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Understanding problems and solutions in binge-eating disorder (BED)

A multimethod study of a two-phased treatment program for patients with BED and overweight

PhD thesis

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Funding

The PhD project was funded by the Danish Health Authority and finalized with the support of Stolpegaard Psychotherapy Center

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Summary

This thesis presents understandings of binge-eating disorder (BED) and weight in the context of a multimethod study of a two-phased treatment for patients with BED at Stolpegaard Psychotherapy Center (SCP) from 2013 to 2018. My ambition was to generate new understandings of BED and engage critically with the question of what constitutes problems and solutions in the BED field. I did this by taking a social constructionist perspective.

The BED treatment at SPC was group psychotherapy targeting BED followed by either a Weight Loss group or a Wellbeing group which conveniently represented *a weight-centered health paradigm* and *a health-centered paradigm*. While obesity is not part of the BED diagnosis, a large majority of people with BED develop obesity, and weight loss is regarded a necessary focus in treatment for health reasons. Weight is also a huge focus in society at large and is a great concern in the Danish health care system. And so, weight also came to play a central role in this thesis.

Responding to what I found was an individualization of BED and a compartmentalization of knowledge productions into 'psychiatric' and 'medical', I chose to take a dialogical and systemic perspective. The findings presented in this thesis come from qualitative data generated through semi-structured interviews and participant observations and quantitative data collected though questionnaires and diagnostic interviews.

The issue of weight is infused with norms and values that move it beyond mere physicality. Looking into obesity research, I was surprised to find that researchers had long established that 1) weight loss is achievable short-term but close to impossible to uphold long-term, and 2) weight is not a clear measure of health. I had not come across this knowledge as a psychologist or citizen, and it was not something the media or public health officials communicated. Looking at BED studies, I was equally surprised to find that these limitations had not influenced how weight was approached in BED; researchers and clinicians continued to try to develop interventions that could reduce weight.

In this thesis, I explore BED and weight as interrelated phenomena that are deeply rooted in social and relational contexts. I present the analytical concept of *a relational weight problem* and demonstrate processes of change in treatment that involve acceptance, a critical awareness of discourses and a feeling of connectedness. The thesis invites discussions about how problems and solutions in the BED field can be described and measured in a way that involves contexts and interactions between people. The findings

raise critical questions about a weight focus in society and in the treatment of BED. The analysis of BED and weight as relational phenomena is an original contribution to the BED literature.

Danish Summary (Dansk resumé)

Denne afhandling præsenterer forståelser af binge-eating disorder (BED) og vægt, som de udforskes i en eksplorativ multimetode-undersøgelse af et tofaset behandlingstilbud til patienter med BED på Psykoterapeutisk Center Stolpegård (PCS) fra 2013 til 2018. Min ambition var at generere nye forståelser af BED og kritisk engagere mig i spørgsmål om, hvad der udgør problemer og løsninger i BED-feltet. Jeg gjorde dette ved at anlægge et socialkonstruktionistisk perspektiv.

Den undersøgte behandling på PCS var psykoterapeutisk behandling målrettet BED efterfulgt af enten en Vægttabsgruppe eller en Velværegruppe, som hver repræsenterede *et vægt-centreret sundheds-paradigme* og *et sundheds-centreret paradigme*. Selvom fedme ikke er del af diagnosekriterierne for BED, så udvikler hovedparten af mennesker med BED fedme, og vægttab anses for at være et nødvendigt behandlingsfokus af helbredsmæssige årsager. Vægt er også i fokus i sundhedsvæsnet og i samfundet generelt, og dermed kom vægt også til at spille en central rolle i denne afhandling.

Jeg fandt i en udpræget individualistisk tilgang til BED i litteraturen og en opdeling i 'psykiatrisk' og 'medicinsk' viden. Herudfra valgte jeg at tage et dialogisk og systemisk perspektiv. I afhandlingen præsenterer jeg fund og resultater baseret på deltagerobservationer, kvalitative interviews, spørgeskemaer og diagnostiske interviews.

Konceptet 'vægt' er mættet med værdier og normer, der bevæger sig langt ud over det rent fysiske. Da jeg gik ind i fedmefeltet, blev jeg overrasket over, at forskningen for længst har fundet, at 1) vægttab er muligt på kort sigt, men svært at opretholde på lang sigt og 2) at vægt ikke entydigt måler sundhed. Det var ikke noget, jeg havde hørt om i min funktion som psykolog eller som borger, og det var heller ikke noget, der blev kommunikeret ud i medierne eller af offentlige sundhedsinstanser. Jeg blev endnu mere overrasket over, at den slags begrænsninger ikke havde påvirket, hvordan vægt blev behandlet inden for BED. Her var målsætningen stadig at udvikle en BED-behandling, der kunne medføre vægttab.

I projektet udforskede jeg BED og vægt som internt forbundne fænomener, der er dybt forankrede i sociale og relationelle kontekster. Jeg præsenterer det analytiske begreb *et relationelt vægtproblem* og

demonstrerer forandringsprocesser i behandlingen, som handler om øget accept, en kritisk bevidsthed om diskurser og en følelse af forbundethed. Afhandlingen inviterer til diskussioner om, hvordan problemer og løsninger i BED-feltet kan beskrives og måles på en måde, der involverer kontekster og interaktioner mellem mennesker. Afhandlingens fund rejser også kritiske spørgsmål om et vægtfokus i samfundet og i behandlingen af BED. Afhandlingens forståelser af BED og vægt som relationelle fænomener er således unikke bidrag til BED-litteraturen.

List of papers

Paper 1. Published in *Qualitative Health Research* (2018)

Title *(Dis-)Solving the Weight Problem in Binge Eating Disorder: Systemic Insights from Three Treatment Contexts with Weight Stability, Weight Loss, and Weight Acceptance*

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Paper 2. Submitted to *Qualitative Research in Psychology*

Title *Reconnecting in Dialogical Spaces: How a Systemic and Narrative Group Intervention for Binge-Eating Disorder helps Patients Reconnect with Themselves and Other People*

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Paper 3. Submitted to *Eating Disorders*

Title *Effectiveness of Integrated Systemic and Narrative Therapy for Patients with Binge Eating Disorder*

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Preface

In 2012, the Danish Health Authority initiated a project to gather knowledge and experiences with the eating disorder Binge-eating disorder (BED) (Title: "Satspujle vedr. Binge Eating Disorder (BED) [In English: Funding regarding Binge Eating disorder (BED)]," 2013). Two places received funding: Stolpegaard Psychotherapy Center (SPC) and The Danish Society for Eating Disorder and Self-harm (Landsforeningen mod Spiseforstyrrelser og Selvskade, LMSOS). SPC had previously offered treatment to a very limited number of patients through internal funding. With the current funding, the treatment facility could develop BED treatment on a larger scale.

At the time of funding, BED was not recognized as an independent diagnosis, but it was expected to be included in the upcoming edition of the American Diagnostic and Statistical Manual of Mental Disorders, the DMS-5, to be released in 2013. As with previous releases of DSM, the World Health Organization (WHO) would soon follow with their 11th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-11). As the Danish Health Authority complies with the recommendations of ICD, the inclusion of BED in ICD-11 would mean that people with BED would have the same legal rights to public treatment as people affected by Anorexia Nervosa (AN) and Bulimia Nervosa (BN). Consequently, the Danish health care system would be required to offer treatment to 40.000 adult Danes with BED which made clinically relevant knowledge about the BED population and effective treatments pertinent. Internationally, there was a persistent call for interventions that could not only reduce eating disorder symptoms but also lead to weight loss.

For the past 6 years, I have been engaged in exploring? what constitutes problems and solutions in the area of BED and weight. I have done this mostly in the context of evaluating a two-phased treatment program at SPC but I have also read extensively about BED and bordering topics, and also tried to take a personal perspective by bringing my reflections into my own life as a researcher, psychologist, mother, and woman. I have been deeply moved and transformed in the process, and I have come to see how diet culture and what seems to be an inescapable focus on body and weight fundamentally disturbs our relationships with food and bodies. The rising number of people with obesity and eating disorders, along with children and teens with body dissatisfaction and dieting behavior, bear witness to that. As I am writing this, the patient organization LMSOS is on the radio talking about 8-year old children who come to see them with eating disorder symptoms.

During this project, new questions arose as I spoke with people affected by BED and entered discussions with dieticians, pediatricians, food coaches, lay people, body activists, the media, eating disorder researchers, and obesity researchers. As a practitioner at an eating disorder unit, I was certain that weight was not the problem for people affected by BED; it was their eating disorder. My colleagues and I at the BED unit at SPC knew that weight loss attempts kept our patients in vicious cycles of restriction and binging, and we knew that giving up weight loss was a necessary part of BED recovery. However, we also knew that our patients wanted to lose weight when they finished psychotherapy treatment, and that they needed help to do this in a way that did not put them at risk for relapse. Nonetheless, I was surprised at the central role weight took in the project. When presenting in academic or clinical arenas, I was without exception confronted with questions like "How can you defend that your treatment does not help patients lose weight?" "Is that ethical?" It was as if it was almost unfathomable that I could be a health care professional and not want obese bodies to lose weight.

To properly respond to these questions, I had to know more about obesity and weight loss. It was a field I could not ignore. When preparing a report for the Danish Health Authority about the project, I started to look into the obesity literature and found that researchers had long moved from a simple energy balance model to an interactional model involving complex interactions between genetic, social, psychological, and physiological factors. I also discovered a critical obesity field that presented results that challenged the underlying assumptions about weight as a problem and weight loss treatments as solutions. Why was this complexity not reflected at the level of treatments? Why was the focus still on getting individuals to lose weight by eating less and moving more? And why had the BED field not heard about these discussions? I found that the eating disorder and obesity fields were caught in separate silos without much transference of knowledge. It was paradoxical that eating disorder practitioners were seemingly uncritically adopting solutions from an obesity field that so obviously promoted weight loss attempts, dieting, and body dissatisfaction which were known problematic factors in eating disorders. What are considered solutions in the obesity field are quite often considered problems in the eating disorder field.

This lack of dialogue between the two fields along with a general individualization of problems seriously constricts what can be known about BED and consequently the available treatment interventions. In this thesis, I argue that interactions between BED and weight and social contexts must be included in our understandings and treatments of BED. In relation to weight, I will also argue that we

need to look outside the traditional understandings if we are to find viable avenues for change for the BED population.

Acknowledgements

I wish to thank the many wonderful people who have made this project possible: Mette Waaddegaard, head of the Unit for eating disorders at SPC, who applied for funding for this project and continues to fight viciously for BED treatment. The practitioners at SPC who let me follow their work and show me and others the importance of engaging with people and not with problems, Marjun Tróndarson, for organizing the project while I was on maternity leave, and Signe, Camilla, Astrid, Lise for doing diagnostic interviews, and my colleagues at the Unit for Psychotherapy research at SPC and at the National Institute of Public Health. A special thank you to all the amazing people affected by BED who shared their insights and allowed me to witness their struggles. The strength and wisdom it takes to live with an eating disorder and live in a body that changes in a weight-focused society, and to move away from all that is truly inspiring. I also wish to thank Marianne Lau for supervising and always standing by my side even after she retired, my co-authors, especially, Stig Poulsen and Annika Helgadóttir Davidsen (who is also a dear friend of mine). Thank you to Lene and Birgitte at 'BEDklinikken' for allowing me time to finish the project, and a special thanks to Tine Tjørnhøj-Thomsen, my primary advisor, for 'thinking with' me and providing excellent academic guidance, support, and passion. A last thank you to my family; Thomas, for knowing me so well, and our children Balder, Marius and Lærke for keeping my heart warm. -Without you, I most probably would have finished sooner.

Outline of the thesis

Chapter 1, *Introduction: Understanding problems and solutions* offers a short overview and critical perspective on prevailing knowledge productions about BED. I also present the guiding assumptions and methods of the *weight-centered health paradigm* and the *health-centered paradigm*. I end the chapter with what I see as limitations of a medical model of BED and potentials in moving BED into a social constructionist framework. This leads me to the aims of the thesis and my research questions.

Chapter 2, *Metatheoretical position*, presents the metatheoretical position of the thesis which is social constructionist, dialogic, and systemic.

Chapter 3, *Methodology,* presents the two empirical studies: a quantitative single group effectiveness study and a qualitative ethnographic study, and the situatedness of the project, my positions, and the processes that focused the study, its design, methods, and analytical perspectives.

Chapter 4, *Generated understandings and results of the studies* presents the understandings and results from the studies summarized in abstracts of Papers 1, 2, and 3.

Chapter 5, *Discussion*, is an attempt to contextualize BED problems and solutions. I discuss the overall understandings and results of Papers 1, 2, and 3, and relate them to existing literature on BED and weight. Finally, I reflect on implications of the studies for treatment and the evaluation of treatments.

Words and communities of knowledge

The propositions developed in this thesis have been shaped by social constructionist, dialogic and systemic literature, and scientific writings in BED and critical obesity research. Theorists, practitioners, and academic scholars include Mikhail Bakhtin, Gregory Bateson, John Shotter, Harlene Anderson, Sheila McNamee, Kenneth Gergen, Traci Mann, Lucy Aphramor and Sígrun Danielsdóttir. I also found inspiration in fat activist and feminist movements; the Danish *Fedfront,* (FatFront), and the American *Body Positive*, *Size Acceptance*, and *Health At Every Size* and social media including *Weight Matters* (UK), *Academy for Eating Disorders* (US), *International Society of Critical Health Psychology*, *Samtök um Likamsvirðingu*/ *Association for Body Respect* (Iceland), *Body Image Project*, *Body Image, Binge Eating Disorder Association* (BEDA, US). I used database searches in PsychInfo and PubMed to acquire published psychological and medical research and browsed key journals including *Body Image*, *Obesity*, *Obesity Reviews, Research and Theory*, *Qualitative Health Research* and different eating disorder journals. I use the psychiatric and medical terms *binge eating*, *body image*, *affect-regulation, Body Mass Index* (BMI) and *overweight/obesity* because I want to engage with the language of my professional community and to describe certain regularities in BED (Bakhtin in Morson & Emerson, 1990). I am aware of the normative connotations and the risk of positioning people as right or wrong (Rehner Iversen,

2005) and that these terms do not tell the whole story about BED or the affected people (Gergen, 1997). To reflect the social constructionist position that reality is not objectively available to be discovered, I use the term *data generation* in the qualitative study while I use *data collection* in the quantitative study.

CHAPTER 1: INTRODUCTION

Understanding problems and solutions

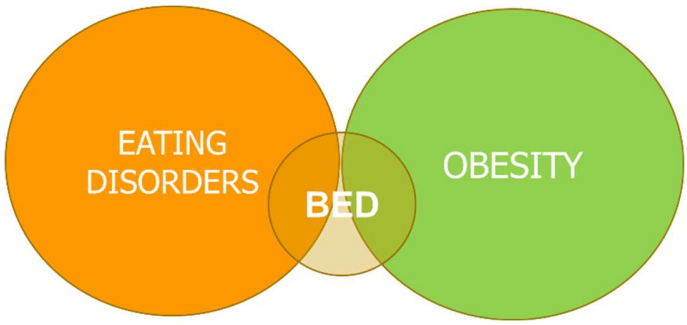


Figure 1. BED lies at the intersection of the eating disorder field and the obesity field

BED inhabits a unique intersection of two fields that have traditionally been isolated: The psychiatric field of eating disorders and the medical field of obesity. BED was first identified by Albert Stunkard in 1955 (A J Stunkard, Grace, & Wolff, 1955) who observed an eating pattern marked by consuming large amounts of food at irregular intervals in a subgroup of people with obesity. Some obesity researchers still consider BED a marker of psychopathology in obese people rather than an eating disorder (Albert J. Stunkard & Allison, 2003). In 1994, BED was introduced in the 4th ed. of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994) and categorized as an eating disorder not otherwise specified (EDNOS), a provisional diagnosis distinct from BN. Leading up to the inclusion of BED as an independent diagnosis in the 5th ed. of the DSM in 2013 (DSM-5; American Psychiatric Association, 2013), a plethora of research was conducted. The initial questions were how BED resembled and differed from the bordering conditions of bulimia nervosa and obesity without BED. This provided valuable knowledge about the population's

characteristics, psychiatric and medical symptoms as well as effective interventions. Some have raised concerns that understanding BED in comparison to what it is distinctly different from runs the risk of not capturing the unique problems of the condition (Wonderlich, de Zwaan, Mitchell, Peterson, & Crow, 2003). With the issue of weight, BED also continues to have a foot in the complicated and contested obesity field.

In this chapter, I share scientific knowledge about the BED population and treatment. Concerning the issue of weight, I first present what I categorize as *weight-focused* treatment interventions. Drawing on critical obesity research, I proceed to question the underlying assumptions that guide a weight-focus in BED and introduce alternative approaches that I believe better align with knowledge generated in the eating disorder field. I end the chapter with what I see as limitations of a psychiatric and medical approach to BED which leads me to the aims of the thesis and my research questions.

Binge-eating Disorder (BED)

BED is a common, yet highly overlooked, eating disorder with profound consequences for the individual's health and social and psychological functioning and well-being (Hudson, Hiripi, Pope, & Kessler, 2007; Kessler et al., 2013).

Population characteristics

There are no Danish studies of prevalence, but large European and US studies show lifetime prevalence rates between 2 - 4 % of the population (Hudson et al., 2007; Keski-Rahkonen & Mustelin, 2016; Kessler et al., 2013; Mustelin, Bulik, Kaprio, & Keski-Rahkonen, 2017; Udo & Grilo, 2018). This equates to an estimated 40,000 adults in Denmark which is the same as Anorexia Nervosa (AN) and Bulimia Nervosa (BN) together. Higher rates of BED are found among older and obese populations with prevalence rates in these groups up to 8 % (Hay, 2013; Johnson, Spitzer, & Williams, 2001). In weight loss treatments, these numbers rise to 10 - 50 % (Adami, Gandolfo, Bauer, & Scopinaro, 1995; de Man Lapidoth, Ghaderi, & Norring, 2006; de Zwaan & Mitchell, 1992; Ruth H. Striegel-Moore & Franko, 2003).

Studies that compare BED to AN and BN show a demographic profile (Castellini et al., 2011; Welch et al., 2016), psychiatric levels, and risk factors that most resemble BN (Hilbert et al., 2014). Compared to AN and BN, there is a more equal male-female ratio in BED with one male for every three females (Kessler et al., 2013). Males have a slightly different profile with a higher tendency for lifetime substance use and obsessive compulsive disorders (C. Grilo, White, & Masheb, 2009), less body dissatisfaction (D. Barry, Grilo, & Masheb, 2002) but an overall level of psychosocial impairment equivalent to females (Striegel, Bedrosian, Wang, & Schwartz, 2012).

Studies find two peaks of onset for BED; one at 14 years, which is immediately after puberty, (Smink, van Hoeken, Oldehinkel, & Hoek, 2014), and one between 18 to 20 years which is in late adolescence (Stice, Marti, & Rohde, 2013). Other studies find later onsets up to 27 years (Hudson et al., 2007; Kessler et al., 2013). Loss of control eating is found in early childhood (Tanofsky-Kraff, Faden, Yanovski, Wilfley, & Yanovski, 2005).

The average illness duration is between 4 to 8 years (Hudson et al., 2007; Kessler et al., 2013). Health care providers struggle to spot BED in their patients (Chao, Rajagopalan, Tronieri, Walsh, & Wadden, 2019; Kornstein, Kunovac, Herman, & Culpepper, 2016) and, compared to AN and BN, people with BED are more likely to seek treatment for comorbid disorders than for eating disorders (Bohrer, Carroll, Forbush, & Chen, 2017; Forrest, Smith, & Swanson, 2017).

As low as 17 % (R. H. Striegel-Moore et al., 2001) of people with BED have ever received BED treatment (Hudson et al., 2007; Kessler et al., 2013) whereas up to 70 % seek weight loss treatment (Hart, Granillo, Jorm, & Paxton, 2011; Mond, Hay, Rodgers, & Owen, 2007) and more than 50 % receive treatment for mood disorders (Hudson et al., 2007; Kessler et al., 2013).

In sum, the people who are affected by BED may vary in age and gender, and will be more likely to seek help for other problems than BED. An increased awareness of BED in the health care system, especially weight loss interventions, and in the general public is therefore important.

The BED diagnosis

According to DMS-5 criteria, BED is characterized by recurrent episodes of binge-eating where the person eats a large amount of food within a discrete period of time accompanied by a sense of loss of control and followed by marked distress. Loss of control eating is defined as an inability to control what and how much the individual eats (American Psychiatric Association, 2013). Contrary to people with BN, people with BED do not engage in regular compensatory behaviors such as purging, fasting, or excessive exercise. Compensatory behaviors may occur but not at the levels seen in BN. For the full diagnostic criteria in DMS-5 and ICD-11, see Appendix 3.

Weight

People with BED often alternate between periods of dietary restriction and binge-eating which lead to dramatic fluctuations in weight (Dingemans & van Furth, 2012) and an overall increase in weight over time. Though not a diagnostic criterion, the large majority, around 2/3, develop overweight or obesity (Kessler et al., 2013). A small minority fall within the normal Body Mass Index (BMI) range defined as a BMI from 20 to 25 but the percentage with obesity increase with age and illness duration (Kessler et al., 2013).

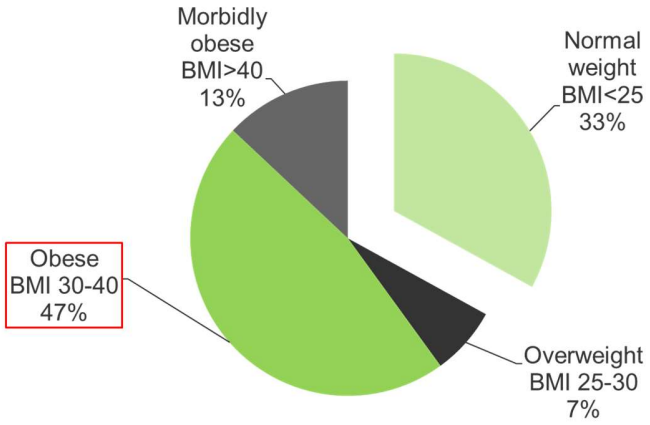


Figure 2. The distribution of people with BED across the Body Mass Index (BMI) categories

Compared to people of the same weight without BED, people with BED have more psychological distress, poorer quality of life, greater prevalence of psychiatric comorbidity, greater weight and shape

concerns, and more fear of weight gain (Fassino, Leombruni, Pierò, Abbate-Daga, & Giacomo Rovera, 2003; Klatzkin, Gaffney, Cyrus, Bigus, & Brownley, 2015; Legenbauer et al., 2011; Ramacciotti et al., 2008; Rieger, Wilfley, Stein, Marino, & Crow, 2005). People with BED also tend to have more chaotic eating patterns, eat larger portions (Engel et al., 2009) and be less physically active (Carr, Lydecker, White, & Grilo, 2019) than people of the same weight without BED.

There are few differences across the weight spectrum of BED but those within the normal weight rage are often younger, are less likely to have received treatment, show lower concerns about weight, and have fewer binge-eating episodes (Dingemans & van Furth, 2012).

Together, this suggests that people with BED are affected beyond what can be explained by weight. It also shows a worsening of weight and eating over time which calls on more knowledge about the processes and mechanisms that link and sustain these problems.

Overvaluation of weight and shape

A central aspect of body image disturbance seen in eating disorders is an undue influence of body shape and weight on self-evaluation often referred to as *overvaluation* (Eating Disorder Examination Interview, Fairburn, Cooper, & O'Connor, 2008). Overvaluation is considered a core defining feature of eating disorders (C. Grilo & Masheb, 2000; C. Grilo, Masheb, & White, 2009) and successfully distinguishes eating disordered populations from non-eating disordered populations (C. M. Grilo, Crosby, et al., 2009). Despite similar levels of overvaluation to BN (Wilfley, Scwartz, Spurrell, & Fairburn, 1999; Masheb & Grilo, 2000), the BED diagnosis does not include a criterion pertaining to body image (C. M. Grilo, 2013). Studies have found that overvaluation is important in the development and maintenance of BED (Fairburn & Wilson, 1993; Pratt, Telch, Labouvie, Wilson, & Agras, 2001; Sonneville et al., 2015). Treatment seeking patients with BED who score high on overvaluation show higher levels of depression, greater general psychological and eating-related psychopathology (A. B. Goldschmidt et al., 2010; C. Grilo et al., 2008; C. M. Grilo, White, & Masheb, 2012), poorer treatment responses, and higher risk of dropout (Hilbert et al., 2007; Ojserkis, Sysko, Goldfein, & Devlin, 2012). Overvaluation is independent of physical weight for people affected by BED (Eldredge & Agras, 1996).

Psychiatric comorbidity

More than 70 % of people affected by BED have at least one other psychiatric illness during their lifetime, and almost 50 % have three or more (Hudson et al., 2007; Ulfvebrand, Birgegård, Norring, Högdahl, & von Hausswolff-Juhlin, 2015). This number is higher (75 %) in treatment seeking populations where 45 % have mood disorders (Ulfvebrand et al., 2015; D. E. Wilfley et al., 2000) and 55 % have anxiety disorders (Grucza, Przybeck, & Cloninger, 2007; Ulfvebrand et al., 2015). Similar high rates are found in AN and BN (Hudson et al., 2007; Ulfvebrand et al., 2015).

Co-occurring psychiatric illness in BED is associated with greater eating disorder severity and poorer prognosis in treatment (C. Grilo, White, et al., 2009; D. E. Wilfley et al., 2000). The causes of these high levels of comorbidity are, however, unclear (A. Goldschmidt, Wall, Choo, Becker, & Neumark-Sztainer, 2016; Sonneville, 2013).

Psychotherapy interventions for BED

Psychotherapy interventions for BED target binge-eating, weight and shape concerns, and weight management. Several psychotherapy interventions are found effective on these measures (Brownley et al., 2016; Effective Health Care Program, 2015; Hilbert et al., 2019; Linardon, 2018; Vocks et al., 2010) with around 50 % of patients reaching full recovery of binge eating (Linardon, 2018). *Cognitive-Behavioral Therapy* (Fairburn & Wilson, 1993) has been considered the first line treatment for many years but evidence is accumulating to support the efficacy of *Interpersonal Psychotherapy* (D. E. Wilfley et al., 2002; D. Wilfley, Frank, Welch, Spurrell, & Rounsaville, 1998). *Dialectical behavior therapy* (Wiser & Telch, 1999) also shows promising results (Chen et al., 2016; Safer & Jo, 2010).

Cognitive-Behavioral Therapy (CBT)

CBT (Fairburn & Wilson, 1993) has received extensive empirical support both in an individual, group, internet-based, and guided self-help format (Hay, 2013; Iacovino, Gredysa, Altman, & Wilfley, 2012; Linardon, Messer, & Fuller-Tyszkiewicz, 2018; Vocks et al., 2010). CBT is a time-limited manualized treatment initially based on the *binge-restraint model* developed for BN where binges are assumed to be

maintained by insufficient food intake. Early CBT targeted dietary restraint by establishing healthy eating patterns, encouraging self-monitoring of food intake, and developing problem solving skills. The recent transdiagnostic "enhanced" version of CBT, CBT-E (Fairburn, Cooper, & Shafran, 2003) posits that a dysfunctional evaluation of self-worth (overly based on weight and shape) is central to all eating disorders. CBT-E is based on an expanded *dual-pathway model* (Stice & Shaw, 2002) where overvaluation is considered to cause binge-eating via dietary restraint and negative affect. Additional maintaining mechanisms include low self-esteem, clinical perfectionism, and interpersonal problems (Fairburn et al., 2003)

Interpersonal Psychotherapy (IPT)

IPT (D. Wilfley et al., 1998) is a time-limited treatment developed around the *interpersonal model* (Ivanova et al., 2015; Ivanova, Tasca, Proulx, & Bissasda, 2016). A central factor in this model is *negative social evaluation* defined as "the perceived and actual negative feedback regarding one's value to another individual or group" (Rieger et al., 2010). Problems in navigating interpersonal interactions is assumed to lead to negative affect which is then regulated by binge-eating. IPT aims to reduce binge-eating indirectly by changing the individual's dysfunctional affect-regulation (Binford, Pederson Mussell, Peterson, Crow, & Mitchell, 2004; D. Wilfley et al., 1998).

Dialectical Behavior Therapy (DBT)

DBT is based on the affect-regulation model of binge-eating which assumes that bingeing occurs in response to intolerable affective experiences. The main goal is to develop adaptive emotional regulation skills and implement these into daily life. Areas for intervention include: mindfulness skills, distress tolerance, emotion regulation and, sometimes, interpersonal effectiveness (Wiser & Telch, 1999).

In Paper 3, I evaluate the effects of psychotherapy for BED, especially the effects of IPT and CBT more thoroughly. My purpose here is to demonstrate that, regardless of the acclaimed theoretical differences and treatment modalities, CBT, CBT-E, IPT, and DBT are all modelled on what some have called the medical or *technological model* (Bracken et al., 2012). This model holds that BED arises from

faulty mechanisms within the individual, these mechanisms are independent of contexts and can be modelled in predictable causal sequences and corrected through technical interventions (Bracken et al., 2012) i.e. through the specific targets of manualized psychotherapy interventions. Even though studies and reviews clearly support the efficacy of these interventions and support the respective models, comparative evaluations still struggle to show modality specific treatment effects (Peat et al., 2017; Wonderlich et al., 2003): IPT is found to improve weight, shape, and eating concerns and binge-eating at levels found in CBT treatments, and CBT improves interpersonal functioning at levels found in IPT. Likewise, how can weight loss treatments reduce binge-eating when dietary restriction is believed to sustain binge-eating. Responding to these questions, Wonderlich et al concluded:

> BED may be viewed as a complex condition with multiple pathophysiologic pathways or maintenance mechanisms that are targeted differentially by a variety of treatments, all of which result in some reduction of symptoms….[This] raise[s] significant questions about the specificity of mechanisms of action and change (Wonderlich et al., 2003, p. S69).

While Wonderlich et al understood this as nonspecific treatment effects, I will argue that a different conceptual model of BED is needed altogether as a linear causal logic and a focus entirely on the individual cannot provide us with a full understanding of the processes that underlie BED. Instead we need to include the contexts and interactions that give rise to these problems and allow for the influence of circular causal mechanisms. This extends to the processes in treatment.

The issue of obesity in BED

The issue of obesity is new in the eating disorder field, and BED researchers and clinicians have unsurprisingly turned to the traditional obesity field for solutions. By doing this, however, they have implicitly accepted the claim that obesity is a problem and weight loss is a solution. Eating disorder researchers and critical obesity researchers question the legitimacy of focusing on weight and warn of adverse effects of a weight-focus on physical and mental health. I present these diverging truth claims under the headings of a *weight-centered health paradigm* and a *health-centered paradigm*.

