(s)?	Appropriate Unclear Inappropriate	Comments
3 Recruitment and data collection			
3.1	Is the recruitment or sampling strategy appropriate to the aims of the research?	Appropriate Unclear Not appropriate	
3.2	Are methods of data collection adequate to answer the research question?	Adequate Not adequate Not reported	Comments
3.3	Are the roles of researchers clearly described	Clear Unclear Not reported	Comments
3.4	Have ethical issues been addressed adequately?	Adequate Unclear Not adequate	Comments
4 Data analysis			
4.1	Is the data analysis sufficiently rigorous?	Rigorous Not rigorous	Comments
5 Findings/interpretation			
5.1.	Are the findings internally coherent, credible (valid)?	Valid Unclear Potential bias	Comments
5.2	Are the findings relevant?	Relevant Unclear Limited relevance	Comments

6 Implications of research			
6.1	Are the implications of the study clearly reported?	Clearly reported Unclear	Comments
6.2	Is there adequate discussion of the study limitations?	Adequate Inadequate Not reported	Comments
OVERALL ASSESSMENT OF THE STUDY			
How well was the study conducted? *Code ++, + or –*			
Are the results of this study directly applicable to the patient group targeted by this guideline?			Yes No

APPENDIX 3

Instructions for authors: IJED

APPENDIX 4

Letter of ethical approval

APPENDIX 5

Information sheet and consent form

UNIVERSITY OF BIRMINGHAM

Loughborough University
Centre for Research into Eating Disorders

Disclosure of eating concerns: Initial responses and their impact

Participant Information Sheet

Introduction

Hi, my name is Nicola Gilbert, I am a Trainee Clinical Psychologist and a Researcher from the University of Birmingham and I am inviting you to take part in an interview-based study where you will be asked to recall what happened when you first told someone about your eating concerns. The study is run in conjunction with Loughborough University supported by Freed Beeches.

What is the purpose of the study?

We are interested in finding out about the process of disclosing eating concerns to another individual; so the factors that came into play when you first told someone, what it was actually like to share your concerns and what happened once your eating concerns had been disclosed.

Why have I been chosen and do I have to take part?

You have been chosen because, as someone with self-identified eating concerns, it would be useful to hear about your experiences. Participation in this study is entirely voluntary; you do not have to take part.

What will happen if I do take part?

I will meet with you and answer any questions you have about the study. If you are then willing to take part I will ask you some questions about what it was like when you first told someone about your eating concerns; the things that helped you to share them with that person and things that made it difficult. There will also be some questionnaires for you to compete relating to your eating concerns. The whole interview will take less than 45 minutes.

What do I have to do?

If you would like to take part, you can book a convenient interview slot with Leah or Paula on reception.

What are the possible disadvantages and risks of taking part?

It is possible that the experience of sharing your eating concerns with another person might not have been a positive one, and if so, a few questions could bring up difficult memories for you. We can pause or stop the interview at any point and support will be available should you require it (e.g., a room where you can go and sit quietly, staff to talk to or information about support groups).

The research that has been done to date has assumed that sharing eating concerns is a positive experience. In order to gain a true picture of the disclosure context it would be good if you felt able to share your experiences whether positive, negative or neutral.

What are the possible benefits of taking part?

There are no direct benefits for you for taking part in the study. Along with the information provided by the other people who agree to take part in this study, your responses could help those individuals who have yet to disclose their eating concerns by giving them a better picture of what they could expect if they did share them. In addition, it could also provide potential confidants with more direction about how best to support individuals with eating concerns if they chose to confide in them. Both of these things could help to facilitate earlier, more positive disclosure interactions and enhanced social support for the individuals with eating concerns from the people around them, and all of this could be beneficial in terms of the enhanced detection of eating disorders and better prognosis. However, any potential benefits are neither assured nor guaranteed.

What happens when the research study stops?

When everyone has participated the information will be gathered together and analysed to reveal general patterns relating to the steps that tend to go on before, during and after the disclosure of eating concerns. This information will be written up in the form of a journal article and you will be able to contact the people at the bottom of this form for a copy of it. You will also be provided with a clear summary of the findings in case you don't want to look through a more lengthy report.

What if there is a problem?

You are free to withdraw from the study at any point, and you will be provided with details of additional forms of support should you need them.

Will my taking part in the study be kept confidential?

We are interested in looking at general patterns rather than examining individual responses. The responses you give to the questionnaires and during the interview will be kept confidential. Your questionnaire pack will be given a numerical code that will match a code on your consent form and this code system will carry through when the data is then entered onto a computer. This is so that your name and other potentially identifying information could not be connected to your responses, but that your data could be located should you choose to withdraw from the study at any point before publication.