The weight-centered health paradigm

The weight-centered health paradigm relies on research that demonstrate detrimental consequences of obesity for physical health seen in increased risk of mortality, morbidity, cardiovascular diseases, hypertension, type 2 diabetes, and certain cancers (Khaodhiar, McCowen, & Blackburn, 1999; Teucher, Rohrmann, & Kaaks, 2010; World Health Organization, 2000). Clinically significant improvements in physical health are seen at 5 – 10 % weight loss (Magkos et al., 2016; Wing et al., 2011). Weight loss interventions include behavioral modifications in eating and physical activity with the aim of inducing an energy deficit. Strengthening motivation and providing information about food, weight, and health are considered helpful supporting strategies (Mann, 2015). In the general population, different varieties of behavioral weight-loss interventions are found to lead to weight loss but follow-up studies are limited. Traci Mann and colleagues have thoroughly evaluated long-term results from weight loss studies and found that overall, 95 % of people who lose weight regain their lost weight 5 years after treatment (Mann et al., 2007). Mann et al also found that not only were follow-up studies scarce, follow-up rates were low and many follow-up studies relied on self-reported weight to determine weight maintenance (Mann et al., 2007). Animal and human models demonstrate how complex and interacting physiological, psychological, and neurological mechanisms work against weight maintenance (Bombak, 2014; Greenway, 2015).

Interventions that offer continued support fare better. The Look AHEAD study provided 8 years of intensive support for their participants and only 25 % regained weight beyond their baseline weight (The Look AHEAD Research Group, 2014).

Weight-focused interventions for BED

Very-Low-Calorie Diet ((VLCD), Yanovski, Gormally, Leser, Gwirtsman, & Yanovski, 1994) and *Behavioral Weight Loss treatments* ((BWLT), Wadden, Butryn, & Byrne, 2004) were originally developed for obesity and promote caloric restriction (in VLCD, down to 800 calories a day consisting of liquid formula) and increased physical activity. VLCD and BWLT have been shown to reduce binge eating and BMI for people with BED (Raymond, de Zwaan, Mitchell, Ackard, & Thuras, 2002; Telch &

Agras, 1993; Yanovski et al., 1994). This has led some obesity researchers to question the necessity of psychotherapy interventions for BED (Albert J. Stunkard & Allison, 2003).

In general individuals with BED are more likely to regain weight following a behavioral treatment (Nauta, Hospers, Kok, & Jansen, 2000) than individuals with the same weight without BED, and some studies shower smaller (Blaine & Rodman, 2007; Keefe, Wyshogrod, Weinberger, & Agras, 1984; Pagoto et al., 2007), larger (Gladis et al., 1998) and equal weight losses (Yanovski et al., 1994) for people affected by BED compared to non-BED. This inconsistency in results may be explained by varying measures of binge eating, small sample sizes, and self-report measures.

Wilson et al (2010) compared BWLT to IPT and guided self-help based on CBT (CBTghs) using validated measures and found no significant differences post treatment in binge-eating and psychopathology but superior weight losses following BWLT. At a 2-year follow-up, IPT and CBTgsh were more effective than BWLT on binge-eating and equally effective on weight loss as the participants in the BWLT had gained weight (Wilson, Wilfley, Agras, & Bryson, 2010). Other studies have shown similar superior effects of CBT to BWLT and similar minimal effects of BWLT on weight (C. Grilo & Masheb, 2005; Munsch et al., 2007).

More recently, BED treatments that integrate psychotherapy and weight loss interventions are under evaluation. These include Physical Exercise- and Dietary therapy (PED-t) (Mathisen et al., 2017), and Healthy Approach to Weight Management and Food in Eating Disorders ((HAPIFED), da Luz et al., 2017). In 16 session, PED-t attempts to change body ideals through an increased focus on the body's functionality rather than body appearance and provide knowledge about the harmful metabolic effects of weight cycling. HAPIFED is a 20 session program that includes psychoeducation, relaxation exercises, monitoring of eating behavior, physical activities, training awareness of hunger and identification of triggers (Mathisen et al., 2017).

Two systematic reviews report reductions in binge-eating, depressive symptoms and anxiety and weight but not body image following physical activity interventions (Blanchet et al., 2018; Vancampfort et al., 2013). In the general population, increased physical activity is associated with improved health and reduced risk of mortality independent of current weight status and weight loss (V. W. Barry et al., 2014; Gaesser, Angadi, & Sawyer, 2011; Teucher et al., 2010).

The health-centered paradigm

Researchers and clinicians in the health-centered paradigm oppose the narrow definition of health based on BMI and challenge the reliance on weight loss for increased physical health. They also point to the negative consequences of categorizing bodies as 'normal' or 'unnormal' based on BMI especially referring to the impact of weight bias and weight stigma (Aphramor, 2005; Bacon & Aphramor, 2011; Dollar, Berman, & Adachi-Mejia, 2017; Mann, Tomiyama, & Ward, 2015).

Weight-neutral interventions

Weight-neutral, nondieting interventions are often guided by a Health at Every Size (HAES) philosophy (Robison, 2005). HAES proponents advocate for body acceptance and the idea that the body is inherently wise. These approaches opposes the "control-discourse" of traditional weight loss interventions and argue that external attempts to control eating and physical activity disturb the body's intuitive regulation of food intake and movement (Bacon & Aphramor, 2011).

Research evaluating weight-neutral interventions have mostly included overweight or obese non-eating disordered populations. Preliminary results for these populations show improvements in physical health, eating behavior, body image, and self-esteem (Bacon et al., 2002; Bacon, Stern, Van Loan, & Keim, 2005; Carbonneau et al., 2017; Carroll, Borkoles, & Polman, 2007; Clifford et al., 2015; Dimitrov Ulian et al., 2018; Gagnon-Girouard et al., 2010; Mensinger, Calogero, Stranges, & Tylka, 2016; Provencher et al., 2009; Tylka et al., 2014). The few studies on HEAS interventions for BED show reduced weight, increased body satisfaction, and improved health behaviors (Goodrick, Poston II, Kimball, Reeves, & Foreyt, 1998; Provencher et al., 2009). Other non-weight focused interventions for BED include mindfulness interventions which also show positive results on eating disorder symptoms, health-related behavior, and weight loss (Godsey, 2013; Kristeller, Wolever, & Sheets, 2014).

Weight stigma as a health factor

The health-focused paradigm puts the effects of weight stigma into the health equation. Weight stigma covers "societal weight-based stereotypes that individuals with obesity are lazy, weak willed, sloppy, lacking in self-discipline, unintelligent, and lacking motivation to improve health" and is fund in intimate relations, in families, in the public space, and in institutions including health care settings (R. Puhl & Suh, 2015).

Weight stigma researchers consistently find that weight stigma increases the risk of depression, disordered eating behaviors (A. Sutin, Robinson, Daly, & Terracciano, 2016), weight gain, obesity-associated diseases and all-cause mortality (Muennig, 2008; R. Puhl & Suh, 2015; A R Sutin, Stephan, & Terracciano, 2015) and is associated with poorer body image (Harriger & Thompson, 2012). Several pathways that link stigma and health have been suggested (Brochu, Pearl, & Simontacchi, 2018): 1) heightened stress in response to experienced and anticipated weight stigma (Tomiyama, 2014; Tomiyama et al., 2014), 2) changes in health-related behavior as people who experience stigma are less motivated to exercise (Vartanian & Shaprow, 2008) and eat more food and food of poorer quality (Araiza & Wellman, 2017), and loose less weight in weight loss treatments (Carels et al., 2009). 3) Stigma in health care settings lead to health care underutilization (Angelina R. Sutin & Terracciano, 2013; Tomiyama et al., 2018), and 4) through reduced social connectedness in families, communities, society and culture (Brochu et al., 2018; Holt-Lunstad, 2018; Holt-Lunstad, Robles, & Sbarra, 2017).

Weight stigma as a risk factor for eating disorders and obesity

Some individuals may internalize weight stigma by applying weight-based stereotypes to themselves (L. E. Durso & Latner, 2008) and this is associated with symptoms of depression and disordered eating, and reduced physical activity (O'Brien et al., 2016). Compared to non-eating disordered people, people with BED are more likely to internalize weight stigma. Compared to BED individuals who have not internalized weight stigma those who have exhibit higher levels of weight and shape concerns (L. Durso et al., 2012; Mensinger, Calogero, & Tylka, 2016).

Weight stigma (R. M. Puhl & Brownell, 2012) and weight related bullying (R. Striegel-Moore, Dohm, Pike, Wilfley, & Fairburn, 2002) are risk factors for body dissatisfaction and dieting. And body dissatisfaction and dieting have consistently been found to increase the risk of developing eating disorders and obesity (Bacon & Aphramor, 2011; Cena et al., 2017; Evans et al., 2017; Hilbert et al., 2014; Neumark-Sztainer, Wall, Larson, Eisenberg, & Loth, 2011). Repeated exposure to negative comments about shape, weight, and eating from family members (Fairburn et al., 1998) and family weight teasing (Saltzman & Liechty, 2016) are specific risk factors for BED.

Weight stigma research clearly demonstrates the impact of how people think about themselves and how other people think about them on health and health related behavior. Supporting this, studies have found that people who are satisfied with their body have better physical health and more positive health-related behaviors than people who are dissatisfied, even when controlling for weight (Blake et al., 2013; Neumark-Sztainer, Paxton, Hannan, Haines, & Story, 2006; Wirth, Blake, Hébert, Sui, & Blair, 2014). Crum et al. explored the importance of mindset for health, and found improvements in physical health simply by giving people the impression that their exercise levels applied with public recommendations (Crum, Leibowitz, & Verghese, 2017). In a Mind-over-milkshake study, Crum and her colleagues found significant differences in metabolism and satiety signals depending on the individual's beliefs about the same drink of milkshake (Crum, Corbin, Brownell, & Salovey, 2011).

These studies demonstrate the impact of weight stigma and mindset on health which is relevant in this thesis because they show important links between physical and mental health and between the social contexts and the health status of the individual.

AIMS OF THE THESIS

While the knowledge claims presented above are valuable, I argue that they do not fully reflect the multiple and varied aspects of BED. My main concerns are the individualization of BED problems and the compartmentalization of scientific knowledge into eating disorder and medical obesity fields.

My overall aim in this thesis therefore to inspire new discussions about what constitutes problems and solutions in the BED field and suggest ways of describing and measuring these problems that take the social contexts and interactions between people into account.

Research questions

1. Which understandings of BED and weight problems and processes of change during treatment can a relational and contextual inquiry of treatment afford? This question is addressed in both Paper1 and 2.
2. What characterizes people who seek treatment for BED in a Danish Mental Health Service, and which measurable changes in eating behavior and weight are observed following an integrative systemic and narrative group psychotherapy intervention? This question is addressed in Paper3.
3. How can relational, contextual and processual understandings of BED help to qualify the current objective measures of BED recovery? This question is discussed in the finale chapter of this thesis.

CHAPTER 2: METATHEORETICAL POSITION

In this chapter, I move the inquiry of BED from the prevailing modernist or medical paradigm (Bracken et al., 2012) to a postmodernist paradigm. In the following, I present social constructionism and dialogical and systemic theories. The dialogical and systemic theories are used as analytical perspectives in papers 1 and 2 and are presented in those papers with that purpose. Here, I present the ontological and epistemological aspects of the two theories and my motivation for choosing this position. Firstly, I am trained as a systemic and narrative therapist and I was inspired by writers of the book *Systemic Inquiry* to "stay living in the first language of [my] professional practice *and* make an inquiry into that professional practice" (Simon & Chard, 2014, p. Preface x). Secondly, using the words of British practitioner-researcher John Shotter, I wanted to "avoid the continual rediscovery of sameness" in the field of BED:

> For clearly, as is obvious, the very search for "nameable things" commits us to finding *only* what in some sense we already have names for, what is already familiar to us. To avoid the continual rediscovery of sameness and to turn to the task of bringing to light genuine innovations, previously unexpected, novel steps forward, we need another form of inquiry (Shotter, 2015, p. 99).

Social constructionism

Social constructionism is a broad movement including a varied community of thinkers who differ on issues of ontology and epistemology but share a common critical stance towards realism, rationalism, structuralism, and reductionism (Wenneberg, 2002). Modernist science is deeply rooted in Cartesian dualism and a fundamental divide between mind and matter, and in the Newtonian conception of the world as a machine governed by mathematical laws that is knowable trough reason (Chard, 2014). Social

constructionism is not *against* modernism but is skeptical of its universal truth claims and instead emphasizes that 'the modernist discourse (…) is only one possible discourse' (Sheila McNamee & Hosking, 2012, p. 33).

Social constructionism was moved into the field of psychology by the American psychologist Kenneth Gergen, who urged psychologists to understand the social, political and economic contexts in order to understand individuals and generate relational understandings of psychological problems. This shifted the attention from underlying rules that governed cognition and behavior to exploring the discursive practices that constituted the self and the world (Gergen, 1997, 2001).

> While these developments in understanding may seem opposed to psychological science, they are not. Rather, they invite a new range of questions about the potentials of traditional research. (…) More importantly, the emerging view of psychological science opens new and exciting vistas of theoretical, methodological, and practical significance (Gergen, 2001, p. 804).

Social constructionism rejects the idea of an objectively accessible truth that bears universal or transcendental value. Instead, truth is considered negotiated, partial, and contingent on social, cultural, and historical contexts (Gergen, 2001). Truth is something people agree on and "part of the coordinated activities of the individuals" (Gergen cited in Steier, 1991, p. 78). Kant proposed that *reason* cannot move beyond reality; the subject is an inseparable part of the process of thinking, we do not just observe order in the world, we actively impose that order: things-in-themselves cannot be known (Chard, 2014). Social constructionism's objection against modernism is that they hold that there is no privileged position for knowing; the observer is always part of what is observed. The subject and the social cannot and should not be excluded from the process of knowing or from science. Instead of an object-subject division, postmodernist theorists claim a necessary subject-subject relation i.e. a relational creation of reality (Simon & Chard, 2014).

The social constructionist position draws on Berger and Luckman's *The Social Construction of Reality* (1966) which presents an anti-essentialist understanding of social life as something we construct and maintain in shared social practices while at the same time perceive them as given, and on the anti-realist methodology introduced by Kuhn (1962). Kuhn is especially important in this thesis because he stated that the production of knowledge depends on the language communities of professionals. Kuhn

thereby challenged the authority of single communities to define truth. In *The Structure of Scientific Revolutions* (1962), Kuhn proposed that a scientific language is not determined by the phenomena under investigation but by the shared assumptions and criteria of a given paradigm (Peace cited in Simon & Chard, 2014, p. 34; Wenneberg, 2002). This also means that anything that falls outside the governing linguistic conventions cannot be discovered through reason but require a paradigm shift. Paradigm shifts can only occur from the outside by means of persuasion and not through reason (Chard, 2014).

Following, social constructionism accuses modernist methodology of creating a hierarchy of knowledge that undermines subjective knowledge and knowledge produced in other social and cultural settings (Gergen, 2001). Objectivity is not neutral (Hoffman Sheila McNamee & Gergen, 1992). Knowledge cannot be separated from power and, so, knowledge and scientific criteria that determine what is considered valid will privilege some and marginalize or silence others (Foucault, 2006).

Language as constitutive of reality was developed further in the *linguistic turn* were linguists and post-structuralists like Derrida (1973), Saussure (1974), Wittgenstein (1953) (In Burr, 2003) opposed the correspondence theory of language and reality; Language does not just describe a reality already out there, language has the power to construct our reality. Our descriptions, the words we use to describe the troubles, values and intentions of people (and everything else) shape the world we live in. Given the constitutive role of language and the relation to power, it becomes less important to determine which perspective is true compared to a common standard and more important to reflect on who is privileged and who is silenced, and which possible futures arise by choosing one perspective over another. A social constructionist inquiry therefore works to *denaturalize* and *democratize* knowledge and requires an ethical reflexivity (Gergen, 1997).

Dialogical theory

In line with social constructionist thinking, the Russian philosopher and linguist Mikhail Bakhtin (Bakhtin, 1984) proposed dialogue as a model of the world. I will present how Bakhtin has influenced my epistemological position in the following and describe his ideas about the self in Paper 2. According

to Bakhtin, the world, selves, and language are by nature messy. All social entities are *oscillating fields* of opposing forces: *Centripetal* forces that push for order, unity and agreement and *centrifugal* forces that seek disruption of order, multiplicity, and disagreement. For life to make sense, both forces must be present. If only order and unity reign nothing new can arise –life and selves will be finalized, closed, and monological. Likewise, if truth, life, and selves are governed only by difference and disruption, an accumulation of meaning becomes impossible.

Bakhtin proposed the concept of *heteroglossia* to explain the ordering forces of language which give specific groups their way of speaking and conceptualizing the world (Morson & Emerson, 1990). The psychological and psychiatric language of BED is one example of such heteroglossia as we see communities of professionals agreeing on using certain words to conceptualize BED and communicate about BED. Another example is 'Body Mass Index' (BMI) and all the knowledge claims that have been produced around this concept including the idea of a 'normal weight' and an 'unhealthy weight' (Nuttall, 2015).

According to Bakhtin, words are shaped by social and historical events and personal experiences. The words we use are therefore "already populated" with accumulated evaluations and intentions. The "already populated" quality of words makes words internally dialogical in the sense that they have many voices within them that can be responded to.

> All words have the 'taste' of a profession, a genre, a tendency, a party, a particular work, a particular person, a generation, an age group, the day and hour. Each word tastes of the context and contexts in which it has been lived its socially charged life; all words and forms are populated by intentions (Bakhtin 1981, 293).

Contrary to modernist psychological research, Bakhtin was not interested in what lies inside the mind of individuals or what can be said once and for all. Truth, unity, and understanding, in a dialogical sense, requires a continued engagement with the many different and inherently dialogical voices of the world.

> Nothing conclusive has yet taken place in the world, the ultimate word of the world and about the world has not yet been spoken, the world is open and free, everything is still in the future and will always be in the future (Bakhtin, cited in Morson & Emerson, 1990, p. 36).

> Real dialogism will incarnate a world whose unity is essentially one of multiple voices, whose conversations never reach finality and cannot be transcribed in monological form. The unity of the world will then appear as it really is: polyphonic (Bakhtin, cited in Morson & Emerson, 1990, p. 61)

According to Bakhtin, things that are meaningful and truly new can only arise at *the borders* in the meetings of voices and people, not inside one single mind or in closed, abstract theoretical descriptions of every-day events. What concerned Bakhtin was that essentialist and structuralist knowing rejects the voice of 'the other' and pretends to be the ultimate word. He called this monologism:

> "Monologism, at its extreme, denies the existence outside itself of another consciousness with equal rights and equal responsibilities, another I with equal rights (thou). (…) Monologue is finalized and deaf to the other's response, does not expect it and does not acknowledge in it any decisive force. Monologue manages without the other, and therefore to some degree materializes all reality. Monologue pretends to be the ultimate word. It closes down the represented world and represented persons."
>
> "Monologic speech seems to come from God or nowhere; it is dissociated from the speaker who originates it, and from the social relations in which that speaker is embedded." (Bakhtin, 1984, pp. 292–293).

On those grounds, Bakhtin also rejected traditional subject-object oppositions and urged researchers and others to gain understandings through their 'willed relationship' to the world and by attending to the many different influences and intentions, values, and complex dialogical relations that are at work in each moment (Morson & Emerson, 1990). Understanding cannot be the *merging* of two minds as this would add nothing new to the encounter; understanding comes from the *surplus of vision* that only 'the other' can give (Morson & Emerson, 1990).

In this thesis, I strive for Bakhtin's concept of *polyphony* where the different voices and perspectives of the project are not merged into one truth about BED but are orchestrated in a way that retains the differences and the potential for newness. Bakhtin is useful because he offers a way to map out the dialogical spaces, the different communities of scholars, the words and positions that are presented in the thesis, and he is a valuable reminder of the dangers of succumbing to one single truth.

Cybernetic systems theory

Systems theory is grounded in the work of Gregory Bateson. Bateson was an anthropologist, biologist and philosopher and wrote *Steps to an Ecology of Mind* (1972) where he argued for the importance of context in shaping and understanding phenomena:

> "And context is linked to another undefined notion called meaning. Without context, words and actions have no meaning at all. This is true not only of the human communication in words but also of all communication whatsoever, of all mental process, of all mind, including that which tells the sea anemone how to grow and the amoeba what he should do next " (Bateson, 1972, p. 79).

Bateson states that all entities that co-vary, be it humans, families or organizations, are systems and all systems comprise subsystems and are embedded in larger supra-systems. Components interact with each other in reciprocal processes simultaneously changing and creating change in each other. From this follows a circular causality (in place of a linear causality) where there is no primary cause and no finale result as everything is at once the cause of what follows and the effect of what comes before it. A central principle is that the whole is more than the sum of its parts; interactions give rise to something new that cannot be ascribed to one person or element alone but must be understood as a co-constructed phenomenon. Bateson called this the *emergent properties* of the system (Bateson, 1972).

A systemic theory of change

Paul Watzlawick and colleagues proposed a systemic theory of change in their book *Problem Formation and Problem Resolution* (Watzlawick, Weakland, & Fisch, 1974). They presented the paradoxical idea that the continuation of a problem requires continued effort whereas the solution to that problem may require the termination of trying. Watzlawick and colleagues argued that problems do not exist, only events exist, and that a system will react to events with attempted solutions. If the attempted solution is wrong the situation will develop into a problem. This means that the attempted solution becomes the problem. Over time, the problem will worsen as the attempts to solve it are intensified. Even when trying seemingly different solutions, the person is caught in a "Game without End"; the more things change the more they stay the same (Ibid. 1974, p. 22). This is termed *first order change* and occurs within a closed

system where it is impossible for those who are involved to identify the causes and effects or change the governing rules or sets of premises that maintain the behavior. Change requires a disturbance from outside the system, a so-called *second order change* (Watzlawick et al., 1974, pp. 9–10).

Watzlawick's theory of change has guided much of my attention in this thesis as I expected that by attending to what was considered problems and solutions, I would learn about how BED problems develop, are sustained, and can be dissolved. The theory is also at the core of the argument developed in Paper 1.

A social constructionist, systemic and dialogic inquiry

The epistemological and ontological assumptions, I have present here, create a space for inquiring into relational being, the complexity of human communication, paradoxes of change, and truth and reality as emergent and evolving. The objects of inquiry in this project are the processes and emergent properties of the systems/patterns of events known as BED. The type of knowledge claims I will produce will be open, negotiated and unfinalized and encourage a continued discussion with and among those who read my work. Where some might hope to find answers on how to solve the weight problem, I offer a new framework for thinking about and conceptualizing the problems. My hope is that this will contribute to change.

Withness-thinking

The American psychologist John Shotter brought dialogical thinking and second order cybernetic systems theory into the realm of psychology and later into the field of research (Bayer & Shotter, 1998; Shotter, 2005, 2012, 2015).

Shotter argued that knowledge and newness is only possible when both the object and the subject remain subjects. To avoid "the continual rediscovery of sameness" (2015 p.99) Shotter suggests a kind of inquiry that especially draws on Bakhtin's dialogical and monological concepts. Shotter operates with ideas of *withness-thinking* (dialogical) and *aboutness-thinking* (monological) which denote two distinct positions of the researcher to the researched: Withness-thinking is to meet the object of inquiry not as an

object but as another subject (Shotter & Shotter, 2008). This requires a *responsiveness* of the researcher and a sensitivity towards what is emerging. Like Bakhtin's concept of active understanding, Shotter foregrounds *Performative Understanding* which is not acquired by a transference of information but involves *embodied communication* and intuitive responses (Anderson, 2014). On this point, Shotter criticizes social constructionists for discarding the body in communication (Shotter, 2010). Performative understanding involves being moved by and engaging with others, "listening" and "looking" rather than "seeing" and "hearing" (Shotter, 2015, p. 99). Shotter thus describes withness-thinking as taking an *alongside position* with the people of inquiry and noticing with them what exists at the peripheries, sensing from within all that is present but not entirely known. Opposed to this, aboutness-thinking represents an outside position where the researcher "lives inside the theories" about the world and remains unchanged by the inquiry (Shotter, 2010).

Each in their way, Shotter, Bakhtin, Bateson and Gergen argues that the modernist paradigm invites researchers into closed conversations and monologues *with* each other *about* the phenomena that they wish to understand. This not only silences the people that are objects of inquiry, it also closes the potential for creating new ways of thinking. I believe that the systemic idea of a "Game without End" (Ibid. 1974, p. 22) were a system tries to find solutions by applying its own elements in different sequences, and a system that is governed by its own laws and logics, neatly illustrates the shortcomings of the current research on BED and BED treatment. The thesis therefore attempts to disturb the governing ideas about BED by taking a perspective that lies outside this system of knowledge.

CHAPTER 3: METHODOLOGY

Together these social constructionists, systemic, and dialogical (meta-)theories have focused the subject of my inquiry and committed me to certain ontological and epistemological positions. In this chapter, I present the research design, the setting and material, the empirical perspectives and methods. The thesis had a dual aim of evaluating a clinical practice and inquiring into BED and weight as social products. While the evaluation part of the project was placed in a modernist paradigm, the qualitative exploration was placed in a postmodern paradigm which, as stated, entail different ideas about knowledge and knowing. This could be a methodological challenge, but, the meta-theoretical shifts that are made here are not moves *away* from a certain type of knowledge but a *repositioning* (S McNamee, 2014) into new dialogical spaces.

As Bakhtin argued, nothing meaningful can emerge through centripetal forces or centrifugal forces alone. These tendencies must coexist as tensions and contradictions. In the same way, I will regard the different types of knowledge produced in this thesis as simultaneously pushing for order and predictability *and* pushing for disruption of order and newness. The centripetal forces of this field include the naming of BED as a diagnosis, the derived scientific and theoretical abstractions, and the ideas about predictable causality. The centrifugal forces come from taking a social constructionist, systemic, and dialogical position which include *denaturalizing* the taken for granted truths, *democratizing* truth (Gergen, 1999), attending to the not-yet quite known (Shotter), attending to knowledge claims that go against consensus (Bakhtin), and *repopulating* the aboutness-conversations with voices of living people (Billig, 1998).

Gergen (2002) and others (Anderson, 2014) suggest looking at realism and constructionism as two different forms of discourse or *research worlds* (S McNamee, 2014) which are brought into generative tensions and conversations with each other. In this thesis, I will move between these different worlds on what Harlene Anderson called a dialogical-monological continuum (Anderson, 2014). The dialogical position of the thesis therefore enables me to orchestrate the different professional, theoretical, analytical, and empirical voices of the studies into a Bakhtinian kind of polyphony of voices.

I have presented the theoretical perspectives that have guided my attention in the field of analysis. I now situate the project and my position by presenting the historical and political contributors that I have responded to and relate these to the choices I have made in the empirical field including how I gained access to the field.

The situatedness of the project

The Danish Health Authority provided funding to expand and scientifically evaluate a BED treatment model at SPCs Unit for Eating Disorders. They were interested in gaining knowledge about the BED population, including how BED could be distinguished from the general population with obesity, and about treatments that could effectively reduce BED symptoms and lead to weight loss.

Positioning

I had worked at the Unit for Eating Disorders as a therapist in groups for patients with bulimia and BED and was employed in the BED team when I started the PhD project in January 2013. As an eating disorder practitioner, I wanted to do research that stayed close to the clinical practice and involved the voices and perspectives of the patients. The first months of the project were a transition phase where I moved from being a clinician to becoming a researcher. During this time, I participated in meetings with the BED team about how to address weight in the new treatment. Our initial discussions concerned whether weight loss treatment should be sequential or parallel to the psychotherapy treatment and if all or just some of the patients (those fully recovered) should be offered the option of weight loss. At the time, our shared clinical knowledge was that our patients were frustrated and anxious at the prospect of ending psychotherapy treatment and having to seek weight loss treatments on their own. We wanted to help them but none of us knew how. Inspired by a BED conference in Washington, I introduced the team to ideas about size acceptance and the HAES movement (Bacon, 2008). I believe this inspired them to develop what came to be called the *Wellbeing* group. I was not part of the process of developing what became the *Weight-Loss* group, but I later learned that it had given rise to many negotiations.

About 3-4 months into the project, I stepped back and created a distance to the treatment setting. During this time, I met with the Head of the BED team to start planning and implementing the

quantitative study which was to begin November 2013. The timeline below gives an overview of the PhD period and depicts the process of data collection and analyses (Figure 3).

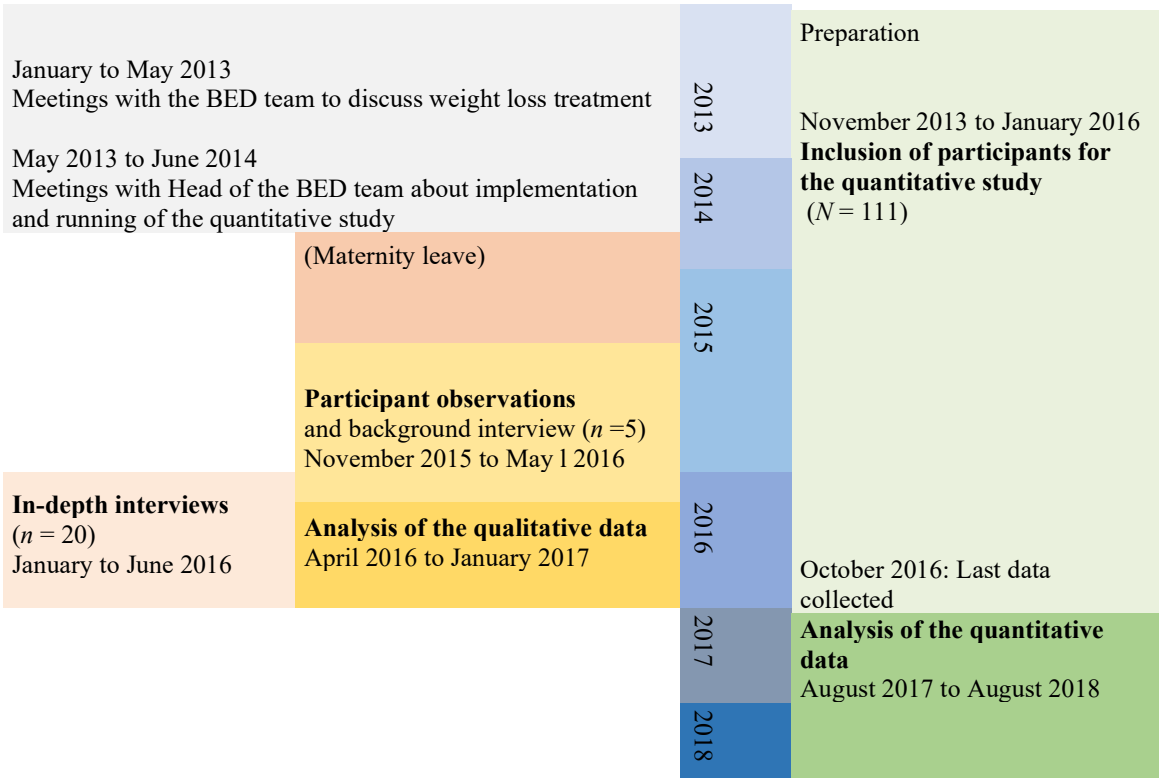


Figure 3. Timeline of the PhD period including inclusion period for participants for the quantitative study, data generation for the qualitative study, and analyses of the quantitative and qualitative data.

The political context

The political context of this thesis is also worth mentioning because it influenced the participants' responses to me and to their treatment. At the time of the study, BED had just been included in the DSM-5 manual and there were many talks among therapists and patients about if and when BED would be recognized in the Danish health care system. Other European countries including Sweden, Germany and the UK offered BED treatment so why not Denmark? Occasionally, there was public awareness about BED following TV programs or newspaper articles. Some of the participants were active in the debate

and wrote articles or participated in interviews. The uncertainty about what to expect affected the participants a great deal. On the one hand, the participants were grateful and felt lucky for being offered treatment at all, and they wanted to participate in my research to give something back to the center. I also believe, they hoped that participating could contribute to securing BED treatment in the future - that I could get the message across that BED was a real diagnosis that was worthy of treatment. On the other hand, the uncertainty also affected many of the participants negatively, especially those who completed treatment right at the end of funding period. They felt that the door was closing behind them, that there would be no more help if they needed it in the future. Which was also the case. Funding from the Danish Health Authority ran out May 2016 and the Mental Health Service in the Capital Region of Denmark agreed to fund the I-SN BED treatment the remaining year. In 2018, the Ministry of Health funded seven BED interventions including LMOSOS and the BED-Clinic [In Danish: BEDklinikken] where the systemic and narrative therapy model was continued. The ICD-11 was released in June 2018 but permanent treatment for BED is not expected until at the earliest 2022.

Setting and interventions

The project was physically situated in a clinical psychiatric setting at the Unit for eating disorders at SPC. Funded by different internal sources, SPC had offered BED psychotherapy group treatment for 10 years (2002-2012) to a limited number of BED patients with BMI of up to 40. With the funding from the Danish Health Authority they were to expand this treatment and include a weight loss module. SPC is part of the Mental Health Service in the Capital Region of Denmark and included three outpatient units for Anxiety Disorders, Personality Disorders, and Eating Disorders. The Unit for Eating Disorders provided treatment for adult, non-psychotic patients with different moderate to severe eating disorders. Treatment followed official guidelines and regulations (Danish Health Authority, 2005). The eating disorder treatment was organized in teams depending on BMI; patients with BMI < 20 were offered AN treatment, patients with BMI 20 – 26 were offered BN treatment and patients with BMI >27 were offered the BED treatment. This meant that approximately 10 % of patients in the BED treatment had BN or EDNOS diagnosis, and that some BED patients with BMI below 27 were offered BN treatment.

The BED treatment was conducted by a core team of two psychologists, two social workers, two physiotherapists, two dieticians, and a psychiatrist. During the quantitative study period, there were four parallel psychotherapy groups and a total of three psychologist, four physiotherapists, and six dieticians. The psychologists, social workers, and two of the physiotherapists had therapeutic degrees in systemic and narrative therapy. The Head of the BED team (a psychologist) was part of the planning and implementation of the new two-phased treatment but stopped June 2014 and was followed by a psychiatrist.

All patients who were accepted for treatment at SPC Unit for Eating Disorders were assessed to determine eligibility for inclusion in the quantitative study. The sample comprised treatment-seeking adult patients (age ≥ 18), referred by their general practitioner in the period of November 2013 to February 2016.

The two-phased treatment

The new and expanded model for BED treatment comprised two phases (see Model 2) Phase 1 was standard systemic and narrative treatment conducted in groups of 7 patients. Focus was primarily on reducing eating disordered behavior and related psychological problems. In Phase 2, the patients could, in collaboration with therapists, choose to proceed either in a Wellbeing/Weight Acceptance group or a Health and Weight Loss group. Dialogue meetings were arranged where patients were informed about treatment and could hear experiences from former patients. Both Phase 2 groups had eight to 10 patients. All groups in the two-phased treatment were open to new patients as others finished. Groups met weekly or bi-weekly (only Wellbeing/Weight Acceptance) from 8:30 a.m. to 12:00 p.m. followed by a joint unsupervised lunch. All patients were weighed prior to group sessions.

I describe the two-phased treatment briefly below and refer to Paper 1 of this thesis and a BED report directed to the Danish Health Authority (Lauest, Meyer, Lau, & Waaddegaard, 2016) for more detail. Also, practitioners at the Unit for Eating Disorders have produced work concerning the clinical practices (Schousboe, 2010, 2011; Svarrer & Rasmussen, 2008).

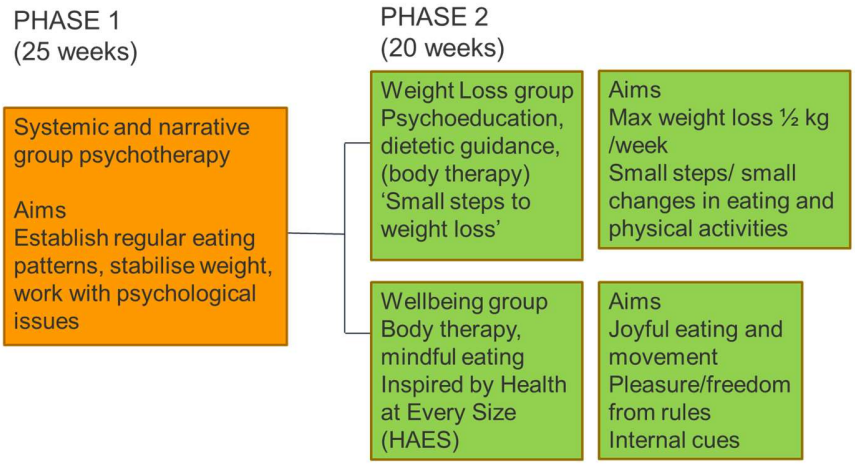


Figure 4. The two-phased treatment model at SPC, Systemic and narrative group psychotherapy and Weight loss and Wellbeing groups

Phase 1 Integrative Systemic and narrative psychotherapy (I-SN)

Prior to Phase 1 treatment, the participants attended two psychoeducational sessions and a preparatory session with an assigned group therapist. The I-SN group treatment comprised 25 weekly systemic and narrative psychotherapy sessions of 3 ½ hours. Every fifth session was nutritional guidance led by a dietician and with a therapist present to secure transitions into therapy. The focus was on normalizing eating patterns by implementing 3 meals and 3 snacks a day and education about the body's physiological needs. To counter the eating disorder's restrictive rules about food, there was a deliberate aim to allow all foods. Before starting treatment, patients were required to sign consent forms agreeing to keep a food diary with the aim of exploring relations between eating behavior and thoughts, emotions and activities in their everyday lives. A stable weight of +/- 5–7 kilos (ll-15.5 lbs.) depending on BMI was required during treatment to underline the point that weight loss attempts were considered a maintaining factor in the eating disorder. If the participants lost or gained weight beyond these limits, they were offered to end treatment or enter a reflection period of three weeks. During this time, the participants were to reflect on why their weight was not stable and decide if they wanted to continue or terminate treatment.

Treatment elements

Some treatment elements were mandatory, and others were optional and offered according to individual treatment needs. In the Table below, I present the average treatment usage for the completers of the quantitative study on mandatory elements i.e. group psychotherapy and nutritional guidance, and the number of completers who chose to attend optional treatment elements and the average usage of each of these treatment elements.

Table 1. Average treatment usage of mandatory treatment elements for completers (N= 82)

Number of completers who chose optional treatment elements and their average usage (varying n's)

Treatment type	**Form and duration**	***n***	**Maximum possible treatment time (Hours) Mean (SD)**	**Average treatment time used (Hours) Mean (SD)**
MANDATORY TREATMENT ELEMENTS (*N* =82)				
Psychoeducation	(2 x 1½ hours)	82	3.0	3.0
Group Psychotherapy Intervention	Systemic/Narrative psychotherapy (20 x 3.5 hours)	82	70.0	63.0 (6.2)
	Nutritional guidance group (5 x 3.5 hours) and individual interventions (3 x 1 hour)		20.5	12.5 (3.2)
OPTIONAL TREATMENT ELEMENTS (Varying *n*'s)				
Mind-Body Intervention	Mindfulness (10 x 120 min) Basic Body Awareness Therapy (10 x 2 hours)	31	40.0	4.0 (6.6)
Individual Intervention	Therapy, social or psychiatric counselling (1 hour)	58	3.0	2.1 (2.3)
Relational/ Interpersonal Intervention	Partners, relatives, support network (2 x 1 hour)	62	7.0	3.0 (2.7)
	Multifamily meetings (2 x 2.5 hours)			

Methods and principles

Treatment was individual therapy in groups: A therapist interviewed each patient based on their diary entries after which the rest of the group and therapists provided feedback modelled on the Norwegian therapist, Tom Andersen's principles for reflecting teams (Andersen, 1987). Patients were

advised to give feedback about what had resonated or inspired them when they were listening and what came across as important to the interviewed patient.

The therapy was systemic and narrative which is grounded in postmodernism thinking where psychological problems are not understood as located within the individual but as embedded in the local and social, cultural contexts of the patients' lives. The narrative method of externalizing (White, 2007) tries to linguistically create a distance between the problems and the affected people. Externalizing is based on an underlying conviction that the person is not the problem, the problem is the problem. The treatment team consistently spoke externalizing about eating disorder-related thoughts, feelings, and behaviors and self-criticism/hopelessness naming these issues *the eating disorder* and *the critical voice* respectively.

In narrative therapy, the therapist's role is to facilitate joint explorations of how the problem affects the patients' lives. In systemic therapy, the problem is understood in terms of patterns of communication and interpersonal relationships (Andersen, 1987): Change relies on widening the 'contextual premises' of the problem and 'trigger new modes of relating' to the problem through the facilitation of dialogues (Andersen, 1987).

Phase 2. Health and Weight loss or Well-being/Weight Acceptance

Health and Weight loss ('Sundhed og vægttab')

The Weight-Loss intervention went through many changes during the course of the project: Initially, the group met every other week and was facilitated by a dietician and a physiotherapist, but many patients relapsed in their eating disorder, so the intervention was re-evaluated. The group ended up meeting weekly and were assisted by a therapist. The focus on weight loss also changed. The expected weight loss was presented as a maximum of ½ kg (1.1 lbs.) a week. This was later accompanied by the instructions of the therapists as: "getting experiences with doing weight loss in a safe environment by making small lifestyle changes in eating habits and physical movement."

Frame and elements

To attend this group, patients had to be fully recovered from binge eating to counter relapse. Fifteen patients completed the treatment.

The Health and Weight Loss group was modelled on a national weight loss project "Small Steps to Weight Loss" (Danish Health Authority, 2015). Care providers were a physician in training, a physiotherapist, and a dietician. Treatment was structured around a series of eclectic psychoeducation sessions (conducted by the physician in training) and supplemented with nutritional guidance and elements of meditation and body therapy.

Well-being/Weight Acceptance ('Trivsel og velvære')

The principles of the Wellbeing/Weight Acceptance group were aligned with the non-normative clinical attitude of the Phase 1 treatment. Treatment in this group also changed because of turnover in the physiotherapists who were responsible for body therapy.

Principles and methods

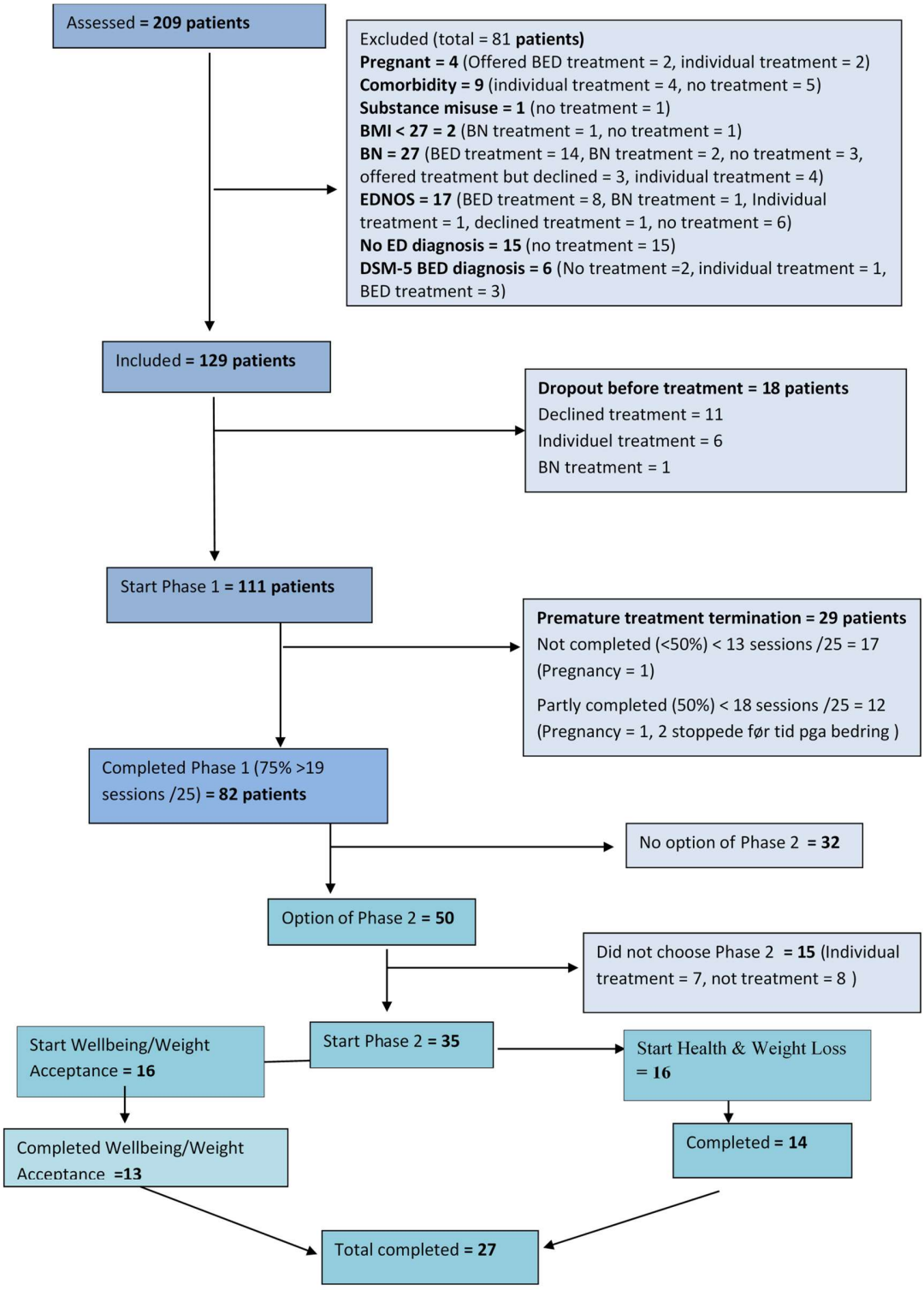
The Wellbeing/Weight Acceptance group was inspired by Health at Every Size principles (HAES®, Bacon, 2008). The aim was presented by the therapists as "gaining greater acceptance of yourself and your body and finding enjoyment in eating and bodily movements."

The main component was Basic Body Awareness Therapy supplemented with mindful eating exercises, meditations, and therapeutic counseling of BED symptoms. Patients were weighed, but there were no weight demands. Care providers were a psychotherapist, a physiotherapist, and a dietician.

Participants

Included in the effectiveness study were 111 patients who fulfilled the criteria for BED according to DSM-IV-TR research criteria (American Psychiatric Association, 1994) and had a Body Mass Index (BMI) ≥ 27. They were all offered I-SN group treatment for BED. Excluded were patients unable to

communicate in Danish, in acute suicidal risk, suffering from current psychosis, having an ongoing substance abuse, were pregnant or in concomitant psychotherapeutic or psychiatric treatment outside the facility. See flow below.


Assessed = 209 patients
Excluded (total = 81 patients)
Pregnant = 4 (Offered BED treatment = 2, individual treatment = 2)
Comorbidity = 9 (individual treatment = 4, no treatment = 5)
Substance misuse = 1 (no treatment = 1)
BMI < 27 = 2 (BN treatment = 1, no treatment = 1)
BN = 27 (BED treatment = 14, BN treatment = 2, no treatment = 3, offered treatment but declined = 3, individual treatment = 4)
EDNOS = 17 (BED treatment = 8, BN treatment = 1, Individual treatment = 1, declined treatment = 1, no treatment = 6)
No ED diagnosis = 15 (no treatment = 15)
DSM-5 BED diagnosis = 6 (No treatment =2, individual treatment = 1, BED treatment = 3)
Included = 129 patients
Dropout before treatment = 18 patients
Declined treatment = 11
Individuel treatment = 6
BN treatment = 1
Start Phase 1 = 111 patients
Premature treatment termination = 29 patients
Not completed (<50%) < 13 sessions /25 = 17
(Pregnancy = 1)
Partly completed (50%) < 18 sessions /25 = 12
(Pregnancy = 1, 2 stoppede før tid pga bedring)
Completed Phase 1 (75% >19 sessions /25) = 82 patients
No option of Phase 2 = 32
Option of Phase 2 = 50
Did not choose Phase 2 = 15 (Individual treatment = 7, not treatment = 8)
Start Wellbeing/Weight Acceptance = 16
Start Phase 2 = 35
Start Health & Weight Loss = 16
Completed Wellbeing/Weight Acceptance =13
Completed = 14
Total completed = 27

Selection of the qualitative subsample

During a 6-month participant observation period (November 2015 to Maj 2016), 32 patients participated in group treatment in Phase 1 and 2. I invited all patients who fulfilled the criteria for the quantitative study and who had completed Phase 1 (*n*= 6) or 2 (*n*= 16) for in-depth interviews. Of these, 20 accepted (Phase 1, *n* = 5; Weight Loss, *n* = 8; Wellbeing/Weight Acceptance, *n* = 7). One participant (Phase 1) did not respond and one (Wellbeing/Weight Acceptance) declined due to work. One participant (Astrid, pseudonym) participated in both Phase 1 and Phase 2 and was interviewed twice. She was asked for separate consent in both instances. All consented to the observational study (*n* =11 in each group). Table 2 provides an overview of the participants who were invited for interviews.

Table 2. Participants who were invited for interviews

	Pseudonyms	Age	Gender	Interview, date, place and length	Marital status	Occupation
Phase 1. Systemic and Narrative therapy. Six were invited and five accepted.						
1	Astrid	53	Female	17-12-2015 Stolpegaard, 1:18 hours	Divorced	Employed
2	Nana	35	Female	01-02-2016 Stolpegaard, 1:10 hours	Divorced	Employed
3	Signe	37	Female	17-02-2016, Stolpegaard, 1:17 hours	Married	Employed
4	Eva	26	Female	30-03-2016 Stolpegaard, 55 minutes	Single	Enrolled in education
5	Andrea	33	Female	13-04-2016 Stolpegaard, 1:12 hours	Single	Sick leave
6		36	Female	Declined	Married	Unemployed
Phase 2. Health and Weight Loss. Eight were invited and all accepted.						
7	Sara	42	Female	20-03-2016 Phone, 42 minutes	Married	Employed
8	Lise	40	Female	17-05-2016 Home, 1:13 hours	Divorced	Self-employed
9	Lucy	42	Female	25-02-2016 Stolpegaard, 1:12 hours	Married	At home wife
10	Frey	27	Female	29-04-2016 Home, 1:29 hours	Single	Enrolled in education
11	Ida	54	Female	26-04-2016 Stolpegaard, 1:10 hours	Single	Employed
12	Liz	29	Female	08-05-2016 Stolpegaard, 1:08 hours	co-living	Employed
13	Erik	27	Male	07-06-2016 Stolpegaard, 52 minutes	Single	Employed
14	Ingrid	58	Female	17-06-2016 Stolpegaard,1:06 hours	Married	self-employed
Phase 2. Wellbeing/Weight Acceptance. Nine were invited and eight accepted.						
15	Astrid	53	Female	06-05-2016 Home, 2:10 hours	Divorced	Employed
16	Asta	30	Female	20-01-2016 Home, 1:19 hours	Single	Employed
17	Tor	34	Male	06-06-2016 Phone, 23 minutes	Single	Employed
18	Thea	43	Female	23-01-2016 Home, 1:30 hours	Married	Unemployed
19	Marius	28	Male	18-04-16 Phone, 40 minutes	co-living	Employed
20	Jade	21	Female	06-04-16 University, 1:06 hours	Single	Employed
21	Tanja	36	Female	07-06-2016 Home, 1:30 hours	Married	Employed
22	Susan	37	Female	20-06-2016 Stolpegaard, 1 hour	Married	Unemployed

Design, methods and materials

The overall aim in this thesis was to inspire new discussions about what constitutes problems and solutions when it comes to BED and weight and how these problems can be addressed in treatment. The specific interests of the Danish Health Authority and myself led to the formulation of two specific purposes; one was to evaluate the treatment intervention and provide knowledge about the patient group, the other was to inquire into the contexts and processes of change. This required a multimethod research design comprising a quantitative pre-post effectiveness study and an ethnographic qualitative study using participant observations and in-depth interviews (See Figure 5 below).

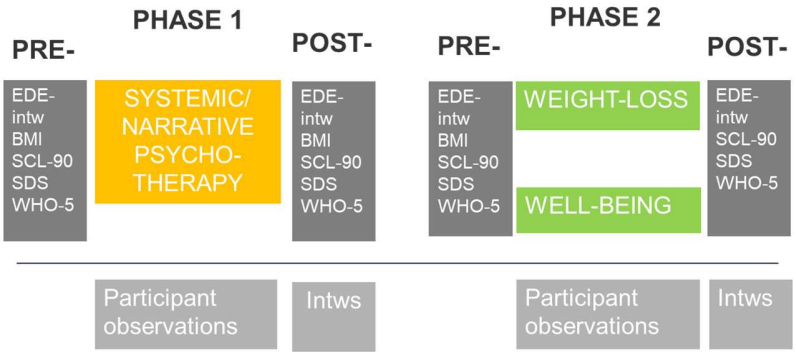


Figure 5. The multimethod design comprising a pre-post effectiveness study and a qualitative ethnographic study

The quantitative measures elicited the necessary data to describe the psychiatric and psychological characteristics of the patients and the aggregated data about their treatment responses. Qualitative data were needed to inquire into contextual and processual aspects of BED and weight in a lived life perspective as well as processes of change in treatment (Tjørnhøj-Thomsen & Whyte, 2008). The multimethod design provided different datasets and different levels of analysis which were consistent with the objective of generating new knowledge through difference and dialogue. Data were analyzed separately in accordance with the specific methods and brought into conversations (Creswell & Plano Clark, 2011). The qualitative data were analyzed before the last quantitative data were collected which limited the possibilities for merging and discussing the qualitative and quantitative findings.

Initially, I expected to evaluate both phase 1 and 2 quantitatively and supplement this with qualitative methods. This changed because Phase 2 was not as suited for quantitative evaluation. There

were many changes in the treatment during the evaluation period and only about 1/3 of the participants chose to proceed in phase 2. Furthermore, due to lack of funding, Phase 2 treatment ended May 1st, 2016, which meant that not all patients had the option of choosing Phase 2 treatment and some patients only received a shortened version. I chose to expand the qualitative study so it became the major part of the project. I start by presenting the qualitative study followed by the quantitative study.

Qualitative study

It follows from the medical model that patients are passive recipients of treatment, which, in a psychotherapy context, means that change happens as patients adopt the solutions presented in treatment (Bracken et al., 2012). Treatment efficacy is then established by comparing pre and post measures of the patients. Following from the social constructionist, dialogical, and systemic ideas of change, I was instead oriented towards processes, language exchanges, and interactions between people, and what the participants identified as problems and solutions. This orientation required that I moved "to the world of action" instead of remaining in the theoretical world, and that I specifically located "conversational action" (Gergen, McNamee, & Barrett, 2001). This meant that I had to be present with the patients and therapists as they engaged in treatment (Tjørnhøj-Thomsen & Whyte, 2008). I also wanted to foreground the subjective knowledge in the field and *repopulate* (Billig, 1998) it with living voices as a counterpoint to the objective knowledge production which meant that I had to ask the participants about their experiences and understandings of their problems in the context of their lived lives (Madden, 2010; Rubin & Rubin, 2005). To accommodate these aims, I designed one part of the study as a qualitative study combining participant observations with interviews with participants.

Following Shotter's ideas of performative understanding and withness-thinking, I wanted to immerse myself "within the area of special interest and take an alongside position with the other speakers" (2005). Taking a withness-position involved that I attended more to the participants' words and understandings and how they moved me than to my preconceived ideas. Between interviews, I also tried to bring the participants' stories and experiences into my own life: When biking, walking, or eating I would imagine what it would be like if someone suddenly yelled at me or commented on my body or what I was eating, and what I would do if my body had changed dramatically and I had to see family or friends or meet new people. I tried to image what it would be like to eat at home and sense that my

boyfriend preferred that I lost weight and did not eat. I did this, not to understand exactly what it was like for the participants as this would not add to their experiences, but to take advantage of the surplus of vision (Bakhtin in Morson & Emerson, 1990) of trying to understand experiences of living in a larger-sized body while having an average-sized body.

Participant observations

From November 2015 to Maj 2016, I did participant observations in the two-phased BED treatment at SPC. I was part of a variety of contexts and this rendered different ways of engaging with the therapists and the participants possible (Tjørnhøj-Thomsen & Whyte, 2008). Each week, I took part in one therapy group (Phase 1) and one Weight-loss group (Phase 2), and every other week I also attended a Wellbeing group (Phase 2) as they only met bi-weekly.

Inspired by Holstein and Gubrium, I strived to oscillate between the *how* and the *what* of the treatment and the *everyday realities* as sources of construction. *The sensemaking processes* (Holstein & Gubrium, 2008, Chapter 19) therefore involved noting the contexts of utterances; who was speaking and in which setting but also the atmosphere in the room, the patients' and therapists' movements and activities and small gestures.

In table 3, I present an overview of the activities in Phase 1 and 2 treatments that I participated in along with what I noted down and when, and examples of my reflections.

Table 3. Overview of activities and participant observations, notes and reflections from participant observations November 2016 to May 2016

Activities	Participation	Notes and reflections
Participant Observations of Phase 1		
Waiting in the waiting area to be weighed and inside the weighing room where each participant was weighed individually.	I sat in the waiting area with the patients until the therapists came and called the first patient in to be weighed. Most often, I followed the first participant to be weighed and then stayed in the weighing room. Occasionally, I remined in the waiting area. Both places, I would join in the conversations with the participants and therapists when invited or briefly commented on something that was said. In the weighing room, I stood in the same place every time, in the corner with my side to the participants. I made an effort to not see the weight to be sensitive to the situation.	**Notes in the waiting area** In the waiting area, I did not make field notes but jotted down notes as soon as I could, either in the weighing room or in the therapy room and elaborated on these notes when I went to my office. I attended to the topics that the participants talked about when they entered the room, stepped on the scale and discussed the weight with the therapist. **Notes in the weighing room** I wrote down what was said and done, and the positions of the participants in the room, how the therapists and patients moved and responded to the issue of weight. **Reflections** In the waiting area, the atmosphere was almost always light and joyful even when the topics were difficult. No one ever spoke of their weight. In the weighing room, the atmosphere was sometimes also joyful but also sometimes tense. I noticed a strange scarcity of words concerning the participants' weight. I often did not know if the weight had gone up or down. **Inspiration for interviews** I asked the participants in the interviews what it was like to be weighed and how they understood the silence concerning weight.
Waiting for the group therapy to start	I sometimes spoke to the participants and casually sat or stood somewhere in the therapy room. If there was silent (most often because someone was writing their food diary), I would sit at my table.	**Notes** I had my notebook on the table and would only take notes if I sat there. Otherwise I jotted down a few notes as reminders when therapy started and elaborated on them when I went to my office.
Group therapy	The patients and therapists sat in a circle, with the therapists closest to me. I sat at a table half turned away from the group with my side to the group. If I glanced to the side, I could see the group. When therapy	**Notes** I wrote extensive field notes about what was said by the therapists and the participants, the atmosphere in the room, and the small gestures and exchanges between the participants.

	included visualizations (such as placing stones on a piece of paper to illustrate the support network) the group would turn towards the participant and so would I. If there were long silences, noises or movements, I would also glance to the side. I never sat facing this group directly.	I noted how the therapists received and returned the patient's food diary (were they handed by the patients or did they get up to get the diary themselves?), which patients sat with pillows over their stomachs, and who passed the tissues when someone was crying, and who passed the bin to put the tissue in. Participants and therapists spoke one at a time, and otherwise there was silent. I found out that I could not use a pencil to write notes, because it made too much noise. Instead I used a pen. I also shifted to a larger notebook, so I did not have to scroll the pages so often. I did this, so the participants did not notice me. **Options for participation** One participant told me in an interview, that she had felt it was difficult to have her difficult thoughts written down as she spoke them. This reminded me to be vigilant at all times. Once, I tried to move to a different seat in the therapy room, just for the variation of it, but a participant objected. She liked that everything was in its usual place. I asked another participant, if she was annoyed at having me breathing down her neck, as I sat quite close to her, but she replied that she only noticed me when I sneezed. I continually reflected on the different needs and preferences of the participants, and I adjusted to the circumstances and tried to be sensitive to the intimate situation.
Break, group therapy	I altered between staying with the patients in the therapy room and going with the therapists to drink coffee.	If I stayed in the therapy room, I would act as in the break before therapy (see above) **Notes** If I went with the therapists, I would listen to what they talked about and write it down if it had to do with the participants. Otherwise, I wrote small notes and elaborated when I got to my office. **Reflections** Breaks with the therapists was especially difficult in terms of defining my position. If the therapist was alone in the group (they were usually two) I was invited into discussions about them, what they thought was challenging what they considered doing. If the two therapists were there together, I would take a position as an apprentice. Sometimes we spoke about private things in the breaks, or they would ask me about how the project was going. I would write some things down during these breaks, but I was also vigilant of not violating the trust

		of the therapists, when they confided in me. Instead, I would reflect on what they had said and write that down. Not their exact words.
Unsupervised patient lunch	The patients would go to lunch together. I never went with them because they had requested that I did not.	
Multi-family meetings	I attended two consecutive multifamily meetings which were held in the afternoon from 3:00 to 5:30 and included patients from all the four groups and their relatives. It started with an introduction by therapists and included different constellations of patients and their relatives. I especially paid attention to the patients and relatives from my group, but I did not sit with them. Instead, I took a similar position as the therapists.	**Positions** I followed the three therapists who were there. **Notes** I made notes of the different constellations that were arranged and the therapists' speech and the speech of patients and their relatives. **Reflections** I also reflected on the relevance of the event for the participants that I knew and their families. I compared these descriptions and reflections with what the participants said about the meeting in the following therapy session.
Individual sessions (therapist, dietician, physician in training)	NO PARTICIPATION	I chose to focus on the group settings and not attend any of the individual sessions or the body therapy group sessions that the participants could chose to attend alongside their therapy.
Sessions with support network		
Post-treatment sessions		
Body therapy		
Dialogue-meetings about Phase 2	The dialogue meetings were arranged to help patients choose Phase 2 groups. Therapists provided information about the two groups (Weight loss and Wellbeing) and a patient from each group shared their experiences. I was presented as the researcher of the BED treatment and I sat in the front of the room facing the same way as the patients and therapists who were presenting to the group.	**Notes** I made small notes while I was in the room and rushed to my office to write more extensively. I was interested in the participants' reflections on which group to choose. I noted if they changed their minds during the meeting or if they had doubts. This attuned me to what the participants, at this point in their treatment, considered to be their problems and what they thought could help them. I also noted how the therapists described the aims of the two treatments and how the former patients described their experiences. **Reflections**

		The dialogue meeting gave me a different perspective on the Phase 2 groups where participants were contemplating their entry into treatment and reflecting after having finished.
Participant observations Phase 2. In the Phase 2 groups, in activities such as waiting and weighing and lunch, I participated in the same way as in Phase 1.		
Weight Loss group Group therapy	During psychoeducation and group discussions I sat more freely than in Phase 1, but still at the table in the corner. In body therapy exercises I participated	**Notes** I wrote extensive notes about what was said and done and the atmosphere in the room **Reflections** In this group, the treatment format was a bit different, and more like a teaching situation with a class and a teacher. The participants wrote notes and put their hands up for questions and comments. **Positioning and reflections** I sat at my usual table, but now turning to see the group. I reflected on the difference in my possibilities for participation from this group and the therapy group in Phase 1. What made most sense to me, was that the teaching setting moved the focus to the psychiatrist and this allowed me to join in alongside the participants.
Wellbeing group	Therapy started in a gym at Stolpegaard where participants sat in a circle in the beginning and end. Here, I sat at a distance facing the group. During body therapy exercises and mindful eating, I joined in about half the times.	**Notes** I wrote extensive notes about activities and verbal exchanges between the participants. I most often joined in the body therapy, but occasionally I would sit at one side and take notes **Positioning and reflections** Body therapy provided me the possibility to see the participants interacting using their bodies. It also gave me different opportunities for participation. What struck me was the agility and joy of movement that many of the participants had. This confronted me with my own preconceived ideas about larger-sized bodies. It also prompted me to ask questions in the interviews about how their relationship with their bodies had changed. For many, sports and exercise had played a large part in their lives before.