Contact Details:

If you would like any further information about the study, please do not hesitate to contact: Dr Nicola Gilbert, Psychologist in Clinical Training, School of Psychology, The University of Birmingham, Edgbaston, Birmingham, B15 2TT. Telephone: 0121 414 7124.
Email:

Or Dr Caroline Meyer, Reader and Director of Loughborough University Centre for Research into Eating Disorders, Department of Human Sciences, Loughborough University, Loughborough, Leicestershire, LE11 3TU. Telephone: 01509 223032. Email: c.meyer@lboro.ac.uk

Support Groups:

Freed Beeches, 39 Park Street, Worksop, Nottinghamshire, S80 1HW. Telephone 01909 479922.www.feedbeeches.org.uk

Beating eating disorders (Beat) help line: 08456 341414. Email: help@b-eat.co.uk. www.beat.co.uk/Home

CONSENT FORM

Disclosure of eating concerns: Initial responses and their impact

Name of Researcher: Dr Nicola Gilbert

I confirm that I have read and understand the information sheet dated 7th January 2008 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

I understand that relevant the data collected during the study, may be looked at by responsible individuals from the University of Birmingham, and Dr Caroline Meyer, where it is relevant to my taking part in this research. I give permission for these individuals to have access to this information.

I agree to take part in the above study.

Name __________________ Signature___________ Date ___________

Researcher ___________ Signature ___________
Date___________

APPENDIX 6

Eating Disorder Disclosure Interview (EDDI)

Disclosure of eating concerns: Facts

Please complete the following background questions. All information given will be treated in strictest confidence

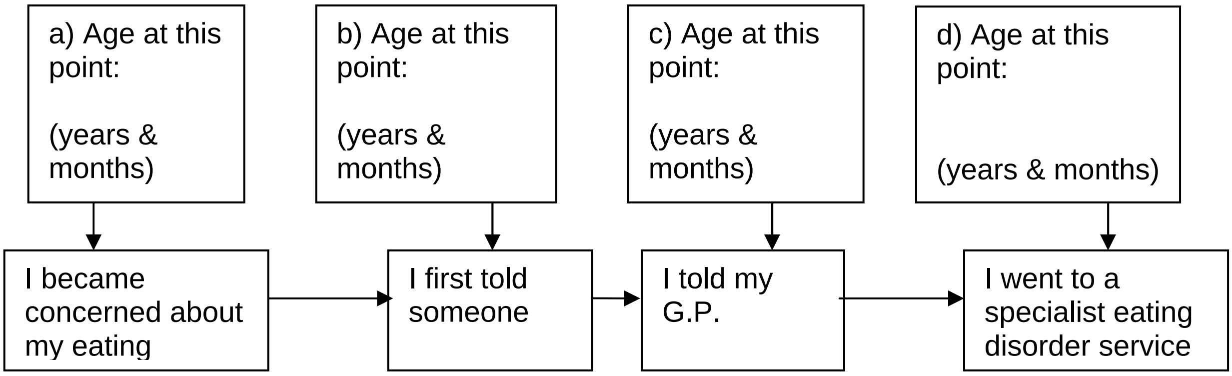
1) Date of Birth ____________________ 2) Gender: Female / male

3) Nationality ______________________

4) First disclosure interaction was:
☐ Volunteered (initiated by you)
☐ Person asked me first (initiated by them)

5) Mapping the temporal relationship between awareness of eating concerns → disclosure of eating concerns. On the diagram below, please complete the following:

a) Your approximate age in years and months between the time when you first become concerned about your eating.
b) Your approximate age in years and months when you first disclosed these eating concerns to another person (either face-to face, over the telephone or through the internet).
c) Your approximate age in years and months when you first told your GP about your eating concerns.
d) Your approximate age in years and months when you first accessed specialist support



B) Eating Disorder Disclosure Interview (EDDI)

1) Out of the list below, please indicate the first person who you shared your eating concerns with?

	Tick Here	
1		Partner (e.g., significant boyfriend / girlfriend, husband / wife)
2		Same sex friend
3		Opposite sex friend
4		Mother
5		Father
6		Sister
7		Brother
8		Aunt
9		Uncle
10		Cousin
11		Clergy / priest / religious figure
12		Counsellor
13		Family doctor / GP
14		Mental Health Professional (e.g., psychologist, psychiatrist)
15		Other medical professional (e.g., nurse, physiotherapist, hospital doctor)
16		Coach
17		Teacher
18		Boss
19		Telephone help line
20		Internet website
21		Someone not listed above (please describe who this was): ____

Please circle the appropriate number to show how you felt about the disclosure interaction and how you felt after sharing your eating concerns with this person.