Interviews

For a while, I contemplated not doing the participant observations but, on conducting the first background interviews, I found that I had to know more about the treatment to be able to ask relevant questions and align myself with the participants (Tjørnhøj-Thomsen & Whyte, 2008). Especially the Phase 2 groups

were difficult to ask about and get a sense of because they were new. The activities in the Phase 1 group also seemed too distant and abstract to speak about without having participated.

In the interviews, I tried to ask questions that invited the participants to speak about processes, contexts, and developments in problems and solutions. I asked about the influences and circumstances that had shaped the participants' experiences, and the actors, times and spaces, patterns of change, decision making, problems and solutions (Watzlawick et al., 1974). The purpose of the qualitative interviews was to hear how participants understood their problems and their experiences of change. I also wanted to get different experiences on certain issues, but I did not want it to be at the expense of what the participants wanted to say or where the conversation was going. I was interested in their accounts and the meaningfulness of their lives and equally interested in learning variations over selected topics which rendered a "flexibly structured" interview appropriate (Whyte, 1979). I tried to create what Burgess calls "conversations with a purpose" (Burgess 1984). The absence of a definite framework helped me maintain the focus on the participant's perspective rather than my own (Moyle 2002) it also helped me balance the dialogical tension of order and newness (Morson & Emerson, 1990)

I introduced the interview to the participants as a conversation without any fixed purpose other than to get to know more about how the treatment had been for them. I also asked if it was okay to go back in time as I could understand that many had a long history with eating and weight issues, and I wanted to hear how it had been for them. If the interview was more than a few weeks after treatment, I started by asking how it had been to end treatment and how they were doing. I made a deliberate effort to mention the group and use names of the therapists and the other group members to create a common ground, a familiarity, and to align myself with the participants. It was important for me to create an atmosphere of a valued conversation to signal my appreciation for all that I had witnessed in therapy where I had not had the opportunity to respond to their stories. I prepared each interview by reading all the field notes about the participant and I told them that I had noted down some things that I wanted to ask them. One reason for this was to show respect for the participants' time, that I had taken the time to prepare the interview, another reason was to align with the participants by citing them and using their words, a way of showing them that their words had made an impression (Anderson, 2014).

I was occupied with the power relation between the interviewer and interviewee, and one of my attempts to balance this was to run my analytical thoughts by the participants. For instance, I had an idea about inner and outer perspectives on the body. Instead of moving the conversation forward, I found that it disturbed the sense of "thinking with them". I realized that the object of my inquiry was the participant. Only *I* was interested in the regularities or emerging, theoretical understandings. Instead, I used each interview to strengthen my withness position (Shotter, 2010). In one of the background interviews, a woman talked about how self-hatred and critical thoughts about her body had manifested physically as lumps. This became a separate point of interest. I did not ask the following participants questions about this directly but acquired a *sensitivity* and *responsiveness* (Shotter, 2010) to the subject, so I could respond if any participant moved in that direction - which many did. Another attempt to balance the power relation was to step forward as a person and share thoughts or events from my own life. Again, this confused the interviewees more than opened the conversation. Instead, I tried to be generous and appreciative of the participants, their time, thoughts, reflections, and highlight their accomplishments.

Ethically, I was aware that the interviews could invite the participants to reflect on their current wellbeing and their eating disorder. Because I spoke with them after they had finished treatment and therefore might not have any support if the interview upset them, I made attempts to emphasize the steps that they had taken and the progress they had made. I also invited them to contact me at any time after the interview if there were regrets or uncertainties or they wanted me to help them get in contact with a therapist. No one did this. I made sure to send an email where I thanked them for their participation and reminded them of the above invitation.

Fieldwork roles and positioning

In the following, I reflect on the circumstances that shaped my positioning in the different settings.

In the therapy group in Phase 1, I was presented by the therapist as a "fly on the wall". I understood this as the therapist's way of letting me and the participants know that I would be present but that I would not interfere in therapy. In the Phase 2 groups, I was presented more like 'the researcher' whom some of the participants already knew from my participation in other contexts. In all settings, I presented myself as a psychologist and researcher who wanted to understand what happened during

treatment and how the participants felt about it, and I said that I would invite them for interviews when they finished treatment.

In interviews, I found that I had different relations with the participants and some expressed their confidence in me directly; “you just ask what you want, Lene, I trust you completely”. Others were more in the line of; “well, I’ve answered so many questions already, so I might as well....” This also attuned me to the sometimes very significant difference in the relation I had to them and they had to me; I felt I knew them intimately, I had smiled and cheered for them during the participant observations and had tears in my eyes, but they did not know this. However, I believe they knew that I was on their side and was sympathetic to their problems. Some seemed surprised that I knew what they had said in therapy because they had forgotten I was there. Often, they had forgotten what they had said and my citations of their speech helped remind them and bring them back in the therapy room.

My relationship with the participants was also shaped by characteristics pertaining to me as a person.

> “The choice of roles is constrained by many characteristics of the interviewer, such as gender, age, social status, race and ethnicity. Even so, it is generally preferable that the interviewer present him- or herself as a learner, a friend, and a member of the interviewee’s group, who has sympathetic interest in the interviewee’s life and is willing to understand it" (Zhang & Wildemuth, 2009, p. 3).

As a person of average size, I could not be accepted as one of them based on body size; I could not pretend to understand what weight stigma felt like. However, as one of the apparently few people outside the therapy setting who acknowledged BED as a diagnosis and understood that the problem was not one of weight, I was aligned with them in advocating for change in society.

As a former therapist in this clinical practice, the issue of distance in the ethnographic knowledge production was pertinent. The therapeutic situation and the words most often used to describe the struggles of living with BED were so familiar to me that I risked missing important perspectives and processes because it seemed self-evident. One strategy to create a distance in the field was to focus on what was new to me, and new to all the other participants in the study, namely the issue of weight. From the beginning, I knew that I wanted to track what was considered and presented as problems and solutions, so that became another focal point.

The closeness and familiarity with the field also had benefits (Tjørnhøj-Thomsen & Whyte, 2008). Knowing the setting and therapists, provided me unique access to the activities and professional and personal discussions about the treatment, and it enabled me to ask questions that were aligned with the language use of the participants when talking about their problems (Anderson, 2014). Had the field of eating disorders been completely alien to me, I would have asked different questions.

Additionally, with the role as participant observer, I found that I had other possibilities and limitations than I had as a therapist. I found that not having to be responsible for the therapeutic dialogue allowed me to attend differently to the details. However, I also found that entering this intimate setting was more difficult as an observer than it had been as a therapist. It required great sensitivity, and sometimes, I felt that it was best if I could just be invisible; not interrupt or disrupt in any way what was being said or done. In some of the treatment contexts or during breaks I could participate more freely (for examples, see Table 3). Here, I found that I became less visible if I did what the participants did (Tjørnhøj-Thomsen & Whyte, 2008) so I laughed, joked, rolled on gym balls, ate raisins and chocolate mindfully and walked mindfully with bare feet. At times, the participants aligned with me as a BED researcher, if they wanted to know something about the future of the BED diagnosis or BED treatment, or the aims of the project. Some participants also asked questions that had to do with their participation in the quantitative study.

Being a participant observer in three different treatment groups at the same time helped me to reflect on the differences in styles of speaking and ways of acting around body and weight issues. One decisive difference was how the three groups worked towards weight (weight stability, weight loss, and weight acceptance). Most notably, I found that the conversations around what seemed to be the same changes in weight could be spoken about as weight stability or weigh loss/weight gain. I also reflected on the different uses of language that arose in the different settings; I found that the psychoeducation in the Weight Loss group differed substantially from the more tentative and explorative styles of the two other groups. This also lead the participates to act differently and allowed me to participate in a different way (for my reflections on this, see Table 3). For both Phase 2 groups, possibly because the participants were further in their treatment, the participants seemed to be less sensitive to my participation. While access to the field was negotiated beforehand, as a participant observer in this psychiatric treatment setting, I was aware of ethical issues and of the need to be constantly responsive to the different roles

and positions that I was invited into by the participants and the possible differences between participants in the same group.

Generated data

The fieldwork generated data in the form of field notes, interview recordings, transcripts and written and recorded memos. Field notes were supplemented with memos that I recorded on a Dictaphone on my long bike rides to and from the setting. In total, the written material comprised 2 - 3 note books with handwritten field notes for each of the three treatment groups, and one separate note book that I used for preparing all interviews and for taking notes during interviews. All relevant material was transcribed verbatim (Kvale & Brinkmann, 2015) and entered into the qualitative analysis program NVivo® -10 for organization and facilitation of analysis (Bazeley & Jackson, 2013).

Understandings

The understandings of BED that arose through these participant observations and interviews are presented in two analyses in Papers 1 and 2.

Quantitative study

To assess the value of the I-SN as a real-life treatment that could be implemented other places in the health care system, I decided to plan an effectiveness study. I wanted to evaluate changes in terms of recovery rate, severity of eating disorder symptomatology, general psychological distress, level of psychosocial functioning, weight management, and quality of life following the I-SN group psychotherapy treatment. Even though an RCT would have given knowledge that is considered more scientifically sound, it was relevant to carry out a study that closely resembled the clinical reality of the patient group and clinical practices. Effectiveness studies are non-intrusive to normal clinical practices and allow variable amounts of treatment according to patients' needs, mixtures of different treatment elements, and inclusion of patients with multiple disorders (Mintz, Drake, & Crits-Christoph, 1996). The knowledge produced in an effectiveness study is therefore considered more generalizable than those of the more methodologically rigorous RCTs (Möller, 2011), and thus more relevant for clinicians who

need to implement it into practice and who might otherwise be skeptical about the applicability and usefulness of the intervention (Cook, Schwartz, & Kaslow, 2017).

The single group effectiveness design made it possible to assess the within-group effects reported as percentage and rates, for instance rates of completion, remission and recovery, instead of reporting the between-group effects of the I-SN treatment compared to a control treatment or waitlist (Linardon, 2018). Furthermore, the effectiveness design has lower study costs and require fewer adjustments to clinical practice compared to the RCT. Overall, I found the effectiveness design was most suitable to answer the initial research questions of this thesis.

In this study, the only adjustment needed in the treatment facility was the implementation of EDE interviews as part of clinical routine of assessment and evaluation. The implementation of EDE into the clinical routine meant that data for the entire patient population became available to me through the Data Security System, Capital Region of Denmark [Access granted. I-Suite no: _01193, ID no.: _RHP-2011-02_]. Patients did not have to provide consent for their data to be used.

Measures

The study generated demographic data and data on ED psychopathology, psychological impairment, psychosocial function, and treatment completion using semi-structured interviews and other patient reported outcome measures (PROM) from the database of PROMs in Mental Health Service, Capital Region of Denmark

Eating disorder symptoms

Eating Disorder Examination interview (EDE) To asses DSM-IV-R criteria for BED, we used the EDE version 12 with the Binge Eating Disorder module from version 16 (Fairburn et al., 2008). EDE is a semi-structured investigator-based interview used to measure eating psychopathology and frequency and duration of binge-eating over the past 6 months. Additionally, EDE contains four subscales (Restraint, Eating Concern, Shape Concern, and Weight Concern), the mean score of which provides a Global score (GS). A high degree of inter-rater reliability, internal consistency and discriminant validity has been reported in a Danish population (Clausen & Rokkedal, 2010)

Body Mass Index (BMI) Body weight and height were measured (in clothing) to compute BMI (kg/m^2).

Psychological symptoms and functional impairment

The mini international neuropsychiatric interview 5.0. (MINI) The Mini International Neuropsychiatric 5.0. (MINI) is a short structured diagnostic interview that is aligned with the diagnostic criteria of the International Classification of Diseases (ICD-10) as well as the DSM-IV (Sheehan et al., 1998). We added appropriate modules from version 6.0 to assess current psychosis, depression, suicidal risk and substance misuse. Studies have shown good sensitivity, specificity, reliability, and validity (Sheehan et al., 1998).

Symptom Checklist-90-Revised (SCL-90-R) The Symptom Checklist-90-Revised (SCL-90-R) is a 90-item multidimensional self-report questionnaire that measures general psychopathology (psychological and affective distress) (Derogatis, Lipman, & Covi, 1973; Derogatis, Rickels, & Rock, 1976). The 90 items are rated on a scale from 0 (not at all) to 4 (very much). The Global Severity Index (GSI) is the mean score of the 90 items. Studies show acceptable internal validity for all subscales except psychoticism (Derogatis et al., 1976).

Sheehan Disability Scale (SDS) Sheehan Disability Scale (SDS) is a self-rated measure that provides functional impairment within the domains of work/school, social and family life. SDS uses three items rated on a scale from 0 to 10. The sum of these provide a global score between 0 (unimpaired) to 30 (highly impaired) (Sheehan, Harnett-Sheehan, & Raj, 1996). Studies have found acceptable reliability, sensitivity to change and construct validity of the SDS (Sheehan & Sheehan, 2008).

The WHO-Five Wellbeing Index (WHO-5) The WHO-5 comprises five items that measure psychological wellbeing over the past two weeks: These concern positive mood (feeling in good spirits and feeling relaxed), vitality (being active and waking up fresh and rested), and being interested in things (Bech, 2004). By multiplying the sum score by 4 we get a total score of which 0 represents worst possible and 100 represents best possible quality of life (Bech, 2004). Studies show good reliability and excellent validity (McDowell, 2010), and the measure is recommended as PROM (Bech, Austin, & Lau, 2018).

Outcome measures

Primary outcome

The primary outcome was recovery of binge-eating defined as zero binge-eating episodes the previous 28 days according to the EDE.

Secondary outcomes

The secondary outcomes were frequency of binge-eating episodes, EDE global score (GS) and subscale scores on restriction, eating concern, weight concern, and shape concern (EDE), scores on GSI, SDS (ref) and WHO-5, and treatment completion defined as at least 75 % attendance of group psychotherapy.

The outcomes were chosen to assess the core diagnostic behavioral symptom of binge-eating and the associated cognitions and emotions often accompanying BED eating disorder psychopathology. These are commonly used outcomes which therefore allowed us to compare the outcomes of this study with other studies of BED treatment. We chose full recovery as an outcome instead of remission as full recovery is of clinical importance for BED. Sub-clinical levels of binge-eating post-treatment have been found predictive of poorer long-term outcomes (Fischer, Meyer, Dremmel, Schlup, & Munsch, 2014).

Procedure

MINI and EDE interviews were conducted at assessment 0 to 40 weeks (mean 14.9, SD 8.2) before treatment and EDE was conducted again 0 to 12 weeks (mean 1.8, SD 3.1) after treatment. At the same time points, patients received links to fill out electronic questionnaires (SDS, SCL-90-R, and WHO-5). In cases of more than 6 weeks from baseline to treatment, PROMs were administered again pre-treatment (n = 76). The substantial time lap between assessment and treatment was a consequence of implementing EDE as part of the clinical assessment routine. EDE-Q self-report measures were also available as these were part of the PROMs database and were thus administered an extra time pre-treatment. Yet, we chose to use data from the EDE interviews, because EDE-Q is found less reliable in identifying binge-eating in general and especially in the BED population (Barnes, Masheb, White, & Grilo, 2010).

A research assistant/I and student helpers made double entries of MINI and EDE interviews into SPSS. A statistician performed the multiple imputation using SAS.

Table 4. Methods and timing of assessment

	Initial assessment (clinical routine)	Psychiatric and somatic assessment (clinical routine)	Start of treatment	End of treatment
Sociodemographic data	X			
Eating Disorder Examination (EDE)		X		x
Mini International Neuropsychiatric Interview (MINI)		X		
Sheehan Disability Scale (SDS)	X		x	x
Symptom Checklist-90-Revised (SCL-90-R)				
WHO-Five Well Being Index (WHO-5)	X		x	x

Assessment

In the study, all patients were assessed using EDE interviews and MINI. MINI interviews were performed by a psychiatrist and a psychiatrist in training. EDE interviews were conducted by two licensed psychologists trained in EDE assessment by Loa Clausen, Unit for Eating Disorders, Risskov. Clausen is the leading figure in EDE assessment in Denmark. Six finale year psychology students were trained through apprenticeship and close supervision to assist in EDE interviews. Clausen functioned as an external supervisor available for feedback and guidance. Also, Yvonne von Hausswolff-Juhlin (MD, PhD), Center for Psychiatry Research, Karolinska Institute was contacted for advice. There were several challenges in assessing BED using EDE which are summed in an EDE-log in Appendix 5. What we found to be particularly difficult was to appropriately categorize regular compensatory behavior. This was decisive as compensatory behavior effectively distinguishes BED from the BN diagnosis. However, extreme dietary restriction is also categorized as compensatory behavior and many patients had an eating pattern where they restricted during the day and had binge-eating episodes at night. Also, patients with bariatric surgery made it difficult to establish the criterion of *a large amount of food*, because they were physically unable to eat unusually large amounts of food. In evaluating binge eating episodes, we therefore stressed the presence of a feeling of loss of control and experiences of binging in large amounts of food prior to surgery. We held bi-monthly EDE-meetings for joint discussions and supervision.

Results

Results are presented in Paper 3.

CHAPTER 4: GENERATED UNDERSTANDINGS AND RESULTS OF THE STUDIES

In this chapter, I present the understandings and results from the qualitative and quantitative studies summarized in three abstracts. Papers 1 and 2 present the understandings generated through the qualitative study, and paper 3 presents the results from the quantitative study.

Paper 1

Title *(Dis-)Solving the Weight Problem in Binge Eating Disorder: Systemic Insights from Three Treatment Contexts with Weight Stability, Weight Loss, and Weight Acceptance*

Published (2018) in *Qualitative Health Research*

Binge-eating disorder (BED) is a severe eating disorder strongly associated with obesity. Treatments struggle to provide safe and effective ways of addressing weight in a BED context. This study explored a two-phased treatment for BED developed at a major out-patient eating disorder service in Denmark. The study used interviews and participant observations to gain insight into experiences and processes related to weight and body issues in three treatment contexts that addressed weight stability, weight acceptance, and weight loss. Using systems theory, the study proposed a relational weight problem that embeds feelings of non-acceptance due to weight, a merge of weight and identity, and an internalized body- and weight-critical gaze of others. Contrary to critical claims that weight acceptance discourages people with obesity from engaging in weight loss efforts, this study suggests that acceptance and a disentanglement of weight and identity are prerequisites for weight loss for this group.

Paper 2

Title *Reconnecting in Dialogical Spaces: How a Systemic and Narrative Group Intervention for Binge-Eating Disorder helps Patients Reconnect with Themselves and Other People*

To be submitted to *Qualitative research in psychology*

This study used Mikhail Bakhtin's dialogical theory to analyze participant observations and semi-structured interviews of a psychotherapy group for people affected by binge-eating disorder (BED). The participants' accounts revealed a profound sense of loss of self that emerged from years of believing that losing weight was necessary to be worthy of living. Using the therapeutic practices of externalizing, reflecting teams, and writing a food diary, the group treatment established different positions for speaking and listening which reflected Bakhtin's concepts of outsideness and otherness. This enabled participants to identify a myriad of voices that made up the eating disorder and critically evaluate them. Overall, treatment served to dialogize the eating disorder and enable the participants to move from closed monological states to living polyvocal spaces. The processes of change involved that the participants reconnected with a sense of self, with other people, and with a sense of belonging in the world. The study contributes to literature about the adverse effects of 'diet culture' and the potential associated with increasing patients' critical awareness of social and cultural influences in the treatment of BED.

Paper 3

Title *Effectiveness of an integrative systemic and narrative group psychotherapy for adult patients with binge-eating disorder*

Submitted to *Eating Disorders: The Journal of Treatment & Prevention*

Systemic and narrative (SN) methods are widely used in treatment of eating disorders (ED), but few studies have examined SN treatments for binge-eating disorder (BED). This naturalistic cohort study evaluated the effectiveness of an Integrative SN (I-SN) group intervention for adults with BED (N =111) at an outpatient ED unit in Denmark. Results showed a completion rate of 74% and significant improvements in ED symptoms and general psychopathology post-treatment with effect sizes ranging from d = 2.00 to d = 1.11. More than half of the full sample achieved full recovery, indicating an effect of I-SN for adults with BED.

CHAPTER 5: DISCUSSION

Contextualizing problems and solutions in BED

The present thesis is my attempt to reframe traditional understandings of BED and accompanying weight problems by moving them into a social constructionist, dialogical, and systemic framework. I wanted to generate descriptions of BED that involved the relational and societal realities of the affected people and to engage with the existing knowledge productions in a critical and reflexive manner. My overall aim was to inspire new discussions about what constitutes problems and solutions in the BED field.

In this finale chapter, I respond to my initial criticism of an individualization of BED by attempting to contextualize BED. I also try to answer how relational, contextual, and processual understandings of BED can help to qualify the current objective measures of BED recovery.

Problems in the BED field

Since BED is a psychiatric diagnosis, BED problems are not surprisingly described in psychological and behavioral terms. Much research offers valuable ways of understanding and communicating about BED, including causal models that try to delineate underlying and maintaining mechanisms. In this thesis, however, I have argued that these symptoms must be understood in the contexts that gave rise to them and that have contributed to their continuation. The theoretical frame allowed me to identify reciprocal, circular influences where people change and give rise to change in each other. Guided by Gergen's plea to psychologists to develop interpersonal descriptions of psychological concepts, I arrived at the analytical concept of *a relational weight problem*. Likewise, guided by a dialogical focus, I was also moved to an analytical field made up of the myriad of voices, words, and, truth claims that shape our relationships to bodies and food.

Following, the abstracted concepts used to describe BED, develop and test treatments like 'binge-eating', 'dietary restriction', 'marked distress', 'BMI', 'obesity', 'weight and shape concerns',

‘overvaluation’, ‘affect-dysregulation’, ‘interpersonal problems’, ‘self-esteem’, ‘mood disorders’, and ‘anxiety disorders’ were moved to an interpersonal arena. Bateson said that context is linked to meaning, and the lived accounts of the participants definitely served to make the symptoms of BED meaningful.

Identity and weight loss attempts were key figures in the participants’ accounts. The people in this thesis described their lives with BED as a life of increasing isolation, hopelessness and chaos that left them with a profound sense of loss of self and loss of direction. The eating disorder was at once their worst enemy and their best friend. The findings in this thesis put weight, weight loss attempts and meanings attached to weight at the center of the participants problems. This echoes concerns raised in the eating disorder literature about consequences of weight focus on body dissatisfaction, dieting behavior, obesity, and eating disorders.

In Paper 1, this was conceptualized as *a relational weight problem* which was independent of the physical weight and embedded an internalized weight critical gaze of others and a merge of identity and weight. The relational weight problem shares features with the eating disorder symptom ‘overvaluation of weight and shape’ and internalized weight stigma in that these concepts reflect an undue link between identity and weight. The concept of a relational weight problem can add an understanding of how this linkage occurs. In Paper 1, we propose processes of interpersonal interactions around weight; as people around the participants began to speak about weight and react to weight as a problem, the participants came to believe that it was in fact them, that they were the problem because they could not lose weight. Indeed, the participants said that decisive changes occurred in the systemic and narrative therapy as they and their relatives began to act and speak differently about weight. Likewise, Paper 1 offers a way to understand the processes that underlie the scientifically established associations between obesity in childhood and the later development of BED (Reed, Micali, Bulik, Davey Smith, & Wade, 2017). The experienced separation of a weight and identity was supported in the highly significant changes in weight and shape concerns following treatment.

In Paper 1, I argue that change became possible for the participants as their ideas about what constituted problems and solutions regarding weight were turned upside down: Change happened when weight loss attempts became the problem and not the solution, *and* the eating disorder became the problem and not the participants. In Paper 2, I demonstrate how weight seemed to have colonized the participants’ self-projects in that they did not believe they were entitled to a life unless they lost weight.

The sense of self, the sense of belonging and being in connection with others was deeply affected by having BED. Important processes of change in treatment can thus be understood as liberation from stigmatization. In Phase 1 treatment, de-stigmatization occurred at all levels. In meeting with the institution and in receiving the diagnosis, participants were relieved of the guilt and self-blame of being out of control and gaining weight. They entered treatment with experiences of structural, public and self-stigma and continued in a process of de-stigmatization by sharing their stories with others and involving their relatives. In Paper 2, we argue that the therapeutic stance of "people are not problems; problems are problems", the non-normative approach to eating and weight (for instance the dietician stating that "lasagna is a perfectly fine food for breakfast"), together with the deconstruction of the voices that constitute the eating disorder, instilled in the participants a sense of self. In all areas of their lives, the treatment encouraged the participants to evaluate who was speaking and what they thought about it. I argue, that this critical awareness and a sense of self independent of weight became part of their new path to reengaging with weight loss in a completely new way that aligned with their own convictions; *their weight* loss project.

Solutions to BED

The quantitative study evaluated the effectiveness of the systemic and narrative group treatment in terms of recovery rate, severity of eating disorder symptomatology, general psychological distress, level of psychosocial functioning, weight management, and quality of life and found clinically significant changes on all measures except functional impairment.

Weight loss

Consistent with effects of other psychotherapy treatment interventions for BED, the systemic and narrative treatment did not lead to weight loss (Vocks et al., 2010). The accounts of the Weight Loss group presented in Paper 1 demonstrated that weight loss attempts were incredibly difficult despite attempts to create very small and individualized adjustments in eating and movement. The very naming of weight loss as a goal reactivated a whole system of eating disorder rules and voices. Given that weight

was so tightly knit to identity, this sensitivity to stepping on a scale is not surprising: The scale did not just weigh the participants' weight but their worth as people. It also seemed that simply contemplating trying to control eating and physical activities reactivated what had been described by the participants as a punishment and reward system that drew the participants into well-known vicious cycles of rewarding themselves with food for having exercised and eating to punish themselves for not losing weight. Attempts at controlling food intake and losing weight also activated a larger system of self-critical thoughts and hopelessness to which the eating disorder served as a comfort.

In both the two Phase 2 groups participants nonetheless experienced decisive changes in their thoughts and feelings about food, bodies, eating and movement which resembled the effects found in weight-neutral approaches to health. In different ways, the participants found pathways for change that had to do with being gentle with their bodies, accepting themselves and their bodies (not loving, but accepting), enjoying food and enjoying the comfort of eating with other people and feeling as if they were part of what everybody else was part of. This bypassed any reliance on control for creating change (and therefore the risk of loss of control). Since the difficulty with weight loss maintenance is long-term adherence, individuals may be more likely to continue with activities that are joyful and meaningful.

The dialogical analysis of the systemic and narrative therapy could possibly explain this common pathway for change despite the different treatment modalities of the two Phase 2 groups. The emphasis on identity and critical awareness

Additionally, even though the participants wanted to lose weight they were extremely afraid of relapsing. It is possible that they sought out safe pathways for change in both groups which then led them towards acceptance and enjoyment. These were complete opposite strategies to the eating disorder.

As weight stigma is negatively associated with eating (Araiza & Wellman, 2017), physical movement (Vartanian & Shaprow, 2008), weight loss (Wott & Carels, 2010), and overall health and well-being (Puhl & Suh, 2015), a treatment that successfully addresses societal and relational issues concerning weight may lead to overall increases in health. All in all, addressing overvaluation of shape and weight along with issues pertaining to weight stigma could prove to be a productive road to increase BED recovery.

Together, the findings and results generated in this thesis suggest that an integrative systemic and narrative group therapy is effective in reducing BED symptoms. Drawing on literature about health effects of weight stigma, body dissatisfaction, social connectedness, and weight fluctuation the treatment may also facilitate increased physical and mental health of the participants by creating changes in these domains. As studies find that full recovery of binge-eating is associated with reduced energy intake and weight lost following treatment, the high recovery rate of this treatment could also facilitate subsequent weight loss. What this thesis also clearly demonstrates, however, is that a focus directly on weight loss severely risks reactivating a whole system of thoughts and behaviors that make up the eating disorder.

I argue that weight focus is not a good idea for people with BED. Instead, a broader view of health is necessary. This includes increasing self-acceptance and body acceptance, and reconnecting with the body's needs and with other people. The study therefore adds to the growing body of research that suggests a weight-neutral and body positive approach to health and also adds to the research on the impact of social connectedness and weight stigma for health.

Measuring solutions in BED treatment

I argue that the suggested causal models of BED that inform most psychotherapy treatments may in fact be affected by social and relational factors and interactions and are not affecting binge eating in the direct, simplistic manner that are claimed. The present contextualization of BED instead suggests an expansion of current models of BED to include reciprocal interactions between people within social contexts.

I argue that measures of weight and identity should be placed at the center of BED models instead of binge-eating and that BMI should no longer be a focus. Despite the importance of overvaluation, this measure is rarely reported in intervention studies and are, to my knowledge, never the primary outcome.

Supporting the importance of the values that are assigned to weight, a comprehensive research project at the University of Copenhagen, Governing Obesity (Governing Obesity, 2013), publicly announced that weight stigma and not the individual's physical weight is the problem. This shifts the problem away from the individual onto the surrounding society. A measure of internalized and

experienced weight stigma is therefore also relevant along with interventions that involve and change the perceptions of the social network.

Validity and reliability

The quantitative study is judged by different criteria than the qualitative. In Paper 3, I present the validity and reliability of the knowledge claims put forward. Additionally, the study used only validated measures to determine the participant characteristics and treatment outcomes and has as already argued in the methodological chapter a lot of strengths being conducted in a naturalistic setting. Since the study was not randomized and thus did not contain a control group, the results cannot be directly attributed to the intervention. It is possible that the change participants experienced was due to other factors. Still, the positive results along with participants' accounts of change warrant a carefully planned randomized study of a fully standardized version of I-SN.

The situatedness and consequences of the study

An evaluation of this thesis must be done in accordance with the social constructionist values and worldview and the guiding assumptions about relativism, language, power, and the relation between the researcher, the researched and the process of producing knowledge.

The present metatheoretical position favours reflexivity over objectivity as it becomes important to be aware of the contexts, words, and preconceptions that shape the field of inquiry and the consequences that follow from the knowledge productions. Concerned with difficulties in formulating quality criteria relevant for qualitative research, Stige and colleagues suggested an *evaluation agenda* (Stige, Malterud, & Midtgarden, 2009) that emphasizes the explication of the *situatedness* and *consequences* of studies. I find that these concepts align well with the social constructionist, dialogical, and systemic position of the thesis. Throughout the thesis I have therefore tried to *situate my responsiveness* (Shotter, 2010) and explicate the words, voices, people, truth claims and "social, cultural and academic contexts" (Stige et al., 2009, p. 1506) that I have chosen to respond to (Anderson, 2014).

The dialogical spaces that this thesis inhabits are made up of different communities of knowledge of which some are in agreement and others are not. From this follows a *conversational reflexivity* at the heart of which:

> "is the notion that reflexivity involves managing conversations between and among people and texts over time (…), use difference as a resource for meaning making and action, and resonate with the people we work with and who read our work" (Barge, Hornstrup & Gill, Systemic Inquiry, 2014:207).

Situating my responsiveness

Throughout the study, I have juggled competing dialogues about BED moving alternately between two systems of knowing. Complying with one study aim of measuring problems and solutions, I have been part of a modernist, medical system of diagnostics and outcomes (an aboutness position and monological and nonresponsive in nature). Complying with another aim of the study to develop relational and contextual understandings of BED and weight, I have been part of a social constructionist research approach. This implies a contradiction based on an assumption that I as a researcher must be soundly positioned within one epistemological framework. However, by moving the fields of inquiry into a dialogical space, I had the opportunity to use both types of knowledge as language productions. I have made an effort to engage these voices in polyphonic dialogues where each retained its unique position but remained open to be enriched by the other.

My experiences as a therapist meant that I was concerned with the systemic idea of how attempted solutions can sustain the very problems they try to solve. Entering the field of inquiry, I responded to the scientific knowledge productions that came up as I put "binge-eating disorder" into the search fields of databases and tried to see the regularities and variations. Bolstered by a social constructionist skepticism, I was responsive to alternative knowledge claims and understandings which led me first to obesity research and soon after to critical obesity research. I also found myself guided further into related but different areas of fat-studies, feminism, and embodiment which I could have pursued further had weight and obesity research not called on my attention. I have tried to position myself so I, in Sheila McNamee's words, was "sensing the new and being changed by it", so I have tried to attend to the periphery of the

agreed upon and 'look to the unexpected' (Alvoesson and Kärreman Simon & Chard, 2014). This included pursuing thoughts generated at the peripheries of research. The voices and perspectives that I invited into the conversations of this thesis were deliberate choices based on the usefulness of the perspectives in creating political change, clinically relevant understandings, and newness.

Ethics

Doing research in a therapeutic setting involves many ethical considerations most of which I have addressed in the articles and mentioned in the relevant places in the thesis. According to Bakhtin, ethical choices cannot be rule-based but must be a constant responsibility of the individual to choose ethically in every single event (Morson & Emerson, 1990).

As a researcher, I was at all times aware that I was part of the system and that whatever I did would render certain responses and positions possible to the people I researched and the people who were to read my work. I was a co-creator of my observations, descriptions and explanations (Steier, 1991). From the very beginning of the PhD project, I reflected on the possible consequences of my research; what type of truth claims would I be making and how would that position people with BED. In this thesis, I made deliberate choices to get as close to the participants' own voices as I could. One reason was to counterbalance what Shotter called aboutness research where the participants were depicted as aggregated data and averages. The other reason was to respond to the political climate where BED was not recognized as an independent diagnosis.

Usefulness

My ambition with this thesis was to encourage discussions about how to understand and treat BED and weight problems. I have presented critical obesity research and research at the peripheries with the hope that these voices will also be part of these discussions. This type of knowledge is not foregrounded in BED contexts. As obesity is a new field for health care professionals in the eating disorder field, a continued communication and collaboration in developing suitable interventions is necessary. I combined knowledge productions in the hope of inspiring understandings and practices for BED rather than present clear guidelines.

The combined qualitative findings and qualitative results provides clinically relevant knowledge about the elements and strategies in treatment that can create change in BED and cooccurring weight problems. The effectiveness study showed relevant results in high completion and recovery rates and significant reductions in BED symptoms that are important for clinicians and policy makers in the face of soon having to provide treatment for 40,000 Danish adults. The presented BED treatment is a well-evaluated "core" treatment that is ready to be implemented in routine clinical practice. To further develop the knowledge about effect, the treatment can be studied under more controlled conditions and in other settings.

The dialogue initiated in this thesis also includes the reader, and it is the reader who must judge for him- or herself if the analytical propositions of the thesis seem reliable (Denzin & Lincoln, 2011) and useful outside of its context (Ramian, 2012). In a dialogical sense, usefulness also means that the propositions presented must 'leave space' to the reader (Gergen & Gergen cited in Simon, 2012). There is a continued need to discuss how the experiences gained in this thesis can translate into practices that can increase the physical and psychological health of people affected by BED.

Conclusion and future work

The thesis answers and poses questions that are relevant in a Danish context and responds to gaps apparent in the international literature. BED is common eating disorder that is often accompanied by obesity and that creates a unique combination of problems. The perspectives and insights brought together in this thesis raise critical concerns about the focus on weight in society. Looking beyond the present research context, promoting weight loss and narrowly focusing on weight as a measure of health runs the risk of recreating the very problems, they set out to solve.

It may be more practical to suggest that the health care system offer treatments that draw on the governing logic concerning BED and weight, and to communicate messages about individual responsibility and health than to advocate for complex changes and practices that span mind and body and social interrelations. Nonetheless, this is what the aggregated perspectives in this thesis suggest.

I end with an invitation to continue the discussion of ways to work with BED and related weight and body problems. I also leave with a plea for continued openness toward defining eating and weight

problems. I believe, that we cannot legitimately separate mind and body, individual and society and the treatment and the prevention of problems. To solve BED and weight problems, I argue that we must first commit ourselves to stop contributing to their continued (re-)creation. This involves how we speak about our own and other's bodies in our roles as practitioners, researchers and fellow human beings.

Reference List

Adami, G. F., Gandolfo, P., Bauer, B., & Scopinaro, N. (1995). Binge eating in massively obese patients undergoing bariatric surgery. *The International Journal of Eating Disorders*, *17*(1), 45–50.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders: DSM-IV*. Washington, DC: American Psychiatric Association.

American Psychiatric Association (Ed.). (2013). *Diagnostic and statistical manual of mental disorders: DSM-5* (5th ed). Washington, D.C: American Psychiatric Association.

Andersen, T. (1987). The reflecting team: Dialogue and meta-dialogue in clinical work. *Family Process*, *26*(4), 415–428. https://doi.org/10.1111/j.1545-5300.1987.00415.x

Anderson, H. (2014). Collaborative-Dialogue Based Research as Everyday Practice. In *Systemic Inquiry. Innovations in Reflexive Practice Research* (pp. 60–73). Farnhill, UK: Everything is Connected Press.

Aphramor, L. (2005). Is A Weight-Centred Health Framework Salutogenic? Some Thoughts on Unhinging Certain Dietary Ideologies. *Social Theory & Health*, *3*(4), 315–340. https://doi.org/10.1057/palgrave.sth.8700059

Araiza, A. M., & Wellman, J. D. (2017). Weight stigma predicts inhibitory control and food selection in response to the salience of weight discrimination. *Appetite*, *114*, 382–390. https://doi.org/10.1016/j.appet.2017.04.009

Bacon, L. (2008). *Health at every size: the surprising truth about your weight*. Dallas, TX: BenBella Books.

Bacon, L., & Aphramor. (2011). Weight science: evaluating the evidence for a paradigm shift. *Nutrition Journal*, *10*(1), 9. https://doi.org/10.1186/1475-2891-10-9

Bacon, L., Keim, N. L., Van Loan, M. D., Derricote, M., Gale, B., Kazaks, A., & Stern, J. S. (2002). Evaluating a'non-diet'wellness intervention for improvement of metabolic fitness, psychological well-being and eating and activity behaviors. *International Journal of Obesity*, *26*(6), 854.

Bacon, L., Stern, J. S., Van Loan, M. D., & Keim, N. L. (2005). Size Acceptance and Intuitive Eating Improve Health for Obese, Female Chronic Dieters. *Journal of the American Dietetic Association*, *105*(6), 929–936. https://doi.org/10.1016/j.jada.2005.03.011

Bakhtin, M. M. (1984). *Problems of Dostoevsky's poetics* (C. Emerson, Trans.). Minneapolis: University of Minnesota Press.

Barnes, R., Masheb, R. M., White, M. A., & Grilo, C. M. (2010). Comparison of methods for identifying and assessing obese patients with binge eating disorder in primary care settings. *International Journal of Eating Disorders*, n/a-n/a. https://doi.org/10.1002/eat.20802

Barry, D., Grilo, C. M., & Masheb, R. M. (2002). Gender differences in patients with binge eating disorder. *International Journal of Eating Disorders*, *31*(1), 63–70. https://doi.org/10.1002/eat.1112

Barry, V. W., Baruth, M., Beets, M. W., Durstine, J. L., Liu, J., & Blair, S. N. (2014). Fitness vs. Fatness on All-Cause Mortality: A Meta-Analysis. *Progress in Cardiovascular Diseases*, *56*(4), 382–390. https://doi.org/10.1016/j.pcad.2013.09.002

Bateson, G. (1972). *Steps to an ecology of mind* (University of Chicago Press ed). Chicago: University of Chicago Press.

Bayer, B. M., & Shotter, J. (Eds.). (1998). *Reconstructing the psychological subject: bodies, practices, and technologies*. London ; Thousand Oaks, CA: Sage Publications.

Bazeley, P., & Jackson. (2013). *Qualitative data analysis with NVivo* (Second edition). Los Angeles London New Delhi: SAGE.

Bech, P. (2004). Measuring the Dimension of Psychological General Well-Being by WHO-5. *Quality of Life Newsletter*, *32*, 15–16.

Bech, P., Austin, S. F., & Lau, M. E. (2018). Patient reported outcome measures (PROMs): examination of the psychometric properties of two measures for burden of symptoms and quality of life in patients with depression or anxiety. *Nordic Journal of Psychiatry*, *72*(4), 251–258. https://doi.org/10.1080/08039488.2018.1451918

Berger, P. L., & Luckmann, T. (1966). *The social construction of reality: a treatise in the sociology of knowledge*. New York: Anchor Books.

Billig, M. (1998). Repopulating Social Psychology: A Revised Version of Evnts. In *Reconstructing the Psychological Subject. Bodies, practices and technologies.* (pp. 126–152). Sage Publications.

Binford, R. B., Pederson Mussell, M., Peterson, C. B., Crow, S. J., & Mitchell, J. E. (2004). Relation of binge eating age of onset to functional aspects of binge eating in binge eating disorder. *International Journal of Eating Disorders*, *35*(3), 286–292. https://doi.org/10.1002/eat.10272

Blaine, B., & Rodman, J. (2007). Responses to weight loss treatment among obese individuals with and without BED: a matched-study meta-analysis. *Eating and Weight Disorders: EWD*, *12*(2), 54–60.

Blake, C. E., Hébert, J. R., Lee, D., Adams, S. A., Steck, S. E., Sui, X., … Blair, S. N. (2013). Adults with Greater Weight Satisfaction Report More Positive Health Behaviors and Have Better Health Status Regardless of BMI. *Journal of Obesity*, *2013*, 1–13. https://doi.org/10.1155/2013/291371

Blanchet, C., Mathieu, M.-È., St-Laurent, A., Fecteau, S., St-Amour, N., & Drapeau, V. (2018). A Systematic Review of Physical Activity Interventions in Individuals with Binge Eating Disorders. *Current Obesity Reports*. https://doi.org/10.1007/s13679-018-0295-x

Bohrer, B. K., Carroll, I. A., Forbush, K. T., & Chen, P.-Y. (2017). Treatment seeking for eating disorders: Results from a nationally representative study. *International Journal of Eating Disorders*. https://doi.org/10.1002/eat.22785

Bombak, A. (2014). Obesity, health at every size, and public health policy. *American Journal of Public Health*, *104*(2), 60–67. https://doi.org/10.2105/AJPH.2013.301486

Bracken, P., Thomas, Timimi, Asen, Behr, Beuster, … Yeomans. (2012). Psychiatry beyond the current paradigm. *The British Journal of Psychiatry*, *201*(6), 430–434. https://doi.org/10.1192/bjp.bp.112.109447

Brochu, P. M., Pearl, R. L., & Simontacchi, L. A. (2018). Weight Stigma and Related Social Factors in Psychological Care. In S. Cassin, R. Hawa, & S. Sockalingam (Eds.), *Psychological Care in Severe Obesity* (1st ed., pp. 42–60). https://doi.org/10.1017/9781108241687.004

Brownley, K. A., Berkman, N. D., Peat, C. M., Lohr, K. N., Cullen, K. E., Bann, C. M., & Bulik, C. M. (2016). Binge-Eating Disorder in Adults: A Systematic Review and Meta-analysis. *Annals of Internal Medicine*, *165*(6), 409. https://doi.org/10.7326/M15-2455

Burr, V. (2003). *Social constructionism* (2nd ed). London ; New York: Routledge.

Carbonneau, E., Bégin, C., Lemieux, S., Mongeau, L., Paquette, M.-C., Turcotte, M., … Provencher, V. (2017). A Health at Every Size intervention improves intuitive eating and diet quality in Canadian women. *Clinical Nutrition*, *36*(3), 747–754. https://doi.org/10.1016/j.clnu.2016.06.008

Carels, R. A., Young, Wott, Harper, Gumble, Oehlof, & Clayton. (2009). Weight Bias and Weight Loss Treatment Outcomes in Treatment-Seeking Adults. *Annals of Behavioral Medicine*, *37*(3), 350–355. https://doi.org/10.1007/s12160-009-9109-4

Carr, M. M., Lydecker, J. A., White, M. A., & Grilo, C. M. (2019). Examining physical activity and correlates in adults with healthy weight, overweight/obesity, or binge-eating disorder. *International Journal of Eating Disorders*, *52*(2), 159–165. https://doi.org/10.1002/eat.23003

Carroll, S., Borkoles, E., & Polman, R. (2007). Short-term effects of a non-dieting lifestyle intervention program on weight management, fitness, metabolic risk, and psychological well-being in obese premenopausal females with the metabolic syndrome. *Applied Physiology, Nutrition, and Metabolism*, *32*(1), 125–142. https://doi.org/10.1139/h06-093

Castellini, G., Lo Sauro, C., Mannucci, E., Ravaldi, C., Rotella, C. M., Faravelli, C., & Ricca, V. (2011). Diagnostic Crossover and Outcome Predictors in Eating Disorders According to DSM-IV and DSM-V Proposed Criteria: A 6-Year Follow-Up Study: *Psychosomatic Medicine*, *73*(3), 270–279. https://doi.org/10.1097/PSY.0b013e31820a1838

Cena, H., Stanford, Ochner, Fonte, Biino, G., De Giuseppe, … Misra. (2017). Association of a history of childhood-onset obesity and dieting with eating disorders. *Eating Disorders*, *25*(3), 216–229. https://doi.org/10.1080/10640266.2017.1279905

Chao, A. M., Rajagopalan, A. V., Tronieri, J. S., Walsh, O., & Wadden, T. A. (2019). Identification of Binge Eating Disorder Criteria: Results of a National Survey of Healthcare Providers. *Journal of Nursing Scholarship*. https://doi.org/10.1111/jnu.12468

Chard, A. (2014). Orientations: Systemic Approaches to Research Practices. In G. Simon & A. Chard (Eds.), *Systemic Inquiry: Innovations in reflexive practice research* (pp. 30–59). Everything is Connected Press.

Chen, E. Y., Cacioppo, J., Fettich, K., Gallop, R., McCloskey, M. S., Olino, T., & Zeffiro, T. A. (2016). An adaptive randomized trial of dialectical behavior therapy and cognitive behavior therapy for binge-eating. *Psychological Medicine*, 1–15. https://doi.org/10.1017/S0033291716002543

Clausen, L., & Rokkedal, K. (2010). Assessment measures in eating disorders [Danish: Undersøgelsesinstrumenter ved spiseforstyrrelser]. In S. Lunn, K. Rokkedal, & B. Rosenbaum (Eds.), *Eating disorders illustrated clinically and culturally [Danish: Fråsog faste Spiseforstyrrelser i klinisk og kulturel belysning].* (pp. 491–505). Virum: Dansk psykologisk Forlag.

Clifford, D., Ozier, A., Bundros, J., Moore, J., Kreiser, A., & Morris, M. N. (2015). Impact of Non-Diet Approaches on Attitudes, Behaviors, and Health Outcomes: A Systematic Review. *Journal of Nutrition Education and Behavior*, *47*(2), 143-155.e1. https://doi.org/10.1016/j.jneb.2014.12.002

Cook, S. C., Schwartz, A. C., & Kaslow, N. J. (2017). Evidence-Based Psychotherapy: Advantages and Challenges. *Neurotherapeutics*, *14*(3), 537–545. https://doi.org/10.1007/s13311-017-0549-4

Creswell, J. W., & Plano Clark. (2011). *Designing and conducting mixed methods research* (2nd ed). Los Angeles: SAGE Publications.

Crum, A. J., Corbin, W. R., Brownell, K. D., & Salovey, P. (2011). Mind over milkshakes: Mindsets, not just nutrients, determine ghrelin response. *Health Psychology*, *30*(4), 424–429. https://doi.org/10.1037/a0023467

Crum, A. J., Leibowitz, K. A., & Verghese, A. (2017). Making mindset matter. *BMJ (Clinical Research Ed.)*, *356*, j674.

da Luz, F. Q., Swinbourne, J., Sainsbury, A., Touyz, S., Palavras, M., Claudino, A., & Hay, P. (2017). HAPIFED: a Healthy APproach to weIght management and Food in Eating Disorders: a case series and manual development. *Journal of Eating Disorders*, *5*(1). https://doi.org/10.1186/s40337-017-0162-2

Danish Health Authority. (2005). *Eating Disorders: Recommendations for organisations adn treatment [Iin Danish: Spiseforstyrrelser: Anbefalinger for organisation og behandling]*. København: Sundhedsstyrelsen.

Danish Health Authority. (2015). *Small steps to weight loss - that last [In Danish: Små skridt til vægttab - der holder]*. Retrieved from https://sundhedsstyrelsen.dk/da/sundhed/~/media/007C9086E1A94D54836586A695B6E29C.ashx

de Man Lapidoth, J., Ghaderi, A., & Norring, C. (2006). Eating disorders and disordered eating among patients seeking non-surgical weight-loss treatment in Sweden. *Eating Behaviors*, *7*(1), 15–26. https://doi.org/10.1016/j.eatbeh.2005.05.006

de Zwaan, M., & Mitchell, J. E. (1992). Binge eating in the obese. *Annals of Medicine*, *24*(4), 303–308.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2011). *The Sage handbook of qualitative research* (4th ed). Thousand Oaks: Sage.

Derogatis, L. R., Lipman, R. S., & Covi, L. (1973). SCL-90: An Outpatient Psychiatric Rating Scale - Preliminary Report. *Psychopharmacological Bulletin*, *9*, 13–28.

Derogatis, L. R., Rickels, K., & Rock, A. F. (1976). The SCL-90 and the MMPI: a step in the validation of a new self-report scale. *The British Journal of Psychiatry*, *128*(3), 280–289.

Dimitrov Ulian, M., Pinto, A. J., de Morais Sato, P., B. Benatti, F., Lopes de Campos-Ferraz, P., Coelho, D., … B. Scagliusi, F. (2018). Effects of a new intervention based on the Health at Every Size approach for the management of obesity: The "Health and Wellness in Obesity" study. *PLOS ONE*, *13*(7), e0198401. https://doi.org/10.1371/journal.pone.0198401

Dingemans, A. E., & van Furth. (2012). Binge eating disorder psychopathology in normal weight and obese individuals. *International Journal of Eating Disorders*, *45*(1), 135–138. https://doi.org/10.1002/eat.20905

Dollar, E., Berman, & Adachi-Mejia. (2017). Do No Harm: Moving Beyond Weight Loss to Emphasize Physical Activity at Every Size. *Preventing Chronic Disease*, *14*. https://doi.org/10.5888/pcd14.170006

Durso, L. E., & Latner, J. D. (2008). Understanding self-directed stigma: development of the weight bias internalization scale. *Obesity*, *16*(S2). https://doi.org/10.1038/oby.2008.448

Durso, L., Latner, J. D., White, M. A., Masheb, R. M., Blomquist, K. K., Morgan, P. T., & Grilo, C. M. (2012). Internalized weight bias in obese patients with binge eating disorder: Associations with eating

disturbances and psychological functioning: Internalized Weight Bias in Bed. *International Journal of Eating Disorders*, *45*(3), 423–427. https://doi.org/10.1002/eat.20933

Effective Health Care Program. (2015). *Management and Outcomes of Binge-Eating Disorder* (No. 160). Comparative Effectiveness Review.

Eldredge, K. L., & Agras, W. S. (1996). Weight and shape overconcern and emotional eating in binge eating disorder. *Int J Eat Disord*, *19*(1), 73–82. https://doi.org/10.1002/(sici)1098-108x(199601)19:1<73::aid-eat9>3.0.co;2-t

Engel, S. G., Kahler, K. A., Lystad, C. M., Crosby, R. D., Simonich, H. K., Wonderlich, S. A., … Mitchell, J. E. (2009). Eating behavior in obese BED, obese non-BED, and non-obese control participants: A naturalistic study. *Behaviour Research and Therapy*, *47*(10), 897–900. https://doi.org/10.1016/j.brat.2009.06.018

Evans, E. H., Adamson, A. J., Basterfield, L., Le Couteur, A., Reilly, J. K., Reilly, J. J., & Parkinson, K. N. (2017). Risk factors for eating disorder symptoms at 12 years of age: A 6-year longitudinal cohort study. *Appetite*, *108*, 12–20. https://doi.org/10.1016/j.appet.2016.09.005

Fairburn, C., Cooper, Z., & Shafran, R. (2003). Cognitive behaviour therapy for eating disorders: a "transdiagnostic" theory and treatment. *Behaviour Research and Therapy*, *41*(5), 509–528. https://doi.org/10.1016/S0005-7967(02)00088-8

Fairburn, C., Doll, H. A., Welch, S. L., Hay, P. J., Davies, B. A., & O'Connor, M. E. (1998). Risk Factors for Binge Eating Disorder: A Community-Based, Case-Control Study. *Archives of General Psychiatry*, *55*(5), 425. https://doi.org/10.1001/archpsyc.55.5.425

Fairburn, C., & Wilson, G. (Eds.). (1993). *Binge eating: nature, assessment, and treatment*. New York: Guilford Press.

Fairburn, Cooper, Z., & O'Connor, M. (2008). Eating Disorder Examination (16.0D). In *Cognitive Behavior Therapy and Eating Disorders.* Guilford Press.

Fassino, S., Leombruni, P., Pierò, A., Abbate-Daga, G., & Giacomo Rovera, G. (2003). Mood, eating attitudes, and anger in obese women with and without Binge Eating Disorder. *Journal of Psychosomatic Research*, *54*(6), 559–566. https://doi.org/10.1016/S0022-3999(02)00462-2

Fischer, S., Meyer, A. H., Dremmel, D., Schlup, B., & Munsch, S. (2014). Short-term Cognitive-Behavioral Therapy for Binge Eating Disorder: Long-term efficacy and predictors of long-term treatment success. *Behaviour Research and Therapy*, *58*, 36–42. https://doi.org/10.1016/j.brat.2014.04.007

Forrest, L. N., Smith, A. R., & Swanson, S. A. (2017). Characteristics of seeking treatment among U.S. adolescents with eating disorders: Forrest et al. *International Journal of Eating Disorders*, *50*(7), 826–833. https://doi.org/10.1002/eat.22702

Foucault, M. (2006). *The order of things: an archaeology of the human sciences* (Repr). London: Routledge.

Gaesser, G. A., Angadi, S. S., & Sawyer, B. J. (2011). Exercise and Diet, Independent of Weight Loss, Improve Cardiometabolic Risk Profile in Overweight and Obese Individuals. *The Physician and Sportsmedicine*, *39*(2), 87–97. https://doi.org/10.3810/psm.2011.05.1898

Gagnon-Girouard, M.-P., Bégin, C., Provencher, V., Tremblay, A., Mongeau, L., Boivin, S., & Lemieux, S. (2010). Psychological Impact of a "Health-at-Every-Size" Intervention on Weight-Preoccupied Overweight/Obese Women. *Journal of Obesity*, *2010*, 1–12. https://doi.org/10.1155/2010/928097

Gergen, K. J. (1997). The Place of the Psyche in a Constructed World. *Theory & Psychology*, *7*(6), 723–746. https://doi.org/10.1177/0959354397076001

Gergen, K. J. (1999). *Realities and relationships: soundings in social construction*. Cambridge, Mass.: Harvard University Press.

Gergen, K. J. (2001). Psychological science in a postmodern context. *American Psychologist*, *56*(10), 803.

Gergen, K. J. (2002). Beyond the Empiricist/Constructionist Divide in Social Psychology. *Personality and Social Psychology Review*, *6*(3), 188–191. https://doi.org/10.1207/S15327957PSPR0603_2

Gergen, K. J., McNamee, S., & Barrett, F. (2001). Toward A Vocabulary of Transformative Dialogue. *International Journal of Public Administration*, (24), 697–707.

Gladis, M. M., Wadden, T. A., Vogt, R., Foster, G., Kuehnel, R. H., & Bartlett, S. J. (1998). Behavioral treatment of obese binge eaters: do they need different care? *Journal of Psychosomatic Research*, *44*(3–4), 375–384.

Godsey, J. (2013). The role of mindfulness based interventions in the treatment of obesity and eating disorders: An integrative review. *Complementary Therapies in Medicine*, *21*(4), 430–439. https://doi.org/10.1016/j.ctim.2013.06.003

Goldschmidt, A. B., Hilbert, A., Manwaring, J. L., Wilfley, D. E., Pike, K. M., Fairburn, C. G., … Striegel-Moore, R. H. (2010). The significance of overvaluation of shape and weight in binge eating disorder. *Behav Res Ther*, *48*(3), 187–193. https://doi.org/10.1016/j.brat.2009.10.008

Goldschmidt, A., Wall, Choo, Becker, & Neumark-Sztainer. (2016). Shared risk factors for mood-, eating-, and weight-related health outcomes. *Health Psychology*, *35*(3), 245–252. https://doi.org/10.1037/hea0000283

Goodrick, G. K., Poston II, W. S. C., Kimball, K. T., Reeves, R. S., & Foreyt, J. P. (1998). Nondieting versus dieting treatment for overweight binge-eating women. *Journal of Consulting and Clinical Psychology; Journal of Consulting and Clinical Psychology*, *66*(2), 363.

Governing Obesity. (2013). https://go.ku.dk/about/.

Greenway, F. L. (2015). Physiological adaptations to weight loss and factors favouring weight regain. *International Journal of Obesity*, *39*(8), 1188–1196. https://doi.org/10.1038/ijo.2015.59

Grilo, C., Hrabosky, J. I., White, M. A., Allison, K. C., Stunkard, A. J., & Masheb, R. M. (2008). Overvaluation of shape and weight in binge eating disorder and overweight controls: Refinement of a diagnostic

construct. *Journal of Abnormal Psychology*, *117*(2), 414–419. https://doi.org/10.1037/0021-843X.117.2.414

Grilo, C. M. (2013). Why no cognitive body image feature such as overvaluation of shape/weight in the binge eating disorder diagnosis? *International Journal of Eating Disorders*, *46*(3), 208–211.

Grilo, C. M., Crosby, R. D., Masheb, R. M., White, M. A., Peterson, C. B., Wonderlich, S. A., … Mitchell, J. E. (2009). Overvaluation of shape and weight in binge eating disorder, bulimia nervosa, and sub-threshold bulimia nervosa. *Behav Res Ther*, *47*(8), 692–696. https://doi.org/10.1016/j.brat.2009.05.001

Grilo, C. M., White, M. A., & Masheb, R. M. (2012). Significance of overvaluation of shape and weight in an ethnically diverse sample of obese patients with binge-eating disorder in primary care settings. *Behav Res Ther*, *50*(5), 298–303. https://doi.org/10.1016/j.brat.2012.02.008

Grilo, C., & Masheb, R. M. (2000). *Binge eating disorder: A need for additional diagnostic criteria*. Comprehensive Psychiatry, vol 41, 3, pp 159-162.

Grilo, C., & Masheb, R. M. (2005). A randomized controlled comparison of guided self-help cognitive behavioral therapy and behavioral weight loss for binge eating disorder. *Behaviour Research and Therapy*, *43*(11), 1509–1525. https://doi.org/10.1016/j.brat.2004.11.010

Grilo, C., Masheb, R. M., & White, M. A. (2009). Significance of Overvaluation of Shape/Weight in Binge-eating Disorder: Comparative Study With Overweight and Bulimia Nervosa. *Obesity*, *18*(3), 499–504. https://doi.org/10.1038/oby.2009.280

Grilo, C., White, M. A., & Masheb, R. M. (2009). DSM-IV Psychiatric Disorder Comorbidity and Its Correlates in Binge Eating Disorder. *The International Journal of Eating Disorders*, *42*(3), 228. https://doi.org/10.1002/eat.20599

Grucza, R. A., Przybeck, T. R., & Cloninger, C. R. (2007). Prevalence and correlates of binge eating disorder in a community sample. *Comprehensive Psychiatry*, *48*(2), 124–131.

Harriger, J. A., & Thompson, J. K. (2012). Psychological consequences of obesity: Weight bias and body image in overweight and obese youth. *International Review of Psychiatry*, *24*(3), 247–253. https://doi.org/10.3109/09540261.2012.678817

Hart, L. M., Granillo, M. T., Jorm, A. F., & Paxton, S. J. (2011). Unmet need for treatment in the eating disorders: A systematic review of eating disorder specific treatment seeking among community cases. *Clinical Psychology Review*, *31*(5), 727–735. https://doi.org/10.1016/j.cpr.2011.03.004

Hay, P. (2013). A systematic review of evidence for psychological treatments in eating disorders: 2005-2012. *International Journal of Eating Disorders*, *46*(5), 462–469. https://doi.org/10.1002/eat.22103

Hilbert, A., Petroff, D., Herpertz, S., Pietrowsky, R., Tuschen-Caffier, B., Vocks, S., & Schmidt, R. (2019). Meta-analysis of the efficacy of psychological and medical treatments for binge-eating disorder. *Journal of Consulting and Clinical Psychology*, *87*(1), 91–105. https://doi.org/10.1037/ccp0000358

Hilbert, A., Pike, Goldschmidt, Wilfley, Fairburn, Dohm, … Striegel Weissman. (2014). Risk factors across the eating disorders. *Psychiatry Research*, *220*(1–2), 500–506. https://doi.org/10.1016/j.psychres.2014.05.054

Hilbert, A., Saelens, B. E., Stein, R. I., Mockus, D. S., Welch, R. R., Matt, G. E., & Wilfley, D. E. (2007). Pretreatment and process predictors of outcome in interpersonal and cognitive behavioral psychotherapy for binge eating disorder. *Journal of Consulting and Clinical Psychology*, *75*(4), 645–651. https://doi.org/10.1037/0022-006X.75.4.645

Holstein, J. A., & Gubrium, J. F. (2008). *Handbook of Constructionist Research*. Guilford Press.