The disclosure was:

bad	1	2	3	4	5	6	7	Good
difficult	1	2	3	4	5	6	7	Easy
valuable	1	2	3	4	5	6	7	Worthless
shallow	1	2	3	4	5	6	7	Deep
relaxed	1	2	3	4	5	6	7	Tense
unpleasant	1	2	3	4	5	6	7	Pleasant
full	1	2	3	4	5	6	7	Empty
weak	1	2	3	4	5	6	7	Powerful
special	1	2	3	4	5	6	7	Ordinary
rough	1	2	3	4	5	6	7	Smooth
comfortable	1	2	3	4	5	6	7	Uncomfortable

After sharing my concerns with this person I felt:

happy	1	2	3	4	5	6	7	Sad
angry	1	2	3	4	5	6	7	Pleased
moving	1	2	3	4	5	6	7	Still
uncertain	1	2	3	4	5	6	7	Definite
calm	1	2	3	4	5	6	7	Excited
confident	1	2	3	4	5	6	7	Afraid
friendly	1	2	3	4	5	6	7	Unfriendly
slow	1	2	3	4	5	6	7	Fast
energetic	1	2	3	4	5	6	7	Peaceful
quiet	1	2	3	4	5	6	7	Aroused

APPENDIX 7

Eating Disorder Examination Questionnaire

EDE-Q: Instructions

The following questions are concerned with the PAST FOUR WEEKS ONLY (28 days). Please read each question carefully and circle the appropriate number on the right. Please answer all the questions.

ON HOW MANY DAYS OUT OF THE PAST 28 DAYS …….		No Days	1-5 days	6-12 days	13-15 days	16-22 Days	23-27 days	Every day
1.	Have you been deliberately trying to limit the amount of food you eat to influence your shape or weight?	0	1	2	3	4	5	6
2.	Have you gone for long periods of time (8 hours or more) without eating anything in order to influence your shape or weight?	0	1	2	3	4	5	6
3.	Have you tried to avoid eating any foods which you like in order to influence your shape or weight?	0	1	2	3	4	5	6
4.	Have you tried to follow definite rules regarding your eating in order to influence your shape or weight; for example, a calorie limit, a set amount of food, or rules about what or when you should eat?	0	1	2	3	4	5	6
5.	Have you wanted your stomach to be empty?	0	1	2	3	4	5	6
6.	Has thinking about food or its calorie content made it much more difficult to concentrate on things you are interested in; for example, read, watch TV, or follow a conversation?	0	1	2	3	4	5	6
7.	Have you been afraid of losing control over eating?	0	1	2	3	4	5	6
8.	Have you had episodes of binge eating?	0	1	2	3	4	5	6
9.	Have you eaten in secret? (Do not count binges.)	0	1	2	3	4	5	6
10.	Have you definitely wanted your stomach to be flat?	0	1	2	3	4	5	6
11.	Has thinking about shape or weight made it more difficult to concentrate on things you are interested in; for example read, watch TV or follow a conversation?	0	1	2	3	4	5	6
12.	Have you had a definite fear that you might gain weight or become fat?	0	1	2	3	4	5	6
13.	Have you felt fat?	0	1	2	3	4	5	6
14.	Have you had a strong desire to lose weight?	0	1	2	3	4	5	6

OVER THE PAST FOUR WEEKS (28 DAYS)

15.	On what proportion of times that you have eaten have you felt guilty because of the effect on your shape or weight? (Do not count binges.) (Circle the number which applies.)	0 – None of the times 1 – A few of the times 2 – Less than half the times 3 – Half the times 4 – More than half the times 5 – Most of the times 6 – Every time

16.	Over the past four weeks (28 days), have there been any times when you have felt that you have eaten what other people would regard as an unusually large amount of food given the circumstances? (Please circle YES or NO and put appropriate number in box.)	YES	NO
17.	How many such episodes have you had over the past four weeks?	(	)
18.	During how many of these episodes of overeating did you have a sense of having lost control over your eating?	(	)
19.	Have you had other episodes of eating in which you have had a sense of having lost control and eaten too much, but have <u>not</u> eaten an unusually large amount of food given the circumstances?	YES	NO
20.	How many such episodes have you had over the past four weeks?	(	)
21.	Over the past four weeks have you made yourself sick (vomit) as a means of controlling your shape or weight?	YES	NO
22.	How many times have you done this over the past four weeks?	(	)
23.	Have you taken laxatives as a means of controlling your shape or weight?	YES	NO
24.	How many times have you done this over the past four weeks?	(	)
25.	Have you taken diuretics (water tablets) as a means of controlling your shape or weight?	YES	NO
26.	How many times have you done this over the past four weeks?	(	)
27.	Have you exercised <u>hard</u> as a means of controlling your shape or weight?	YES	NO
28.	How many times have you done this over the past four weeks?	(	)