Holt-Lunstad, J. (2018). Why Social Relationships Are Important for Physical Health: A Systems Approach to Understanding and Modifying Risk and Protection. *Annual Review of Psychology*, *69*(1), 437–458. https://doi.org/10.1146/annurev-psych-122216-011902

Holt-Lunstad, J., Robles, T. F., & Sbarra, D. A. (2017). Advancing social connection as a public health priority in the United States. *American Psychologist*, *72*(6), 517–530. https://doi.org/10.1037/amp0000103

Hudson, J. I., Hiripi, Pope, & Kessler. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. *Biological Psychiatry*, *61*(3), 348–358. https://doi.org/10.1016/j.biopsych.2006.03.040

Iacovino, J. M., Gredysa, D. M., Altman, M., & Wilfley, D. E. (2012). Psychological Treatments for Binge Eating Disorder. *Current Psychiatry Reports*, *14*(4), 432–446. https://doi.org/10.1007/s11920-012-0277-8

Ivanova, I. V., Tasca, G. A., Hammond, N., Balfour, L., Ritchie, K., Koszycki, D., & Bissada, H. (2015). Negative Affect Mediates the Relationship Between Interpersonal Problems and Binge-Eating Disorder Symptoms and Psychopathology in a Clinical Sample: A Test of the Interpersonal Model: Interpersonal Model of Binge Eating. *European Eating Disorders Review*, *23*(2), 133–138. https://doi.org/10.1002/erv.2344

Ivanova, I. V., Tasca, G. A., Proulx, G., & Bissasda, H. (2016). Contribution of Interpersonal Problems to Eating Disorder Psychopathology via Negative Affect in Treatment-seeking Men and Women: Testing the Validity of the Interpersonal Model in an Understudied Population: Interpersonal Model of ED in Men and Women. *Clinical Psychology & Psychotherapy*. https://doi.org/10.1002/cpp.2060

Johnson, J. G., Spitzer, R. L., & Williams, J. B. (2001). Health problems, impairment and illnesses associated with bulimia nervosa and binge eating disorder among primary care and obstetric gynaecology patients. *Psychological Medicine*, *31*(8), 1455–1466.

Keefe, P. H., Wyshogrod, D., Weinberger, E., & Agras, W. S. (1984). Binge eating and outcome of behavioral treatment of obesity: a preliminary report. *Behaviour Research and Therapy*, *22*(3), 319–321. https://doi.org/10.1016/0005-7967(84)90012-3

Keski-Rahkonen, A., & Mustelin, L. (2016). Epidemiology of eating disorders in Europe: prevalence, incidence, comorbidity, course, consequences, and risk factors. *Current Opinion in Psychiatry*, *29*(6), 340–345. https://doi.org/10.1097/YCO.0000000000000278

Kessler, R. C., Berglund, Chiu, Deitz, Hudson, Shahly, … Xavier. (2013). The Prevalence and Correlates of Binge Eating Disorder in the World Health Organization World Mental Health Surveys. *Biological Psychiatry*. https://doi.org/10.1016/j.biopsych.2012.11.020

Khaodhiar, L., McCowen, K. C., & Blackburn, G. L. (1999). Obesity and its comorbid conditions. *Clinical Cornerstone*, *2*(3), 17–31.

Klatzkin, R. R., Gaffney, S., Cyrus, K., Bigus, E., & Brownley, K. A. (2015). Binge eating disorder and obesity: Preliminary evidence for distinct cardiovascular and psychological phenotypes. *Physiology & Behavior*, *142*, 20–27. https://doi.org/10.1016/j.physbeh.2015.01.018

Kornstein, S. G., Kunovac, J. L., Herman, B. K., & Culpepper, L. (2016). Recognizing Binge-Eating Disorder in the Clinical Setting: A Review of the Literature. *The Primary Care Companion For CNS Disorders*. https://doi.org/10.4088/PCC.15r01905

Kristeller, J., Wolever, R. Q., & Sheets, V. (2014). Mindfulness-Based Eating Awareness Training (MB-EAT) for Binge Eating: A Randomized Clinical Trial. *Mindfulness*, *5*(3), 282–297. https://doi.org/10.1007/s12671-012-0179-1

Kuhn, T. S. (1962). *The structure of scientific revolutions* (Fourth edition). Chicago ; London: The University of Chicago Press.

Kvale, S., & Brinkmann, S. (2015). *InterViews: learning the craft of qualitative research interviewing* (Third edition). Los Angeles: Sage Publications.

Lauest, J., Meyer, L. B., Lau, M., & Waaddegaard, M. (2016). *Erfaringsopsamling vedr. BED [In English: Accumulated experiences with BED]*. Retrieved from https://www.sst.dk/da/sygdom-og-behandling/psykisk-sygdom/sygdomme/~/media/EB8F6F6E426740C08262C2047E5C8F51.ashx

Legenbauer, T., Vocks, Betz, Baguena Puigcerver, Benecke, Troje, & Ruddel. (2011). Differences in the Nature of Body Image Disturbances Between Female Obese Individuals With Versus Without a Comorbid Binge Eating Disorder: An Exploratory Study Including Static and Dynamic Aspects of Body Image. *Behavior Modification*, *35*(2), 162–186. https://doi.org/10.1177/0145445510393478

Linardon, J. (2018). Rates of abstinence following psychological or behavioral treatments for binge-eating disorder: Meta-analysis. *International Journal of Eating Disorders*. https://doi.org/10.1002/eat.22897

Linardon, J., Messer, M., & Fuller-Tyszkiewicz, M. (2018). Meta-analysis of the effects of cognitive-behavioral therapy for binge-eating-type disorders on abstinence rates in nonrandomized effectiveness studies: Comparable outcomes to randomized, controlled trials? *International Journal of Eating Disorders*, *51*(12), 1303–1311. https://doi.org/10.1002/eat.22986

Madden, R. (2010). *Being ethnographic: a guide to the theory and practice of ethnography*. Thousand Oaks, CA: SAGE Publications.

Magkos, F., Fraterrigo, G., Yoshino, J., Luecking, C., Kirbach, K., Kelly, S. C., … Klein, S. (2016). Effects of Moderate and Subsequent Progressive Weight Loss on Metabolic Function and Adipose Tissue Biology in Humans with Obesity. *Cell Metabolism*, *23*(4), 591–601. https://doi.org/10.1016/j.cmet.2016.02.005

Mann, T. (2015). *Secrets from the eating lab: the science of weight loss, the myth of willpower, and why you should never diet again*. New York, NY: HarperWave.

Mann, T., Tomiyama, & Ward. (2015). Promoting Public Health in the Context of the "Obesity Epidemic" False Starts and Promising New Directions. *Perspectives on Psychological Science*, *10*(6), 706–710. https://doi.org/10.1177/1745691615586401

Mann, T., Tomiyama, Westling, Lew, Samuels, & Chatman. (2007). Medicare's search for effective obesity treatments: Diets are not the answer. *American Psychologist*, *62*(3), 220–233. https://doi.org/10.1037/0003-066X.62.3.220

Mathisen, T. F., Rosenvinge, J. H., Pettersen, G., Friborg, O., Vrabel, K., Bratland-Sanda, S., … Sundgot-Borgen, J. (2017). The PED-t trial protocol: The effect of physical exercise –and dietary therapy compared with cognitive behavior therapy in treatment of bulimia nervosa and binge eating disorder. *BMC Psychiatry*, *17*(1). https://doi.org/10.1186/s12888-017-1312-4

McDowell, I. (2010). Measures of self-perceived well-being. *Journal of Psychosomatic Research*, *69*(1), 69–79. https://doi.org/10.1016/j.jpsychores.2009.07.002

McNamee, S. (2014). Research as Relational Practice: Exploring Modes of Inquiry. In *Systemic Inquiry. Innovations in Reflexive Practice Research* (pp. 74–94). Farnhill, UK: Everything is Connected Press.

McNamee, Sheila, & Gergen, K. J. (Eds.). (1992). *Therapy as social construction*. London ; Newbury Park: Sage Publications.

McNamee, Sheila, & Hosking, D. M. (2012). *Research and social change: a relational constructionist approach*. New York: Routledge.

Mensinger, J. L., Calogero, Stranges, & Tylka. (2016). A weight-neutral versus weight-loss approach for health promotion in women with high BMI: A randomized-controlled trial. *Appetite*, *105*, 364–374. https://doi.org/10.1016/j.appet.2016.06.006

Mensinger, J. L., Calogero, & Tylka. (2016). Internalized weight stigma moderates eating behavior outcomes in women with high BMI participating in a healthy living program. *Appetite*, *102*, 32–43. https://doi.org/10.1016/j.appet.2016.01.033

Mintz, J., Drake, R. E., & Crits-Christoph, P. (1996). *Efficacy and effectiveness of psychotherapy: Two paradigms, one science.* Retrieved from http://psycnet.apa.org/psycinfo/1996-06398-015

Möller, H.-J. (2011). Effectiveness studies: advantages and disadvantages. *Dialogues in Clinical Neuroscience*, *13*(2), 199–207.

Mond, J. M., Hay, P. J., Rodgers, B., & Owen, C. (2007). Health service utilization for eating disorders: Findings from a community-based study. *International Journal of Eating Disorders*, *40*(5), 399–408. https://doi.org/10.1002/eat.20382

Morson, G. S., & Emerson, C. (1990). *Mikhail Bakhtin: creation of a prosaics*. Stanford, Calif: Stanford Univ. Press.

Muennig, P. (2008). The body politic: the relationship between stigma and obesity-associated disease. *BMC Public Health*, *8*(1). https://doi.org/10.1186/1471-2458-8-128

Munsch, S., Biedert, E., Meyer, A., Michael, T., Schlup, B., Tuch, A., & Margraf, J. (2007). A randomized comparison of cognitive behavioral therapy and behavioral weight loss treatment for overweight individuals with binge eating disorder. *International Journal of Eating Disorders*, *40*(2), 102–113. https://doi.org/10.1002/eat.20350

Mustelin, L., Bulik, C. M., Kaprio, J., & Keski-Rahkonen, A. (2017). Prevalence and correlates of binge eating disorder related features in the community. *Appetite*, *109*, 165–171. https://doi.org/10.1016/j.appet.2016.11.032

Nauta, H., Hospers, H., Kok, G., & Jansen, A. (2000). A comparison between a cognitive and a behavioral treatment for obese binge eaters and obese non-binge eaters. *Behavior Therapy*, *31*(3), 441–461. https://doi.org/10.1016/S0005-7894(00)80024-6

Neumark-Sztainer, D., Paxton, Hannan, Haines, & Story. (2006). Does Body Satisfaction Matter? Five-year Longitudinal Associations between Body Satisfaction and Health Behaviors in Adolescent Females and Males. *Journal of Adolescent Health*, *39*(2), 244–251. https://doi.org/10.1016/j.jadohealth.2005.12.001

Neumark-Sztainer, D., Wall, Larson, Eisenberg, & Loth. (2011). Dieting and Disordered Eating Behaviors from Adolescence to Young Adulthood: Findings from a 10-Year Longitudinal Study. *Journal of the American Dietetic Association*, *111*(7), 1004–1011. https://doi.org/10.1016/j.jada.2011.04.012

Nuttall, F. Q. (2015). Body Mass Index: Obesity, BMI, and Health. *Nutrition Today*, *50*(3), 117–128. https://doi.org/10.1097/NT.0000000000000092

O'Brien, K. S., Latner, Puhl, Vartanian, Giles, Griva, & Carter. (2016). The relationship between weight stigma and eating behavior is explained by weight bias internalization and psychological distress. *Appetite*, *102*, 70–76. https://doi.org/10.1016/j.appet.2016.02.032

Ojserkis, R., Sysko, R., Goldfein, J. A., & Devlin, M. J. (2012). Does the overvaluation of shape and weight predict initial symptom severity or treatment outcome among patients with binge eating disorder? *Int J Eat Disord*, *45*(4), 603–608. https://doi.org/10.1002/eat.20981

Pagoto, S., Bodenlos, J. S., Kantor, L., Gitkind, M., Curtin, C., & Ma, Y. (2007). Association of Major Depression and Binge Eating Disorder with Weight Loss in a Clinical Setting. *Obesity*, *15*(11), 2557–2559. https://doi.org/10.1038/oby.2007.307

Peat, C. M., Berkman, N. D., Lohr, K. N., Brownley, K. A., Bann, C. M., Cullen, K., … Bulik, C. M. (2017). Comparative Effectiveness of Treatments for Binge-Eating Disorder: Systematic Review and Network Meta-Analysis: BED Comparative Effectiveness. *European Eating Disorders Review*. https://doi.org/10.1002/erv.2517

Pratt, E. M., Telch, C. F., Labouvie, E. W., Wilson, G. T., & Agras, W. S. (2001). Perfectionism in women with binge eating disorder. *The International Journal of Eating Disorders*, *29*(2), 177–186.

Provencher, V., Bégin, C., Tremblay, A., Mongeau, L., Corneau, L., Dodin, S., … Lemieux, S. (2009). Health-At-Every-Size and Eating Behaviors: 1-Year Follow-Up Results of a Size Acceptance Intervention. *Journal of the American Dietetic Association*, *109*(11), 1854–1861. https://doi.org/10.1016/j.jada.2009.08.017

Puhl, R. M., & Brownell. (2012). Fight obesity, not the people. *The Atlanta Journal-Constitution*. Retrieved from http://www.ajc.com/news/opinion/fight-obesity-not-the-people/2J8JayrYJCJSUox0RLDBzN/

Puhl, R., & Suh, Y. (2015). Stigma and Eating and Weight Disorders. *Current Psychiatry Reports*, *17*(3). https://doi.org/10.1007/s11920-015-0552-6

Ramacciotti, C. E., Coli, E., Bondi, E., Burgalassi, A., Massimetti, G., & Dell'Osso, L. (2008). Shared psychopathology in obese subjects with and without binge-eating disorder. *International Journal of Eating Disorders*, *41*(7), 643–649. https://doi.org/10.1002/eat.20544

Ramian, K. (2012). *Casestudiet i praksis.* Kbh.: Hans Reitzel.

Raymond, N. C., de Zwaan, M., Mitchell, J. E., Ackard, D., & Thuras, P. (2002). Effect of a very low calorie diet on the diagnostic category of individuals with binge eating disorder. *International Journal of Eating Disorders*, *31*(1), 49–56. https://doi.org/10.1002/eat.1110

Reed, Z. E., Micali, N., Bulik, C. M., Davey Smith, G., & Wade, K. H. (2017). Assessing the causal role of adiposity on disordered eating in childhood, adolescence, and adulthood: a Mendelian randomization analysis. *The American Journal of Clinical Nutrition*, ajcn154104. https://doi.org/10.3945/ajcn.117.154104

Rehner Iversen, R. (2005). Assessment and Social Construction: Conflict or Co-Creation? *British Journal of Social Work*, *35*(5), 689–708. https://doi.org/10.1093/bjsw/bch200

Rieger, E., Van Buren, D. J., Bishop, M., Tanofsky-Kraff, M., Welch, R., & Wilfley, D. E. (2010). An eating disorder-specific model of interpersonal psychotherapy (IPT-ED): Causal pathways and treatment implications. *Clinical Psychology Review*, *30*(4), 400–410. https://doi.org/10.1016/j.cpr.2010.02.001

Rieger, E., Wilfley, D. E., Stein, R. I., Marino, V., & Crow, S. J. (2005). A comparison of quality of life in obese individuals with and without binge eating disorder. *International Journal of Eating Disorders*, *37*(3), 234–240. https://doi.org/10.1002/eat.20101

Robison, J. (2005). Health at Every Size: Toward a New Paradigm of Weight and Health. *Medscape General Medicine*, *7*(3), 13.

Rubin, H., & Rubin, I. (2005). *Qualitative Interviewing (2nd ed.): The Art of Hearing Data*. https://doi.org/10.4135/9781452226651

Safer, D. L., & Jo, B. (2010). Outcome from a randomized controlled trial of group therapy for binge eating disorder: comparing dialectical behavior therapy adapted for binge eating to an active comparison group therapy. *Behavior Therapy*, *41*(1), 106–120.

Saltzman, J. A., & Liechty, J. M. (2016). Family correlates of childhood binge eating: A systematic review. *Eating Behaviors*, *22*, 62–71. https://doi.org/10.1016/j.eatbeh.2016.03.027

Satspujle vedr. Binge Eating Disorder (BED) [In English: Funding regarding Binge Eating disorder (BED)]. (2013).

Schousboe, B. H. (2010). Systemic/narrative group treatment of BInge Eating Disorder - Deconstructing a treatment concept [In Danish: Systemisk/narrativ gruppebehandling af Binge Eating Disorder – Dekonstruktion af et behandlingskoncept]. *Fokus På Familien*, *2010*(1), 4–25.

Schousboe, B. H. (2011). Binge-eating disorder - early intervention and treatment [In Danish: Binge eating disorder – opsporing og behandling af tvangsoverspisning]. *Månedsskrift for Almen Praksis*, *89*(4), 283–392.

Sheehan, Harnett-Sheehan, K., & Raj, B. (1996). The measurement of disability. *Int Clin Psychopharmacol*, *11*(3), 98–95.

Sheehan, K. H., & Sheehan, D. V. (2008). Assessing treatment effects in clinical trials with the Discan metric of the Sheehan Disability Scale. *International Clinical Psychopharmacology*, *2008*, 70–83.

Sheehan, Lecrubier, Sheehan, Amorim, P., Janavs, Weiller, E., … Dunbar, G. C. (1998). The Mini-International Neuropsychiatric Interview (M.I.N.I.): the development and validation of a structured diagnostic

psychiatric interview for DSM-IV and ICD-10. *The Journal of Clinical Psychiatry*, *59 Suppl 20*, 22-33;quiz 34-57.

Shotter, J. (2005). The short book of 'withness'-thinking. *London, KCCF*. Retrieved from http://www.academia.edu/download/43197615/The_Short_Book_on_Withness_Thinking_Full.pdf

Shotter, J. (2010). *Social construction on the edge: withness-thinking and embodiment*. Chagrin Falls, Ohio: Taos Institute Publications.

Shotter, J. (2012). More than cool reason:"Withness-thinking" or "systemic-thinking" and "thinking about systems." *International Journal of Collaborative Practices*, *3*(1), 1–13.

Shotter, J. (2015). Methods in Inquiring into "the Stuff" of Everyday Life. In *Systemic Inquiry. Innovations in Reflexive Practice Research*. Everything is Connected Press.

Shotter, J., & Shotter, J. (2008). *Conversational realities revisited: life, language, body and world* (2nd ed). Chagrin Falls, Ohio: Taos Institute Publications.

Simon, G. (2012). Relational Ethnography: Writing and Reading in Research Relationships. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, *14*(1). Retrieved from http://www.qualitative-research.net/index.php/fqs/article/view/1735

Simon, G., & Chard, A. (2014). *Systemic inquiry innovations in reflexive practice research*. Franhill: Everything is Connected.

Smink, F. R. E., van Hoeken, D., Oldehinkel, A. J., & Hoek, H. W. (2014). Prevalence and severity of DSM-5 eating disorders in a community cohort of adolescents: Prevalence and Severity of DSM-5 Eating Disorders. *International Journal of Eating Disorders*, *47*(6), 610–619. https://doi.org/10.1002/eat.22316

Sonneville. (2013). Longitudinal associations between binge eating and overeating and adverse outcomes among adolescents and young adults: Does loss of control matter? *JAMA Pediatrics*, *167*(2), 149–155. https://doi.org/10.1001/2013.jamapediatrics.12

Sonneville, K. R., Grilo, C. M., Richmond, T. K., Thurston, I. B., Jernigan, M., Gianini, L., & Field, A. E. (2015). Prospective Association Between Overvaluation of Weight and Binge Eating Among Overweight Adolescent Girls. *Journal of Adolescent Health*, *56*(1), 25–29. https://doi.org/10.1016/j.jadohealth.2014.08.017

Steier, F. (1991). *Research and reflexivity*. London; Newbury Park, Calif.: Sage.

Stice, E., Marti, C. N., & Rohde, P. (2013). Prevalence, incidence, impairment, and course of the proposed DSM-5 eating disorder diagnoses in an 8-year prospective community study of young women. *Journal of Abnormal Psychology*, *122*(2), 445–457. https://doi.org/10.1037/a0030679

Stice, E., & Shaw, H. E. (2002). Role of body dissatisfaction in the onset and maintenance of eating pathology: A synthesis of research findings. *Journal of Psychosomatic Research*, *53*(5), 985–993.

Stige, B., Malterud, K., & Midtgarden, T. (2009). Toward an Agenda for Evaluation of Qualitative Research. *Qualitative Health Research*, *19*(10), 1504–1516. https://doi.org/10.1177/1049732309348501

Striegel, R. H., Bedrosian, R., Wang, C., & Schwartz, S. (2012). Why men should be included in research on binge eating: Results from a comparison of psychosocial impairment in men and women. *International Journal of Eating Disorders*, *45*(2), 233–240. https://doi.org/10.1002/eat.20962

Striegel-Moore, R., Dohm, F.-A., Pike, K. M., Wilfley, D. E., & Fairburn, C. G. (2002). Abuse, bullying, and discrimination as risk factors for binge eating disorder. *American Journal of Psychiatry*, *159*(11), 1902–1907.

Striegel-Moore, R. H., Cachelin, F. M., Dohm, F. A., Pike, K. M., Wilfley, D. E., & Fairburn, C. G. (2001). Comparison of binge eating disorder and bulimia nervosa in a community sample. *The International Journal of Eating Disorders*, *29*(2), 157–165.

Striegel-Moore, Ruth H., & Franko, D. L. (2003). Epidemiology of binge eating disorder. *International Journal of Eating Disorders*, *34*(S1), S19–S29. https://doi.org/10.1002/eat.10202

Stunkard, A J, Grace, W. J., & Wolff, H. G. (1955). The night-eating syndrome: a pattern of food intake among certain obese patients. *Am Journal of Medicin*, *19*, 78–86.

Stunkard, Albert J., & Allison, K. C. (2003). Binge eating disorder: Disorder or marker? *International Journal of Eating Disorders*, *34*(S1), S107–S116. https://doi.org/10.1002/eat.10210

Sutin, A R, Stephan, Y., & Terracciano, A. (2015). Weight discrimination and risk of mortality. *Psychological Science*, *26*(11), 1803–1811.

Sutin, A., Robinson, E., Daly, M., & Terracciano, A. (2016). Weight discrimination and unhealthy eating-related behaviors. *Appetite*, *102*, 83–89. https://doi.org/10.1016/j.appet.2016.02.016

Sutin, Angelina R., & Terracciano, A. (2013). Perceived Weight Discrimination and Obesity. *PLoS ONE*, *8*(7), e70048. https://doi.org/10.1371/journal.pone.0070048

Svarrer, T., & Rasmussen, S. (2008). Reflecting processes and witnessing - A critical comparison of theory and practice with perspectives from insiders [In Danish: Reflekterende processer og bevidning – En kritisk sammenligning af teori og praksis med synspunkter fra insidere]. *Fokus På Familien*, *2008*(03), 166–183.

Tanofsky-Kraff, M., Faden, D., Yanovski, S. Z., Wilfley, D. E., & Yanovski, J. A. (2005). The perceived onset of dieting and loss of control eating behaviors in overweight children. *International Journal of Eating Disorders*, *38*(2), 112–122.

Telch, C. F., & Agras, W. S. (1993). The effects of a very low calorie diet on binge eating. *Behavior Therapy*, *24*(2), 177–193. https://doi.org/10.1016/S0005-7894(05)80262-X

Teucher, B., Rohrmann, S., & Kaaks, R. (2010). Obesity: Focus on all-cause mortality and cancer. *Maturitas*, *65*(2), 112–116. https://doi.org/10.1016/j.maturitas.2009.11.018

The Look AHEAD Research Group. (2014). Eight-year weight losses with an intensive lifestyle intervention: The look AHEAD study: 8-Year Weight Losses in Look AHEAD. *Obesity*, *22*(1), 5–13. https://doi.org/10.1002/oby.20662

Tjørnhøj-Thomsen, T., & Whyte, S. R. (2008). Fieldwork and participant observations. In S. Vallgårda & L. Kock (Eds.), *Research Methods in Public Health* (pp. 91–210).

Tomiyama, A. J. (2014). Weight stigma is stressful. A review of evidence for the Cyclic Obesity/Weight-Based Stigma model. *Appetite*, *82*, 8–15. https://doi.org/10.1016/j.appet.2014.06.108

Tomiyama, A. J., Carr, D., Granberg, E. M., Major, B., Robinson, E., Sutin, A. R., & Brewis, A. (2018). How and why weight stigma drives the obesity 'epidemic' and harms health. *BMC Medicine*, *16*(1). https://doi.org/10.1186/s12916-018-1116-5

Tomiyama, A. J., Epel, E. S., McClatchey, T. M., Poelke, G., Kemeny, M. E., McCoy, S. K., & Daubenmier, J. (2014). Associations of weight stigma with cortisol and oxidative stress independent of adiposity. *Health Psychology*, *33*(8), 862–867. https://doi.org/10.1037/hea0000107

Tylka, T. L., Annunziato, R. A., Burgard, D., Daníelsdóttir, S., Shuman, E., Davis, C., & Calogero, R. M. (2014). The Weight-Inclusive versus Weight-Normative Approach to Health: Evaluating the Evidence for Prioritizing Well-Being over Weight Loss. *Journal of Obesity*, *2014*, 1–18. https://doi.org/10.1155/2014/983495

Udo, T., & Grilo, C. M. (2018). Prevalence and Correlates of DSM-5–Defined Eating Disorders in a Nationally Representative Sample of U.S. Adults. *Biological Psychiatry*, *84*(5), 345–354. https://doi.org/10.1016/j.biopsych.2018.03.014

Ulfvebrand, S., Birgegård, A., Norring, C., Högdahl, L., & von Hausswolff-Juhlin, Y. (2015). Psychiatric comorbidity in women and men with eating disorders results from a large clinical database. *Psychiatry Research*, *230*(2), 294–299. https://doi.org/10.1016/j.psychres.2015.09.008

Vancampfort, D., Vanderlinden, J., De Hert, M., Adámkova, M., Skjaerven, L. H., Catalán-Matamoros, D., … Probst, M. (2013). A systematic review on physical therapy interventions for patients with binge eating disorder. *Disability and Rehabilitation*, 1–6. https://doi.org/10.3109/09638288.2013.771707

Vartanian, L. R., & Shaprow. (2008). Effects of Weight Stigma on Exercise Motivation and Behavior: A Preliminary Investigation among College-aged Females. *Journal of Health Psychology*, *13*(1), 131–138. https://doi.org/10.1177/1359105307084318

Vocks, S., Tuschen-Caffier, Pietrowsky, Rustenbach, Kersting, & Herpertz. (2010). Meta-analysis of the effectiveness of psychological and pharmacological treatments for binge eating disorder. *International Journal of Eating Disorders*, NA-NA. https://doi.org/10.1002/eat.20696

Wadden, T. A., Butryn, M. L., & Byrne, K. J. (2004). Efficacy of Lifestyle Modification for Long-Term Weight Control. *Obesity Research*, *12*(S12), 151S-162S. https://doi.org/10.1038/oby.2004.282

Watzlawick, P., Weakland, & Fisch. (1974). *Change: Principles of Problem Formation and Problem Resolution*.

Welch, E., Jangmo, A., Thornton, L. M., Norring, C., von Hausswolff-Juhlin, Y., Herman, B. K., … Bulik, C. M. (2016). Treatment-seeking patients with binge-eating disorder in the Swedish national registers: clinical course and psychiatric comorbidity. *BMC Psychiatry*, *16*(1). https://doi.org/10.1186/s12888-016-0840-7

Wenneberg, S. B. (2002). *Social Constructivism: Positions, problems and perspectives. [Danish: Socialkonstruktivisme: positioner, problemer og perspektiver]*. Frederiksberg: Samfundslitteratur.

Wilfley, D. E., Friedman, M. A., Dounchis, J. Z., Stein, R. I., Welch, R. R., & Ball, S. A. (2000). Comorbid psychopathology in binge eating disorder: Relation to eating disorder severity at baseline and following treatment. *Journal of Consulting and Clinical Psychology*, *68*(4), 641–649. https://doi.org/10.1037/0022-006X.68.4.641

Wilfley, D. E., Welch, R. R., Stein, R. I., Spurrell, E. B., Cohen, L. R., Saelens, B. E., … Matt, G. E. (2002). A Randomized Comparison of Group Cognitive-Behavioral Therapy and Group Interpersonal Psychotherapy for the Treatment of Overweight Individuals With Binge-Eating Disorder. *Archives of General Psychiatry*, *59*(8), 713. https://doi.org/10.1001/archpsyc.59.8.713

Wilfley, D., Frank, M., Welch, R., Spurrell, E., & Rounsaville, B. (1998). Adapting Interpersonal Psychotherapy to a Group Format (IPT-G) for Binge Eating Disorder: Toward A Model for Adapting Empirically Supported Treatments. *Psychotherapy Research*, *8*(4), 379–391. https://doi.org/10.1080/10503309812331332477

Wilson, G. T., Wilfley, Agras, & Bryson. (2010). Psychological Treatments of Binge Eating Disorder. *Archives of General Psychiatry*, *67*(1), 94. https://doi.org/10.1001/archgenpsychiatry.2009.170

Wing, R. R., Lang, W., Wadden, T. A., Safford, M., Knowler, W. C., Bertoni, A. G., … the Look AHEAD Research Group. (2011). Benefits of Modest Weight Loss in Improving Cardiovascular Risk Factors in Overweight and Obese Individuals With Type 2 Diabetes. *Diabetes Care*, *34*(7), 1481–1486. https://doi.org/10.2337/dc10-2415

Wirth, M. D., Blake, C. E., Hébert, J. R., Sui, X., & Blair, S. N. (2014). Chronic weight dissatisfaction predicts type 2 diabetes risk: Aerobic center longitudinal study. *Health Psychology*, *33*(8), 912–919. https://doi.org/10.1037/hea0000058

Wiser, S., & Telch, C. F. (1999). Dialectical behavior therapy for binge-eating disorder. *Journal of Clinical Psychology*, *55*(6), 755–768. https://doi.org/10.1002/(SICI)1097-4679(199906)55:6<755::AID-JCLP8>3.0.CO;2-R

Wonderlich, S. A., de Zwaan, M., Mitchell, J. E., Peterson, C., & Crow, S. (2003). Psychological and dietary treatments of binge eating disorder: Conceptual implications. *International Journal of Eating Disorders*, *34*(S1), S58–S73. https://doi.org/10.1002/eat.10206

World Health Organization. (2000). Obesity: preventing and managing the global epidemic. Report of a WHO consultation. *World Health Organization Technical Report Series*, *894*, i–xii, 1–253.

Yanovski, S. Z., Gormally, J. F., Leser, M. S., Gwirtsman, H. E., & Yanovski, J. A. (1994). Binge Eating Disorder Affects Outcome of Comprehensive Very-Low-Calorie Diet Treatment. *Obesity*, *2*(3), 205–212.

Zhang, Y., & Wildemuth, B. (2009). Unstructured_interviews. In *Applications of Social Research Methods to Questions in Information and Library Science* (pp. 222–231). Westport, CT: Libraries Unlimited.

Appendix

1. Abbreviations
2. Figures and tables
3. DSM-IV & DSM-5 criteria for BED
4. Covariates used for multiple imputation
5. EDE-log
6. Information, invitations, and consent forms
7. Papers 1-3

Appendix 1: Abbreviations

AN = Anorexia Nervosa

BED = Binge eating disorder

BMI = Body Mass Index

BN = Bulimia Nervosa

BWLT = Behavioral Weight Loss treatment

CBT = Cognitive Behavioral Therapy

CBTgsh = Cognitive Behavioral Therapy guided self-help

DSM = Diagnostic and Statistical Manual of Mental Disorders.

EDE = Eating Disorder Examination

ICD = International Classification of Diseases

I-SN = Integrative systemic and narrative therapy

IPT = Interpersonal Therapy

LMSOS = Landsforeningen mod Spiseforstyrrelser og Selvskade

RCT = Randomized Controlled Trial

SPC = Stolpegaard Psychotherapy Center [Danish Psykoterapeutisk Center Stolpegård]

VLCD = Very Low Calorie Diet

Appendix 2: Figures and tables

Figure 1. BED lies at the intersection of the eating disorder field and the obesity field

Figure 2. The distribution of people with BED across the Body Mass Index (BMI) categories

Figure 3. Timeline of the PhD period including inclusion period for participants for the quantitative study, data generation for the qualitative study, and analyses of the quantitative and qualitative data.

Figure 4. The two-phased treatment model at SPC, Systemic and narrative group psychotherapy and Weight loss and Wellbeing groups

Figure 5. The multimethod design comprising a pre-post effectiveness study and a qualitative ethnographic study

Table 1. Average treatment usage of mandatory treatment elements for completers (N= 82)
Number of completers who chose optional treatment elements and their average usage (varying n's)

Table 2. Participants who were invited for interviews

Table 3. Overview of activities and participant observations, notes and reflections from participant observations November 2016 to May 2016

Table 4. Methods and timing of assessment

Appendix 3: DSM-5 and ICD-11 criteria for BED

DSM-5 compared to DSM-IV criteria

Criteria Set	
Criterion 1	Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following: 1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances 2. The sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)
Criterion 2	Binge-eating episodes are associated with three (or more) of the following: 1. Eating much more rapidly than normal 2. Eating until feeling uncomfortably full 3. Eating large amounts of food when not feeling physically hungry 4. Eating alone because of being embarrassed by how much one is eating 5. Feeling disgusted with oneself, depressed, or very guilty after overeating
Criterion 3	Marked distress regarding binge eating is present.
Criterion 4	The binge eating occurs, on average, 1. at least 2 days a week for 6 months (DSM-IV frequency and duration criteria) 2. at least 1 day a week for 3 months (DSM-5 frequency and duration criteria)
Criterion 5	The binge eating is not associated with the regular use of inappropriate compensatory behavior (e.g., purging, fasting, excessive exercise) and does not occur exclusively during the course of anorexia nervosa or bulimia nervosa.
Severity Grading	DSM-IV does not include a BED severity grading scale. Applicable to DSM-5 only, BED severity is graded as follows: • Mild: 1 to 3 episodes per week • Moderate: 4 to 7 episodes per week • Severe: 8 to 13 episodes per week • Extreme: 14 or more episodes per week

BED = binge-eating disorder; DSM = Diagnostic and Statistical Manual of Mental Disorder

ICD-11 criteria for Binge eating disorder
Parent: Feeding and eating disorders

Description: Binge eating disorder is characterized by frequent, recurrent episodes of binge eating (e.g., once a week or more over a period of several months). A binge eating episode is a distinct period of time during which the individual experiences a subjective loss of control over eating, eating notably more or differently than usual, and feels unable to stop eating or limit the type or amount of food eaten. Binge eating is experienced as very distressing, and is often accompanied by negative emotions such as guilt or disgust. However, unlike in Bulimia Nervosa, binge eating episodes are not regularly followed by inappropriate compensatory behaviours aimed at preventing weight gain (e.g., self-induced vomiting, misuse of laxatives or enemas, strenuous exercise).

Exclusion: Bulimia Nervosa

Foundation Id: http://id.who.int/icd/entity/1673294767

Appendix 4: Covariates used for multiple imputation

Variable	Variable NAME		Covariates
EDE – Binge-eating frequency (Days) EDE – Binge-eating frequency (episodes) EDE – Restraint EDE - Eating concern EDE - Shape concern EDE - Weight concern EDE - Global score SDS – Sumscore Funktionsniveau på skole/job, familie, social SCL-90-R SUMscore WHO-5 BMI	EDE10A_2 EDE10B_2 EDE_restrik_2 EDE_spisebek_2 EDE_vegtbek_2 EDE_figurbek_2 EDE_totalscore_2 SDS_SUMscore_2 SCL_GSI_2 SCL_GSI_2 WHOscore_2 BMI_2	**Demographics** Gender Age Marital status Children Occupation Illness duration Prior treatment **Pre-post scores on:** BMI EDE – Binge-eating frequency (Days) EDE – Binge-eating frequency (episodes) EDE subscales EDE Global score WHO-5 SCL-90 SUMscore	gender Alder_henv egtestan borntotal hvilken aktbeske_1 varighed indlagt tidl.psyh.beh opvekst sygemeldt_1 WHOscore_1 WHOscore_2 SCL_GSI_1 SCL_GSI_2 SDS_SUMscore_1 SDS_SUMscore_2 BMI_0 BMI_2 EDE10A_1 EDE10A_2 EDE10B_1 EDE10B_2 EDE_restrik_1 EDE_spisebek_1 EDE_vegtbek_1 EDE_figurbek_1 EDE_restrik_2 EDE_spisebek_2 EDE_figurbek_2 EDE_vegtbek_2

Appendix 5: EDE-log

Dokumentet har til hensigt at dokumentere retningslinjer, der gør sig gældende for udførelsen og scoring af EDE-interview i dette projekt. Der kommer tilføjelser i forbindelse med EDE-møder, supervision og rådgivning fra Loa Clausen, Yvonne Linné og andre fagpersoner.

Retningslinjer for scoring.

Dette er et supplement til de retningslinjer for scoring af EDE version 12 + BED tillægget fra 16

EMNE	DATO	
Spørgsmål 30 ∗*Har du i løbet af de seneste 4 uger følt dig fed ?* Undlad, hvis pt. er overvægtig og under alle omstændigheder, hvis BMI >30 scor 7.		Vi spørger alligevel, fordi de fleste patienter sagtens kan svare. Det at have et højt BMI betyder ikke nødvendigvis, at folk føler sig fede. Faktisk er det ofte heller ikke alle dage, at patienterne har det på den måde.
	Tilføjelse 29.04.2014 EDE-møde	Vi spørger stadig. F-EAT projektet på PCS har vist, at BED pt har samme grad af fedmefølelse som BN. Start med at tydeliggøre, at spørgsmålet går på <u>fedme-følelsen</u>, ikke at føle sig tyk eller overvægt, eller hvad andre måtte tænke. Men en følelse af at være fed.
Spørgsmål 31 ☞*Har du i løbet af de seneste 4 uger haft et klart ønske om at have en flad mave ?*		Vi spørger alligevel, fordi nogle enkelte patienter, der ønsker en flad /konkav mave.
	Tilføjelse 29.04.2014 EDE-møde	Spørgsmålet har vist sig meget sjældent at være relevant. Samtidig kræver spørgsmålet en del forklaring, hvorfor det fremover udelades. Scores som 7 i EDE og udgår af opgørelsen og beregningen af subskalaen.
Opgørelse	Tilføjelse 13.05.14	Hvis det er nødvendigt at score 9 eller lignende, fordi spørgsmålet ikke passer til pt. eller det ikke er relevant/muligt at besvare, så tælles det ikke med i opgørelsen. Divider da med et tal mindre end normalt.
Overspisninger *Mængde*		Der er diskussioner om, hvad der udgør en stor mængde mad for meget overvægtige mennesker, fordi deres energibehov vil være anderledes end normalvægtige. Dog har nogle meget overvægtige mennesker et relativt lavt aktivitetsniveau og derfor et mindre energibehov og en lavere forbrænding. <u>Retningslinjen i vores undersøgelse vil derfor følge EDE som er, at en stor mængde mad svarer til det dobbelte af, hvad andre mennesker ville spise i en lignende situation.</u>
Ved gastric bypass (se case 1) Pt med gastric bypass kan ikke spise store mængder mad på en gang, hvorfor nogle beskriver at have overspisninger hele dagen. Hvordan scores det?	Tilføjelse 29.04.2014 EDE møde	<u>Ang. mængde:</u> Sammenligne mængder med, hvad andre med gastric bypass ville spise, ikke (som ellers) med hvad andre ville spise i en lignende situation. Spørg tilbage i tiden for at afdække om der var overspisninger *før* gastric bypass. <u>Ang. episoder</u>: Hvordan tælle episoder, hvis overspisning fordeles over længere tid, fordi der ikke er plads til at have en hel overspisning på en gang? Spørg til pauser: hvad laver pt i pausen mellem overspisningerne. Hvis ligger og venter på at få plads i maven så tælles som en. Hvis har aktiviteter, der kan indikere, at der er et reelt ophold i overspisningen tælles det som flere.
Kontroltab		Nogle ptt med BED har haft deres lidelse så længe, at de ikke oplever kontroltab i forbindelse med overspisningerne. Det kan være fordi det efterhånden føles naturligt, det sker automatisk eller de bare helt har opgivet at have kontrol. I de tilfælde kan det være en ide at spørge til patienternes oplevelser med overspisningerne, da de startede. For andre patienter er det vanskeligt at sætte ordet *kontroltab* på, fordi de har planlagt deres overspisninger og evt. glæder sig til dem. Spørg da, om de kunne

		have forhindret overspisningen i at opstå, eller hvordan de ville have haft det, hvis de blev afbrudt.
Kompenserende adfærd		Svarer antallet og omfanget af den kompenserende adfærd til antallet og omfanget af overspisningerne? Fx svarer en gåtur på 10 minutter ikke til en stor overspisning, og skal ikke registreres som kompenserende adfærd til trods for, at pt har gjort det med den hensigt at påvirke vægt, figur og krop. På samme måde vil én opkastning på en uge ikke være tilstrækkeligt som kompenserende adfærd for eksempelvis 5 overspisninger. Lav evt. også en note i journalnotatet, om at der har været kompenserende adfærd, men at omfanget ikke svarer til overspisningerne. Hvis du er i tvivl, så skriv noter i EDEen og diskuter det med Lene eller Marjun eller andre umiddelbart efter, og tag det op på supervision eller på EDE-møde.
Restriktion (se case 1 og 2) Spørgsmål 7 og 3 *Kostrestriktioner uden for bulimiske episoder. / Undlader at spise.*		Mange pt. med BED spiser restriktivt hele dagen og overspiser eftermiddag og aften. Det kan være vanskeligt at afgøre, om der er tale om ekstrem restriktion, fordi de kan have spist så store mængder mad, at de ikke oplever at være sultne. Det kan også være svært at afgøre, om der er tale om kompenserende adfærd. Følgende er retningslinjer gør sig gældende for scoring. Restriktion skal svare til størrelsen og omfanget af overspisningen, for at kunne tælle som kompenserende adfærd. Restriktion skal have som formål, at påvirke vægt, figur og krop. –Altså ikke fordi pt ikke er sulten.
18. Undladelse af ekstrem vægtkontrollerende adfærd		Dette spørgsmål hænger sammen med de forudgående om kompenserende adfærd. Læg mærke til, at adfærden kun tæller med, hvis det har været over tærskel niveau. Dvs mere end 1 gang om ugen for hver af de kompenserende adfærd og mere end 2 gange om ugen for alle former for adfærd tilsammen. (Se vejledning for EDE version 16 for uddybning) Hvis der har været restriktion og kompenserende adfærd i mindre grad end det nævnte anses det for at være uger fri.
19. utilfredshed med vægt/figur	Tilføjelse EDE møde 29.04.2014	Der står i vejledningen *Scor kun 4,5,6 hvis der har været pinefulde oplevelser.* En pinefuld oplevelse dækker over en række ting. Kan bl.a. være at stå op på vægten. Hvordan vælge mellem score 4,5,6? Hjælpsomt at bruge ordet pinefuldt til at differentiere det fra utilfredshed. ”Forbliver tankerne hos dig i lang tid efterfølgende?” Varsom med ordet ulykkelig (eng: unhappy). Pt kan godt være utilfreds og påvirket uden at være ulykkelig. ”Er der dage, hvor der er mere accept? ”
25. Figurens vigtighed/26, Vægtens vigtighed		Det er vigtigt at tydeliggøre for pt., at der er en skelnen mellem, hvad der er vigtigst for dem og hvad der er vigtigst for, hvordan de ser sig selv. Det kan være et svært spørgsmål. Retningslinjerne for EDE anbefaler at lave en top-10.
	Tilføjelse EDE møde 29.04.2014	Varsom med at introducere aspekter, der kan være vigtige, ex børn, job, rolle som mor, veninde, partner. Det kan indikere, at der er noget, der brude være vigtigere for pt end vægt og figur. Forslag til at spørge: ”Er vægt / figur en betydelig del af din selvopfattelse?” I så fald: ”hvordan bliver det tydeligt?” ”Af alle de ting, der har betydning, hvor placerer vægt/figur sig?” Derudover, så kan det hjælpe at tænke spørgsmålet i sammenhæng med resten af pts besvarelser.

Appendix 6: Information, invitations, and consent forms

Psykiatri

Psykoterapeutisk Center Stolpegård

Stolpegårdsvej 20
2820 Gentofte

Telefon 3864 5300
Fax 3864 5353
Mail pcstolpegaard@regionh.dk
Web www.psykiatri-stolpegaard.dk

Telefontid: man-torsdag kl. 8-15
& fredag til kl. 14

Dato: okt 2015

OBSERVATION I TRIVSEL OG VELVÆRE GRUPPE
Evaluering af BED-behandling (Binge Eating Disorder)
på Psykoterapeutisk Center Stolpegård

Praktisk information

Kære deltager i BED gruppe

Her er lidt praktisk information om observationsstudiet i din gruppe.

Den første gang jeg er med i gruppen er **torsdag 29.oktober 2015 og den sidste gang er torsdag d.21. april 2016.**

Jeg vil være med de fleste gange, men nogle gange kan jeg ikke deltage. Jeg giver selvfølgelig besked på forhånd, så du ved, om jeg er der eller ej.

Jeg vil gerne være med hele dagen dvs. fra vejning og indtil I går til frokost. Jeg går ikke med til frokost og jeg er heller ikke med i jeres pause kl 10.30-11.

I gymnastiksalen vil jeg oftest sidde på en skammel i hjørnet, men nogle gange deltager jeg i aktiviteterne. I grupperummet sidder jeg ved et bord bagved rundkredsen og skrive noter om det jeg ser, hører og tænker undervejs. Mit håb er at forstyrre mindst muligt.

Hvis der er dage, hvor du ikke ønsker at jeg er med til vejning eller til gruppe, så er du velkommen til at sige det, så springer jeg over den dag.

Alt materiale bliver behandlet med fortrolighed.

Hvis du er usikker på noget, håber jeg, at du vil kontakte mig.

Telefon: 38 64 53 16 eller mail: lene.bomholt.meyer@regionh.dk

Mange hilsner, Lene Meyer

Information om et observationsstudie som del af evalueringen af BED-behandling (Binge Eating Disorder) på Psykoterapeutisk Center Stolpegård

Præsentation

Jeg hedder Lene Meyer. Jeg er psykolog og er i gang med et ph.d. projekt, hvor vi evaluerer BED-behandlingen på Stolpegård. Som del af evalueringen af BED-behandlingen vil jeg gerne bede om lov til at deltage som observatør i din behandlings-gruppe.

Observationsstudie

I dette observationsstudie er jeg med i gruppen uden at deltage i terapi, interview eller tilbagemeldinger. Jeg vil sidde uden for kredsen. Jeg lytter, iagttager og noterer, hvad jeg ser.

Finansieret af satspuljemidler

Interview

Når du afslutter behandlingen, vil jeg spørge dig, om du vil deltage i et interview. Her bedes du fortælle om dine oplevelser af behandlingen. Du vil modtage mere information, hvis du til den tid ønsker at deltage.

Formål

Formålet med at observere og interviewe er at få indsigt i, hvad der sker undervejs i behandlingen, og hvad der har betydning for deltagerne.

Hvad kræver det af dig?

Observationsstudiet kræver ikke noget aktivt fra dig – bortset fra din accept. Før du beslutter, om du vil give din accept, er det vigtigt, at du forstår, hvad forskningsprojektet går ud på, og hvorfor vi gennemfører det.

Vi vil derfor bede dig om at læse den følgende deltagerinformation grundigt.

Forskningsprojektet

Forskningsprojektet formål er at evaluere et nyudviklet behandlingstilbud til patienter med BED og overvægt. Vi vil undersøge, hvad der udgør en effektiv og meningsfuld behandling. Der anvendes spørgeskemaer og strukturerede diagnostiske interview, som gør det muligt at dokumentere en effekt af behandlingen for den samlede patientgruppe. Det suppleres med observationer og patientinterview, der giver en erfaringsbaseret indsigt i BED-behandlingen og en nuanceret forståelse af behandlingens effekt.
Projektet har to dele:

1. Én del af projektet undersøger udbyttet af behandlingen via de EDE interview og de elektroniske spørgeskemaer, som patienter på PC Stolpegård besvarer før og efter behandling.
2. En anden del af projektet er et observationsstudie af behandlingen, som suppleres med en interviewbaseret undersøgelse, hvor vi interviewer 15-20 deltagere på forskellige tidspunkter i behandlingsforløbet.

   Interviewene vil handle om deltagernes oplevelser og overvejelser med at være i behandling for BED.

Deltagelse

Hvis du har spørgsmål eller gerne vil høre mere, inden du beslutter dig, kontakter vi dig gerne. Hvis du beslutter dig for at deltage, har vi brug for, at du underskriver en samtykkeerklæring. Husk, at din identitet forbliver fuldkommen anonym. Du har ret til betænkningstid, før du beslutter, om du vil underskrive samtykkeerklæringen.

Det er frivilligt at deltage i undersøgelsen. Du kan når som helst og uden at give en grund trække dit samtykke tilbage. Det vil ***ikke*** få konsekvenser for din videre behandling.

Plan for undersøgelsen

Undersøgelsen indgår i et treårigt ph.d. projekt. Inden projektets afslutning vil datamaterialet blive opgjort og analyseret.

Nytte ved undersøgelsen

BED er en ny spiseforstyrrelse. Der mangler viden om, hvilke behandlingsbehov mennesker med BED har, og hvordan de behov bedst imødekommes.

Mange mennesker med BED har også overvægt. Vi mangler viden om, hvordan behandlingen bedst imødekommer denne overvægt, og de tanker og følelser og fysiske konsekvenser som overvægt kan give anledning til hos et menneske med BED.
Din deltagelse er af stor betydning for forskningen i BED og BED-behandling.

Ved at deltage i dette projekt giver du os vigtig viden og er på den måde med til at forbedre behandlingen for de mennesker, som i fremtiden bliver ramt af en spiseforstyrrelse. Derfor vil vi også forsøge at indsamle så mange informationer som muligt.

Risici eller ulemper

Deltagelse i projektet er frivillig, og projektet udsætter ikke deltagerne for nogen risici.

Adgang til undersøgelsens resultater

Dato for første inklusion af deltagere var 1. november 2013, og projektet forventes afsluttet d. 1. april 2017. Undersøgelsens resultater vil blive udgivet i en offentligt tilgængelig afhandling samt i videnskabelige tidsskrifter. Dine udsagn gengives ikke, og din anonymitet er sikret i alle dele af undersøgelsen.

Finansiering

Ambulatorium for Spisefor-styrrelser på Psykoterapeutisk Center Stolpegård har modtaget satspuljemidler til at udvikle en behandling til mennesker med BED og overvægt. Undersøgelsen er del af et ph.d. forløb, der er støttet af satspuljemidlerne.

Vi håber, at du med denne information har fået tilstrækkeligt indblik i, hvad det vil sige at deltage i undersøgelsen, og at du føler dig rustet til at tage beslutningen om din eventuelle
deltagelse.

Vi håber på din deltagelse.
Med venlig hilsen
Lene Meyer
Cand.psych. og ph.d. studerende

Marianne Lau
Overlæge og leder af Psykoterapeutisk Forskningsenhed, PC Stolpegård

---

Hvis du vil vide mere om undersøgelsen, er du meget velkommen til at kontakte os.

Lene Meyer
Stolpegårdsvej 20, 2820 Gentofte.
Tlf. 38 64 53 16

Mail: lene.bomholt.meyer@regionh.dk.

INTERVIEW EFTER PSYKOTERAPEUTISK GRUPPEFORLØB

Evaluering af BED-behandling (Binge Eating Disorder) på Psykoterapeutisk Center Stolpegård

Vi vil spørge dig, om du vil deltage i et interview i forbindelse med en videnskabelig undersøgelse, som udføres af Lene Meyer, psykolog og Marianne Lau, overlæge.

Undersøgelsen udføres på Ambulatorium for Spiseforstyrrelser, Psykoterapeutisk Center Stolpegård, Stolpegårdsvej 20, 2820 Gentofte.

Formål med interviewet

Dette interview indgår i en undersøgelse af BED-behand-lingen på PC Stolpegård. Formålet er at få indsigt i behandlingen fra et patientperspektiv.

Vi vil spørge dig om dine oplevelser med at deltage i gruppeforløbet.

Finansieret af satspuljemidler

Vi vil især gerne høre, hvordan du har oplevet din tid i gruppen, og hvad der har været vigtigt for dig undervejs og efterfølgende.

Hvad kræver det af dig?

Interviewet tager cirka **1 time.** Det kan afholdes i forbindelse med et andet møde herude eller over telefonen. Hvis du ønsker det, og det er praktisk muligt, kan interviewet også udføres hjemme hos dig.

Samtalen vil blive lydoptaget, skrevet ud og anvendt i projektet i anonymiseret form.

Før du beslutter, om du vil være med til interviewet, er det vigtigt, at du forstår, hvad den overordnede undersøgelse går ud på, og hvorfor vi gennemfører den.

Vi vil derfor bede dig om at læse den følgende deltagerinformation grundigt.

Forskningsprojektet

Forskningsprojektet formål er at evaluere et nyudviklet behandlingstilbud til patienter med BED og overvægt. Vi vil undersøge, hvad der udgør en effektiv og meningsfuld behandling. Der anvendes spørgeskemaer og strukturerede diagnostiske interview, som gør det muligt at dokumentere en effekt af behandlingen for den samlede patientgruppe. Det suppleres med observationer og patientinterview, der giver en erfaringsbaseret indsigt i BED-behandlingen og en nuanceret forståelse af behandlingens effekt.
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1. Én del af projektet undersøger udbyttet af behandlingen via de EDE interview og de elektroniske spørgeskemaer, som patienter på PC Stolpegård besvarer før og efter behandling.

2. En anden del af projektet er et observationsstudie af behandlingen, som suppleres med en interviewbaseret undersøgelse, hvor vi interviewer 15-20 deltagere på forskellige tidspunkter i behandlingsforløbet.

Interviewene vil handle om deltagernes oplevelser og overvejelser med at være i behandling for BED.

Deltagelse

Hvis du har spørgsmål eller gerne vil høre mere, inden du beslutter dig, kontakter vi dig gerne. Hvis du beslutter dig for at deltage, har vi brug for, at du underskriver en samtykkeerklæring. Husk, at din identitet forbliver fuldkommen anonym. Du har ret til betænkningstid, før du beslutter, om du vil underskrive samtykkeerklæringen.

Det er frivilligt at deltage i undersøgelsen. Du kan når som helst og uden at give en grund trække dit samtykke tilbage. Det vil ***ikke*** få konsekvenser for din videre behandling.

Plan for undersøgelsen

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Din deltagelse er af stor betydning for forskningen i BED og BED-behandling.

Ved at deltage i dette projekt giver du os vigtig viden og er på den måde med til at forbedre behandlingen for de mennesker, som i fremtiden bliver ramt af en spiseforstyrrelse. Derfor vil vi også forsøge at indsamle så mange informationer som muligt.

Risici eller ulemper

Deltagelse i projektet er frivillig, og projektet udsætter ikke deltagerne for nogen risici.

Adgang til undersøgelsens resultater

Dato for første inklusion af deltagere var 1. november 2013, og projektet forventes afsluttet d. 1. april 2017. Undersøgelsens resultater vil blive udgivet i en offentligt tilgængelig afhandling samt i videnskabelige tidsskrifter. Dine udsagn gengives ikke, og din anonymitet er sikret i alle dele af undersøgelsen.

Finansiering

Ambulatorium for Spiseforstyrrelser på Psykoterapeutisk Center Stolpegård har modtaget satspuljemidler til at udvikle en behandling til mennesker med BED og overvægt. Undersøgelsen er del af et ph.d. forløb, der er støttet af satspuljemidlerne.

Vi håber, at du med denne information har fået tilstrækkeligt indblik i, hvad det vil sige at deltage i undersøgelsen, og at du føler dig rustet til at tage beslutningen om din eventuelle
deltagelse.

Vi håber på din deltagelse.

Med venlig hilsen
Lene Meyer
Cand.psych. og ph.d. studerende

Marianne Lau
Overlæge og leder af Psykoterapeutisk Forskningsenhed, PC Stolpegård

---

Hvis du vil vide mere om undersøgelsen, er du meget velkommen til at kontakte os.

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Sundhedsstyrelsen

Psykiatri

Psykoterapeutisk Center Stolpegård

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& fredag til kl. 14

OBSERVATION AF BED-GRUPPEBEHANDLING
Evaluering af BED-behandling (Binge Eating Disorder)
på Psykoterapeutisk Center Stolpegård

Dato: marts 2015

Samtykke-erklæring

Navn: _____ **Cpr.:** _____ _____

Jeg samtykker hermed i at deltage i et forskningsprojekt omkring behandling af personer med BED (Binge Eating Disorder) på PC Stolpegård.

Jeg er mundtligt og skriftligt blevet informeret om projektet. Ligeledes er jeg informeret om, at min deltagelse indebærer, at der er en observatør, der deltager i den behandlingsgruppe, jeg er i. Observatøren vil skrive noter.

Alle oplysninger og data vil blive behandlet fortroligt og i anonymiseret form, og observatøren er underlagt en professionel tavshedspligt. Jeg er klar over, at jeg når som helst kan trække dette samtykke tilbage.

Dato Underskrift.

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Papers 1-3
Paper 1

Abstract

Binge eating disorder (BED) is a severe eating disorder strongly associated with obesity. Treatments struggle to provide safe and effective ways of addressing weight in a BED context. This study explored a two-phased treatment for BED developed at a major out-patient eating disorder service in Denmark. The study used interviews and participant observations to gain insight into experiences and processes related to weight and body issues in three treatment contexts that addressed weight stability, weight acceptance, and weight loss. Using systems theory, the study proposed *a relational weight problem* that embeds feelings of non-acceptance due to weight, a merge of weight and identity, and an internalized body- and weight-critical gaze of others. Contrary to critical claims that weight acceptance discourages people with obesity from engaging in weight loss efforts, this study suggests that acceptance and a disentanglement of weight and identity are prerequisites for weight loss for this group.

Eating disorders (EDs) are serious psychiatric illnesses that affect broadly across race, gender, and socioeconomic status (Kessler et al., 2013). Age-of-onset typically occurs in childhood or adolescence with body dissatisfaction and unhealthy weight loss behaviors as shared risk factors (Hilbert et al., 2014). Binge Eating Disorder (BED) is the lesser-known but most prevalent of the EDs affecting 2 - 3 % of the population (Hudson, Hiripi, Pope, & Kessler, 2007; Kessler et al., 2013). BED is strongly associated with obesity, but long-term weight loss remains a challenge in treatment. To fully understand the complex problems that arise at the intersection of BED and obesity, the present article argues that we need to move

beyond the individualized psychiatric or medical framework and attend to contextual and interactional influences.

Background

BED was acknowledged as an independent diagnosis in the 5th edition of the Diagnostic and Statistical Manual of Disorders (DSM-5; American Psychiatric Association [APA], 2013) and is characterized by episodes of binge eating in the absence of inappropriate compensatory behaviors. People affected by BED often alternate between periods of binge eating and strict dieting leading to dramatic fluctuations in weight as well as an overall increase in weight over time (Dingemans & van Furth, 2012). The majority eventually develop obesity (Hudson et al., 2007)). Psychotherapies effectively reduce BED psychopathology, but rarely lead to weight loss (Vocks et al., 2010). In light of a steep weight trajectory pre-treatment, weight stabilization is considered a good outcome (Barnes, Blomquist, & Grilo, 2011). However, the dominant conviction is that obesity severely affects physical health, and so weight loss remains a separate treatment goal for BED (for critical reviews of weight loss treatments and BMI as a predictor of physical health; Mann et al., 2007; Clark, Fonarow, & Horwich, 2014). Behavioral Weight Loss Treatments for BED show moderate short term results (Wilson, Wilfley, Agras, & Bryson, 2010).

BED and obesity exhibit shared risk factors (Haines & Neumark-Sztainer, 2006), and crossover is common (Dianne Neumark-Sztainer, 2005), yet, the ED and obesity fields are fundamentally divided with limited exchange of knowledge (Neumark-Sztainer, 2009). This leaves the intersection of BED and obesity greatly underexplored and, as we shall argue, critically restricted in terms of how to understand and address weight problems. The ED and obesity fields represent counteracting goals and health messages (Neumark-Sztainer, 2005; Ferrari, 2011; Greenhalgh, 2016). While public health interventions

target obesity by promoting early detection of weight problems and initiation of behavioral weight loss efforts (Mann, Tomiyama, & Ward, 2015a.), ED studies persistently warn of the adverse effects seen in unhealthy dieting behavior and increased weight and shape concerns. Dieting and poor body image are strongly and consistently predictive of EDs and obesity (Dianne Neumark-Sztainer, Wall, Larson, Eisenberg, & Loth, 2011; Cena et al., 2017; Bacon & Aphramor, 2011). Parental obesity and eating disordered behavior and parental perceptions (Allen, Byrne, Forbes, & Oddy, 2009; Allen, Byrne, Oddy, Schmidt, & Crosby, 2014) and comments about the child's weight, shape, and eating (Hilbert et al., 2014; Dianne Neumark-Sztainer et al., 2010; Wansink, Latimer, & Pope, 2017) have been associated with increased body dissatisfaction and BMI. Perceived weight stigma and weight-related bullying have equally been associated with later development of obesity, EDs, and poorer body image (Friedman et al., 2005; Puhl & Brownell, 2012; Aphramor, 2005). Epidemiological and prevention studies have clearly established EDs and obesity as complex problems that span individual, interpersonal, and social levels. However, the present article argues that much research that informs BED and obesity treatment is constricted by a tendency to de-contextualize problems and focus entirely on the individual (Bracken et al., 2012).

Therefore, the present study used a systemic framework to explore how BED and weight problems developed, were sustained, and changed within the contexts of three different treatment settings. The aim was to inspire relational and contextual understandings of BED and weight that could point to alternative pathways for change in treatment.

Theoretical Framework

The study used cybernetic systems theory (Bateson, 1972) to inquire into the multiple factors, relationships, and contexts that made up the problems identified as BED and obesity. Systems theory involves a shift in focus from individualism to contextualism and from linear to circular reasoning. This moves the subject of inquiry from isolated factors and primary causes to structures, relations, and processes. The present study analyzed BED and obesity as open complex systems comprising smaller systems of self-sustaining thoughts and behavior patterns within larger social and interpersonal systems. Systems theory poses that phenomena are more than the sum of their parts, and we assumed that BED together with obesity gave rise to phenomena that could not be explained by either one in isolation. We also assumed that interactions between the person with BED and other people would generate phenomena that were not ascribable to either one person, but had to be understood as a relational product. The systemic notion of circular causality occasions a simultaneous inquiry into problems and solutions as any cause is always also the effect of what came before it. This led to an attempt to "understand the problem by its solutions" (Nardone, 2004). Similarly, systems theory holds no assumptions about a beginning of a problem; instead we looked for disturbances to which the problem was a reaction. In second order cybernetic systems thinking, long-lasting problems are understood as arising from continual maladaptive attempts to solve them:

> "We assume that once a difficulty begins to be seen as a "problem", the continuation, and often the exacerbation, of this problem results from the creation of a positive feedback loop, most often centering around those very behaviors of the individuals in the system that are intended to resolve the difficulty: The original difficulty is met with an attempted "solution" that intensifies the original difficulty, and so on and on" (Watzlawick, Weakland, & Fisch, 1974:4).