OVER THE PAST FOUR WEEKS (28 DAYS) (PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES YOUR BEHAVIOUR.)		NOT AT ALL		SLIGHTLTY		MODERATELY		MARKEDLY
29.	Has your weight influenced how you think about (judge) yourself as a person?	0	1	2	3	4	5	6
30.	Has your shape influenced how you think about (judge) yourself as a person?	0	1	2	3	4	5	6
31.	How much would it upset you if you had to weigh yourself once a week for the next four weeks?	0	1	2	3	4	5	6
32.	How dissatisfied have you felt about your weight?	0	1	2	3	4	5	6
33.	How dissatisfied have you felt about your shape?	0	1	2	3	4	5	6
34.	How concerned have you been about other people seeing you eat?	0	1	2	3	4	5	6
35.	How uncomfortable have you felt seeing your body; for example, in the mirror, in shop window reflections, while undressing or taking a bath or shower?	0	1	2	3	4	5	6
36.	How uncomfortable have you felt about others seeing your body: for example, in communal changing rooms, when swimming or wearing tight clothes?	0	1	2	3	4	5	6

APPENDIX 8

Hospital Anxiety and Depression Scale

Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983).

Tick only one box in each section

I feel tense or ‘wound up’:

Most of the time…………… ☐
A lot of the time…………… ☐
Time to time, occasionally… ☐
Not at all…………………. ☐
[redacted]

I still enjoy the things I used to enjoy:

[redacted]
Definitely as much………… ☐
Not quite so much..……….. ☐
Only a little……………… ☐
Hardly at all……………… ☐

I get a sort of frightened feeling as if something awful is about to happen:

Very definitely and quite badly ☐
Yes, but not too badly……… ☐
A little, but it doesn’t worry me ☐
Not at all…………………. ☐
[redacted]

I can laugh and see the funny side of things:

[redacted]
As much as I always could …… ☐
Not quite so much now……… ☐
Definitely not so much now…… ☐
Not at all…………………….. ☐

Worrying thoughts go through my mind:

A great deal of the time ……. ☐
A lot of the time………………… ☐
From time to time, but not too often…………………………… ☐
Only occasionally……………… ☐
[redacted]

I feel cheerful:

[redacted]
Not at all ……………………….. ☐
Not often………………………. ☐
Sometimes …………………… ☐
Most of the time ………….. ☐

I can sit at ease and feel relaxed:

Definitely ……………………… ☐
Usually ………………………... ☐
Not often………………………. ☐
Not at all …………………….. ☐
[redacted]

I feel as if I am slowed down:

[redacted]
Nearly all the time………. ☐
Very often…………………. ☐
Sometimes………………… ☐
Not at all…………………. ☐

I get a sort of frightened feeling like ‘butterflies’ in the stomach:

Not at all………………… ☐
Occasionally……………. ☐
Quite often………………. ☐
Very often…………………. ☐
[redacted]

I have lost interest in my appearance:

[redacted]
Definitely………………… ☐
I don’t take so much care as I should….. ☐
I may not take quite as much care ☐
I take just as much care as ever ☐

I feel restless as if I have to be on the move:

Very much indeed ……….… ☐
Quite a lot …………………… ☐
Not very much……………… ☐
Not at all…………………… ☐
[redacted]

I look forward with enjoyment to things:

[redacted]
As much as ever I did ………. ☐
Rather less than I used to……… ☐
Definitely less than I used to… ☐
Hardly at all…………………… ☐

I get sudden feelings of panic:

Very often indeed ……….…… ☐
Quite often…………………… ☐
Not very often ………………… ☐
Not at all………………………. ☐
[redacted]

I can enjoy a good book or radio or TV programme:

[redacted]
Often ……….……………… ☐
Sometimes……………………. ☐
Not often ……………………… ☐
Very seldom ………………….. ☐

APPENDIX 9

Rosenberg Self Esteem Scale

RSE

This is a list of statements dealing with your general feelings about yourself. If you agree with the statement, circle A. If you strongly agree, circle SA. If you disagree, circle D. If you strongly disagree, circle SD.

1.	On the whole, I am satisfied with myself.	SA	A	D	SD
2.	At times, I think I am no good at all.	SA	A	D	SD
3.	I feel that I have a number of good qualities.	SA	A	D	SD
4.	I am able to do things as well as most other people.	SA	A	D	SD
5.	I feel I do not have much to be proud of.	SA	A	D	SD
6.	I certainly feel useless at times.	SA	A	D	SD
7.	I feel that I am a person of worth, at least on an equal plane with others.	SA	A	D	SD
8.	I wish I could have more respect for myself.	SA	A	D	SD
9.	All in all, I am inclined to feel that I am a failure.	SA	A	D	SD
10.	I take a positive attitude toward myself.	SA	A	D	SD