One analytical trail was therefore to outline the positive feedback loops and resulting behavior patterns that underlie the construction, exacerbation, and eventual resolution of BED and weight problems. A second analytical trail was to attend to the constitutive capacities of language and communication in the creation and dissolution of problems. We used Anderson and Goolishian's concept of *problem-defined systems* (Anderson & Goolishian, 1988) which suggests that the reality of a problem is linguistically shaped by those interacting around it. This includes family relations, society, and people in the treatment setting. If there is no languaged concern or complaint, there is no problem. Problem-defined systems surpass objective definitions such as "BED" and "obesity".

Method

Design

Data for this article were taken from a multimethod study exploring a two-phased treatment for BED. The study comprised a quantitative single group effectiveness study evaluating Phase 1 (systemic and narrative group psychotherapy) using pre-post measures of functional level (SDS), general psychopathology (SCL-90R), quality of life (WHO-5), treatment satisfaction, and eating pathology (EDE-Q5) from an internet-based questionnaire system and Eating Disorder Examination (EDE) interviews. We conducted a qualitative ethnographic study of Phase 1 and Phase 2 (Weight Loss and Wellbeing/Weight Acceptance) using in-depth interviews and participant observations. Qualitative data were analyzed before the completion of the quantitative data collection. Data were analyzed separately in accordance with the specific methods. Quantitative and qualitative data concerning Phase 1 were

converged to compliment results and explore contradictions (Creswell & Plano Clark, 2011). These insights are discussed elsewhere.

Setting and Treatments

The study was conducted at a major out-patient ED-unit in the capital region of Denmark. Complying with the European International Criteria for Diseases (ICD, World Health Organization, WHO), BED is yet to be recognized as an independent diagnosis in Denmark. The presented ED-unit is the only public treatment service in Denmark that offers psychotherapy treatment to patients with BED. From 2013 to 2016, the unit received funding by the Danish Health Authority to evaluate and expand their treatment program to include added weight management and a larger patient group. At the same time, the present study was funded thus gaining access to the treatment facility, patients, and data.

Treatment was multimodal and in accordance with official recommendations and guidelines for treatments of EDs (Danish Health Authority, 2005). The full treatment lasted 1-1½ years. *Phase 1:* Treatment consisted of 25 weekly group sessions of systemic and narrative therapy including five group sessions of dietetic counseling. Groups had two trained therapists and 7-8 patients. New patients entered as others finished. Additional treatment elements included consultations for couples, individual dietetic and social counseling, and two consecutive multifamily meetings for family and support networks. Parent groups, mindfulness, and Basic Body Awareness Therapy (BBAT) were offered on demand. Patients were to keep a food diary and work towards regularizing eating patterns to reduce binges, and to stay at a stable weight within plus/minus 5 or 7 kg (11 or 15.5 lbs.) depending on BMI. Patients signed consent forms in agreement. Weight was monitored before each therapy session. Excessive weight changes elicited extra dietetic guidance and a reflection period of three weeks where no attention was given to

weight. During this period, patients were to explore the causes of weight change and decide whether to continue or terminate treatment. Treatment was conducted as individual therapy in groups. One therapist interviewed a patient and group members and the two therapists gave feedback according to Tom Andersen's principles for reflecting teams (Andersen, 1987). Listeners shared what had resonated with them or inspired them on hearing the interview, and what came across as important to the interviewed person. Therapists, dieticians, physiotherapists, and medical physicians used the narrative practice of externalizing (White, 2007). Externalizing separates problems from the person and involves questions such as, "What is the eating disorder's plan for you/ your life?" and "Do you agree with it?" The rationale is to minimize shame and blame and encourage a joint effort to explore and work against the identified problems. Two main problems were externalized in the treatment: *The eating disorder* and *the critical voice.* The eating disorder was used about thoughts, feelings, and behaviors ascribable to the eating disorder. The critical voice was presented as an "ally of the eating disorder" and represented feelings and expressions of self-criticism and hopelessness. *Phase 2:* In collaboration with therapists, patients could choose to proceed in a Weight Loss group or a Wellbeing/Weight Acceptance group for six months. To aid patients in choosing groups, assemblies were arranged where therapists and former patients from the two groups shared information and experiences. Groups had 8 - 10 patients and were open to new patients as others finished. Groups met weekly (Weight Loss group) or bi-weekly (Wellbeing/Weight Acceptance group) from 8.30 – 12.00 followed by a joint unsupervised lunch. *The Weight Loss group* was modeled on a national weight loss project "Small steps to weight loss" (Danish Health Authority, 2015), and structured around a series of eclectic psychoeducation sessions supplemented with dietetic guidance and elements of meditation and body therapy. The expected weight loss was presented as a maximum of ½ kg (1.1 lbs.) a week or, as announced by the therapists: "Getting experiences with doing weight loss in a safe environment by making small life style changes in eating habits and physical movement".

Attendance required absence of binge eating to counter relapse. Care providers were a medical physician, a physiotherapist, and a dietician. *The Wellbeing/Weight Acceptance group* was inspired by Health at Every Size® principles (HAES®, Bacon, 2008). The aim was presented by the therapists as "gaining greater acceptance of yourself and your body, and finding enjoyment in eating and bodily movements". The main component was BBAT supplemented with mindful eating exercises, meditations, and therapeutic counseling of BED symptoms. Patients were weighed, but there were no weight demands. Care providers were a therapist, a physiotherapist, and a dietician.

Participants

The participants for this study were a subsample of a larger explorative study that included 110 participants who entered Phase 1 treatment. Of these, 81 completed, and 36 continued in Phase 2 (Weight Loss 20, Wellbeing/Weight Acceptance 16) of which 26 completed (Weight Loss 13, Wellbeing/Weight Acceptance 13). Twenty-two patients who completed Phase 1 or 2 during a six-month observation period were invited for in-depth interviews. Twenty accepted (Phase 1 5, Weight Loss 8 (of which one had dropped out), Wellbeing/Weight Acceptance 7). One participant (Wellbeing/Weight Acceptance) declined due to work load and one (Phase 1) did not respond. Participants were three men and 17 women, aged 22 – 58 (mean 34.8), and BMI 28 – 55 (mean 39). Twelve were married or living with someone, 20 were unmarried or divorced, 11 had children under the age of 15. Eleven were actively employed and nine were absent owing to illness. A large majority (27) had previously received more than five psychological or psychiatric sessions, and five had previously been admitted to inpatient care. All but two had been affected by BED for more than five years. The majority (25) had experienced trauma before their 11th year. All (33) consented to the observational study (11 in each group). The nine participants,

cited in this article, were given the pseudonyms; Astrid, Sara, Liz, Ida, Signe, Tanja, Marius, Ingrid, and Eva.

Data Generation

Data for the present study were generated by the first author at an out-patient ED-Unit in Denmark from November 2015 to Maj 2016 using participant observations and in-depth interviews.

Participant Observations

The first author simultaneously attended a Phase 1 group, a Weight Loss group, and a Wellbeing/ Weight Acceptance group. The researcher was present in all weighing sessions and group sessions and stayed with either patients or therapists for breaks. On request by the patients, the researcher was not present for lunch as they wished to speak freely about issues outside of treatment. When invited by the patients, the researcher took part in informal conversations, in body therapy activities, mindful eating, and meditation during Phase 2. During Phase 1, the researcher attended multifamily meetings and no other activities outside the therapy room. During observations, the researcher took handwritten notes of conversations, activities, and reflections which were later transcribed. Observations provided insights into processes and interactions underlying change during treatment, especially how participants and therapists worked together around body and weight issues.

Interviews

Participants were invited for interviews in their homes, at the treatment facility, or over the phone. Interviews lasted between 30 minutes and 3 hours with interviews in the participants' homes taking longer than interviews over the phone. Interviews were flexibly structured; the researcher invited the participants to engage in a conversation about BED, weight, and treatment and was responsive to what

the participants thought was relevant while at the same time trying to explore how BED and weight problems developed, worsened, and eventually changed in treatment (Burgess, 1984). All participants were asked about their experiences of weight demands in treatment, choosing Phase 2 (when relevant), and their bodily experiences. All were asked about treatment elements (writing a food diary, the group, multifamily meetings, and the method of externalizing), and about sequences from the observational study that had stood out to the observer as difficult or decisive for the participants. The participants generally engaged with the interviewer as a messenger, who could convey relevant knowledge to the public, so BED would be recognized as an independent diagnosis.

The observations and interviews served to mutually contextualize and complement each other: Interviews provided contextual knowledge about the problems and solutions in the development and treatment of BED and unfolded the changes apparent in therapy in "real life". Observations allowed the researcher to trace the small steps, dilemmas, and negotiations that made up these changes.

Ethics

Referring to the committee law § 2, the National Committee on Health Research Ethics (DNVK) [40503] judged that the study could proceed without approval due to the nature of the methods. Participants received oral and written information about the study and gave separate written consent to the interviews and the participant observations. Observations of group psychotherapy raise ethical concerns about respecting the needs and boundaries of individual participants. The observer was presented as "a fly on the wall" and sat at a table in a corner facing away from the group. Participants could ask the observer to not attend or leave at any moment. The observer contemplated eventually facing the group, but felt it was too invasive. During an interview, a participant shared an experience of feeling overwhelmed by having her difficult thoughts written down by the observer as she spoke them, but she had decided it was

easier to let the observer stay. This served as a reminder to be vigilant and discrete throughout. During weighing sessions, the observer took care not to see the participants' weight as this was judged sensitive. An ethical commitment was to give voice to the participating people and strive to present the inherent meaningfulness of their stories.

Data Analysis

All interviews and field notes concerning weighing sessions, patient-therapist interviews and feedback from patients and therapists (except notes on recurring routines and long passages of informal talk during breaks) were transcribed and entered into NVivo®-10. Audio recordings of interviews were continually revisited to preserve meaning and contextualize codes and general findings. Data were coded for: *Context, Actors, Interpretive nodes,* and what was perceived as a *Problem* or *Solution*. Coding, organization of data, and processes of analyses followed NVivo® guidelines (Bazeley & Jackson, 2013) as these appropriately operationalized the systemic analytical framework. Organizing the codes in *node trees* provided overview of structures and relations between codes. Listening through the interviews, we found that participants talked from many perspectives and with many voices. This inspired us to subcode *Actors* as *Internal:* Eating disorder, self, body, weight. *External*: Relatives, strangers, group members, staff, and external health care professionals., and *Context* as *Time*: Childhood, problem development period, before, during, and after treatment Phase 1 and 2. *Place:* Treatment facility, home, public spaces, other health care settings. Exploring the *eating disorder, self, body, and weight* in *matrixes,* we found important differences across time, actors, and contexts in what was considered problems and solutions. These revealed relational and social processes underlying the development of eating and weight problems and changes in the participants' sense of self. We also became aware of circular mechanisms between

the different internal and external actors that worsened the eating and weight problems over time. The analytical process was aided by journaling and node memos to keep track of emerging ideas.

Findings

The applied systemic perspective pointed to two central features that characterized changes in eating and weight problems over time and across contexts. First, the accounts outlined a *relational weight problem* that emerged in communicative interactions between people occupied with the participants' weight at a young age. Second, self-sustaining behavior patterns developed around a shared belief that weight loss was the solution and the person was the problem. We will demonstrate how demands for weight stability in treatment created an overall sense of calm as problems and solutions changed place: Weight loss was no longer considered a solution and the participants were no longer considered the problem. As participants and their close relatives began to act, think, and speak differently about weight, the relational weight problem was gradually dissolved. The outside world continued to pose demands for weight loss and pass weight-based judgments, but the participants found themselves relating differently. Overall, meeting oneself with acceptance and being met with acceptance by others emerged as a pathway for change.

On the Creation of a Weight Problem

> Astrid: I've been fat all my life (....) It's always been like, Astrid, she's chubby or fat. It's kind of a family weakness. It's something in the genes. And at 7, I needed specially tailored clothes and I was put on a diet at the doctors. So, I went there with my mum and was weighed, and I learnt that it had to be skimmed milk and half a piece of rye bread for breakfast and da da da.
>
> Interviewer: When you were 7 years old? That's a long career (…)

Astrid: Yes. I think I've tried everything; cabbage diets, egg diets, da da da da, always at it. I've always considered myself to be way way too fat.

Interviewer: Your weight was a problem that needed to be solved?

Astrid: Yes.

Interviewer: Or your body was something that needed to be solved?

Astrid: Yes, well, it's always been like, when I couldn't keep a diet and put on weight, then it was like it was me, that I wasn't okay (starts to cry). It's always been like, when I couldn't do the simplest thing in the world, eat food and keep a stable weight, then it had to be because I was stupid or something. So, it's always been about hiding it, you know, always, thinking, 'am I good enough?' depending on my weight. And when it's high, it's filled with self-hatred.

Astrid explained that the problem for her was not so much her body and weight. It was how unsuccessful weight loss attempts had made her feel about herself. *She* became the problem and weight loss the solution, presumably the solution to feeling wrong and unacceptable. She felt that her inability to lose weight had to be kept 'hidden' which meant keeping her body hidden. Like Astrid, most participants' stories of their eating and weight problems began in childhood. For some, the weight problem was almost congenital as they were exposed to intergenerational bodily self-hatred and stories about how their genes predisposed them to weight gain. It is unclear if participants were objectively overweight as children as no one spoke of their weight, weight related health problems, or their experiences of their own body or weight. Marius remembered how the heaviness of his body had limited him in sports and how this compromised his identity as competitive. Otherwise, the body and weight as problems were almost entirely understood and recounted from the perspectives of others: Health care professionals, parents and others talked about or reacted to the participant's body and weight as wrong and in need of dietary

restrictions and forced exercise. The following is from an interview with Sara who had just completed the Weight Loss group. She remembered how her mother's face had functioned as her scale:

> My mother was my scale when I came home, even when I moved out, then I always knew when she looked at me that she would think iiih, you've lost weight or uuh you've gained weight. So, I didn't need to weigh myself.

This and similar accounts pointed to an outside gaze on the body and a weight-dependent acceptance that were both internalized. Eva reflected on childhood memories of weight related bullying where experiences of being fat merged with a deep-seated sense of being wrong.

> There's always been something completely wrong [with me], and I've never known what, so the only thing that I could think of was that it was because I was overweight.

The accounts clearly depicted weight as an arena for interpersonal positioning. Stepping on a scale, looking at their bodies, imagining others looking at their bodies all became ways for the participants to know themselves and relate to other people. Within this context, binge eating served multiple purposes: It comforted and protected against unpleasant feelings, comments, and self-critical thoughts, and it became acts of resistance to own or other's demands for weight loss or restrictive eating. This is evident in the following interview excerpts:

> It could be some stupid little thing, a comment, something, and then I could just feel how I would get hungry. You know, completely. (Astrid)

> Maybe it's like, when I've spoken badly to myself then maybe I'd comfort myself because I'd been so cruel to myself. Actually, that might be the reason: That it [the eating disorder] isn't as justified when I speak nicely to myself. (Liz)

> (…) then, the eating disorder is a good friend, one that accepts you when you're sad and, "I'll comfort you". Someone who accepts that, "that dietician she is such an asshole and well stupid", and then "just you go ahead and eat something", because, "poor you, that she talks to you that way". (Ida)

> Even now, at 42, if food is forbidden, I instantly feel an urge to eat it. (Sara)

For a subgroup, binge eating began as a response to other life stressors (divorce, loss, ADHD, asthma, arthritis, or accidents) which tended to reappear after treatment. Signe explains:

> But the further away the eating disorder gets, the less I can use it as a way of coping, and then these things slowly reappear which might have been what I'd used the eating disorder for in the first place.

Others felt a complete loss of control and estrangement from their body because rapid weight gain due to medication, injuries, or cessation of smoking. Irrespective of the "initial problem", a system of interrelated problems and solutions developed around the endless attempts to lose weight. For some, this lasted up to 50 years. Once the "weight problem" was talked, acted, and experienced into being, the problem moved beyond physicality and became relational and about identity; knowing you are fat and knowing that others know you as fat. This distinction between "a physical weight" and "a relational weight" was neatly summed up by Ida: "Well, I've always known I was fat, even before I was fat". An emergent conviction was that "I am the problem and weight loss is the solution" which was greatly reinforced by others (health care professionals and close relatives). We now look at how treatment initiated changes by claiming that neither weight nor the person was the problem.

Weight Stability - Chaos and Calm

The combined treatment demands for weight stability and eating regular meals, as well as weight monitoring, led to several interrelated changes that were consistent with the treatment rationale. Participants saw that their weight actually could be stable even when eating without restrictions, and that weight loss attempts sustained their eating problems. In recognizing their stories in other group members and consistently talking about the eating disorder as something separate to them, they also came to see that they were not the problem, the BED was. Overall, participants tried on a set of *alternative behavior patterns* (Weakland, Fisch, Watzlawick, & Bodin, 1974) where previous problems became solutions.

The following field notes are from one of the weekly weighing sessions preceding therapy, where participants were required to step on a scale and see their weight. The researcher started in the waiting area and walked in with the first participant who was called in by one of the therapists.

> In the waiting area, group members laugh and talk about life in general, body issues, what they consider the latest silly diets, society, health care politics, news on the BED diagnosis, and where to buy clothes. They leave for the adjacent weighing room one at a time, one therapist in the corner, the other noting down today's weight in a folder. Some participants leap in with a loud "good morning", others fall quiet. Based on the exchange of words, it is hard to guess the current weight status. Fluctuations of plus minus 100 g (3.5 oz.) to 2 kg (4.4 oz.) are presented by the therapists as "this is what we call a stable weight" and participants are encouraged to "come and have a look. If we look at your chart over time you can see that your weight is stable". If weight continuously goes up or it changes dramatically, the therapists ask about episodes of binge eating, birthdays, indulgence, or they suggest extra dietetic counseling. Mostly, there are logical explanations to weight changes. One participant reacts to her weight with an "ahgr" to which one of the therapists replies rather abruptly "What was that?" Reactions to weight are met with "So what are your thoughts? Does the eating

> disorder have an opinion about this?" Another participant steps on the scale and looks at the ceiling, steps down and rushes off. The therapist quietly calls her back, and the participant explains how the eating disorder had reacted with thoughts about restrictive eating after her last weighing. The participant is allowed not to see her weight this time as a way of experimenting with the eating disorder, to observe how it reacts. The overall aim, however, is for her to look at her weight.

The silence in the weighing sessions suggested that participants were to endure any distress related to weight change or being weighed, and eventually come to experience the intended effect. In an interview, Astrid recounted an episode where she had gained 1.4 kg (3.1 lbs.) in one week. She was very upset, but had felt it was impossible to bring it up in the group as she knew it was "foolish" to react so strongly. Like others, she explained that her fear was that her weight would sky-rocket.

> I was certain I could gain 10 kg [22 lbs.] in a week or two weeks (…) but I was also on it [the scale] eight times a day; before and after I went to the toilet, washed my hands, brushed my teeth, almost even after changing my clothes (…) And after having weighed far more than 100 kg [220 lbs.], then gaining 2 kg [4.4 lbs.] for example would make me panic completely. Two kilos meant that I now weigh 78 [172 lbs.] and tomorrow 80 [176.5 lbs.].

The following week, Astrid had lost 1.5 kg (3.3 lbs.) and concluded that having to be confronted with her weight was "both the worst and the best". Generally, weight emerged as a sensitive topic best hidden from one's own and other's gaze. Group members went to great lengths not to see each other's weight. If someone by accident entered the weighing room before the therapists were ready, they quickly covered their eyes in case the scale showed the last participant's weight.

Like many others, Astrid explained in the interview how she was initially surprised and frustrated at the prospect of weight stability, but ended up feeling calm.

> So, during the first 3 weeks, it turned out to be the most wonderful thing that I had to be weight stable. That's what's given me the whole calmness I think. My husband even says that the whole family has felt it as a kind of calmness that I had to be weight stable, because there had always been that quest for "next week, I'm being weighed".

Relatives' perceptions of what constituted the problem also shifted as they were involved in treatment. Gradually, they stopped pressing for weight loss which Ingrid experienced as a big relief.

> And after they've kind of understood what BED was about and what it had done to me and others, then there wasn't this expectation from them that, now, comes that weight loss that I've accomplished so many times in my life; big weight losses that eventually resulted in everything coming back on. So, that actually freed me of a burden that it wasn't about weight loss.

In treatment, the physical weight did not change, but the conversations about weight did, thus gradually dissolving the relational weight problem. At a multifamily meeting for BED patients and support network, however, a husband said that, while he had come to understand that weight loss was not the answer, he still struggled every time he had to explain it to others. The understanding of the problem as one of weight persisted in the outside world.

Weight Acceptance and Weight Loss –Two Choices, One Destination

On completing Phase 1 treatment, some participants chose to continue in a Weight Loss group or a Wellbeing/Weight Acceptance group in Phase 2. Despite the different goals and modules of change in the groups, the participants' reflections and transformations occurred around the same question: Do I actually want to lose weight, and why? For some, for the first time in their lives, simply being given the

choice of weight loss had a dramatic effect. The following will demonstrate that irrespective of the intervention that participants chose, a paradoxical turn led them all in the direction of acceptance. Every single participant wanted to lose weight for health reasons, but they came to realize that weight was not their biggest problem, and they would never be able to lose weight before they began to accept themselves.

Choosing Weight Acceptance

Like many others who chose the Weight Acceptance group, Astrid remembered initially wanting to choose the Weight Loss group. At an assembly arranged to help patients decide on which group to choose, she heard a former patient reflect on weight and self-acceptance, and she changed her mind.

> Listening to her made me think; "I've been on loads of diets, but did I ever feel happy when I was thin? No, I didn't. So, it must be something else". Then I thought, "Yes, that's exactly it. It's something else". It's about thinking what other people think of me because I weigh 80 kg [176.4 lbs.] and worrying that they might like me more if I weighed 60 kg [132.3 lbs.]. That's the real problem. (Interview)

The problem was "something else" and the solution to that problem was not weight loss, it was greater self-acceptance and acceptance from others regardless of weight.

In this group, participants had goals of letting their lives be guided by enjoyment. This was in complete contrast to what they described as "the eating disorder's punishment and reward system". In a treatment session, Tanja said that she used to binge after exercising to reward and comfort herself for what had felt like a punishment. When enjoying exercise, it felt rewarding in itself. Astrid said she would exercise only to punish herself for binging. For everyone, moving their bodies for purposes other than weight loss was new and provoking. After many years of living "from the neck up", body therapy elements made the

participants sense a need to reconcile and reconnect with their bodies. Acceptance entailed the courage to be gentle and caring towards the body rather than constantly working against it and trying to "get it into a certain size". Participants shared experiences of self-hatred that had manifest itself as lumps and tensions in the body. Many had viewed their body entirely from an imagined outside gaze. Eva explained how this had shaped the way she would sit in a chair.

> (…) The whole thing about letting go and suddenly not having to think about how I stand and walk and lie and sit. It made me cry. (…) I realized just how hard it is to sit and squeeze your legs together when they naturally want to fall to each side. It's extremely hard on your thighs and hips. I can't even do it anymore, because I'm aware of just how hard it is. (…) And I don't want to. It's not like, if my knees are 5 cm [2 in.] closer to each other that people will suddenly think that I weigh 30 kg [66 lbs.] less.

The concept of a relational weight, comprising a weight critical gaze and a weight defined identity, seemed to have also been embodied. It had shaped the way Eva moved, sat, and held herself. Like many others, body therapy elements helped Eva to attend to her body through her senses and shift attention inwards away from the critical gaze. Once she became aware of how constricted she had been, it became more important to her to feel comfortable than to meet outside expectations.

In mindful eating sessions, participants were encouraged to use their senses to experience food, but, mostly, participants ended up in their heads instead of their bodies. Many encountered "the voice of the eating disorder" in the form of an all-or-nothing attitude; having to eat every bite and every meal mindfully, or rules about not being permitted to enjoy food, doing it wrong, or food seeming dangerous and disgusting. Here, it helped to not think too much and shift attention outwards. Sharing food experiences with others became a source of enjoyment, appreciation, and reconnection. In treatment,

Susan shared an experience where she had eaten a roll with butter with her daughter, and in connecting with her, the shame of eating an otherwise completely forbidden food had disappeared.

> You know, I enjoyed eating the exact same as my daughter (...) the comfort of it because it was something we were doing together. I haven't allowed myself to do it in many years. It wasn't shameful.

Others used the increased awareness of eating to reassure themselves that they had in fact eaten and they had met their needs. This came across as related to earlier experiences of food deprivation.

Choosing Weight Loss

On entering the Weight Loss group, participants reencountered weight loss as a solution. Ingrid was initially relieved, and she expected "a magic cure" that could finally save her:

> I think my expectations were that, "Now, it'll save me" kind of thing. "Now, comes Phase 2 with the solution that I didn't get in Phase 1".

However, alongside the reintroduction of weight loss as a solution, participants were overwhelmed with feelings of self-blame and of being wrong. In a telephone interview, Sara reflected on why she had not managed to lose weight in her Weight Loss treatment.

> Sara: [T]hose self-blaming thoughts that I had had before they just came back. They hadn't gone.
>
> Researcher: And they came back once you began to think that, "Now, I have to lose weight?"
>
> Sara: Yes. Because, then, when I didn't lose weight or did what I was supposed to then I began to blame myself quite a lot again. And then I realized that maybe that wasn't what I had to do right now, because it triggered the eating disorder so much.
>
> Researcher: (…) is the self-blame something that you have known to be linked to the eating disorder?

Sara: Yes, very much. Every time I opened the fridge, I've almost had a voice speaking to me very reproachfully, which to some extent has been my mother, because she was always on my back when I was younger, because I was a bit chubby. And every time I opened the fridge then [she makes a shaming sound with her tongue] then she would be there. Well, she's not alive anymore, so she was just there when I opened the fridge, and lately it's really just been my own voice, but it was somehow sparked by her years ago.

Throughout the Weight Loss treatment, participants and therapists struggled to understand why participants so clearly wanted to lose weight, but consistently failed to make any changes. The primary therapist encouraged participants to "practice" doing whatever could trigger the eating disorder in the "safe environment" of the treatment. This suggested that strength and courage were the necessary driving forces, but, like in the Wellbeing/Weight Acceptance group, it eventually became clear that change was only possible through enjoyment and self-compassion. Week after week, Liz worked with the therapists to strengthen her "motivation" to go on long bike rides. The driving argument was that, for change to happen, she had to do something differently. She had all the right bike gear and a nice bike, but she told the therapists that as soon as she went on her bike, she critical thoughts would overwhelm her. In the interview, the researcher reminded her of the bike rides and her struggles to stay motivated. She laughed and said "there was nothing good about those bike rides" and elaborated:

I could sometimes feel that because I couldn't keep up the same pace then "I'm just in such poor shape" you know compared to others or something, feel wrong, you know, too fat or, it would start off a negative spiral of thoughts about, like, everything.

The issue was never resolved in treatment, but, at home, where no one could see her, Liz began to do small exercises. She gradually began to meet herself with "a gentleness", and at the time of the interview,

she biked to “enjoy the feeling of the wind” and to “just get out a bit and use my body”. Despite not having lost weight during treatment, she found that she was in a “more valuable place”: She related differently to herself and others, she compared herself less, and took it in when other people complimented her. Once, a bus stopped next to her and someone stared, and she concluded it was because of her funny helmet:

> How liberating that it wasn’t about me maybe being too fat; that there might be other reasons for people to look at me. (Interview)

Overall, self-compassion and acceptance stood out as solutions which implicitly pointed to non-acceptance as an important problem. When asked in the interview what the Weight Loss group had done for her, Ingrid replied that, now, weight had become a purely physical thing.

> In Phase 1, I had to separate myself from the eating disorder (...) Now, I’ve separated my eating disorder from my weight. Now, weight is purely physical. Everything else was a mix of other people’s expectations about weight loss and my own self-critical thoughts, and all those ups and downs that followed when the weight went up and down.

Ingrid was the only participant to lose weight during the time of the observations, but she had tried to ignore her weight loss in fear that “the eating disorder would like it too much”. Reflecting the duality of the eating disorder, Ida had realized that her eating disorder had prevented her from losing weight because she wanted to be accepted for who she was.

> Generally, my desire to lose weight has been about acceptance from my surroundings. Whereas now, it’s become my own wish, and [that’s] made it possible for me to lose weight.

On returning to the outside world, participants were consistently confronted with weight loss demands. This threatened their progress, but they found themselves relating and reacting differently: They no longer agreed that weight loss was the solution and they were the problem.

Discussion

The present study used systems theory to explore BED and body and weight issues in three different treatment settings with weight stability, weight acceptance, and weight loss. The purpose was to inspire relational and contextual understandings of BED, and present alternative pathways for change in treatment. The analytical trails revealed two systemic problems centered on weight: A life time of weight loss attempts created behavior patterns that sustained and exacerbated the participants' eating and weight problems. By installing weight stability, the continuous recreation of these emerging problems ended leaving participants and their relational network with a deep sense of calm. As suggested by Weakland and colleagues (Weakland et al., 1974), the solution to long-lasting problems is available at all times, but difficult to implement because of strong cultural norms and beliefs. In this instance, the idea of weight loss as a solution to excess weight is so powerfully supported in all contexts that no one considered prescribing weight stability to people with obesity. Mirroring the literature, the presented personal accounts revealed that participants' eating and weight problems did not develop in a social vacuum. We suggested a relational weight problem that emerged from the communicative interactions between those people who were concerned about the participant's weight. These included parents, peers, partners, health care professionals, and even strangers. The relational weight problem embedded feelings of non-acceptance due to weight, a merge of the individual's weight and identify, and an internalization of a body and weight critical gaze. In this context, binge eating comforted and protected the participants, but also caused more self-hatred, thus illustrating the relational influences and circular processes underlying

both the eating and weight problems. We found that self-critical thoughts affected the participants' willingness to let their bodies be visible, to take up space, and be active in public. This finds support in established effects of weight stigma and internalized weight stigma on exercise habits (Vartanian & Novak, 2011) eating, and weight loss (Carels et al., 2009; Mensinger, Calogero, & Tylka, 2016). When trying to lose weight, participants were confronted with self-hatred and feelings of being wrong which made change impossible. Across the three treatment contexts, change only occurred when the participants' weight ceased to be the main problem. One reason seemed to be that, consequently, the participants themselves were no longer the problem, thus allowing room for self-acceptance and self-compassion. Consistent with prior research showing recovery for people with BED through reconnecting with the body in yoga (McIver, McGartland, & O'Halloran, 2009), overall acceptance helped participants reconnect with their bodies and with other people which again enabled them to eat and move more freely. A misconception that drives much critique of size acceptance initiatives (A, 2001; Bombak, 2014) is that acceptance discourages people from losing weight (Mann, Tomiyama, & Ward, 2015b). On the contrary, the present study adds to the growing body of literature supporting a weight neutral and body accepting approach to health (Mensinger, Calogero, Stranges, & Tylka, 2016; Bacon, 2008; Dollar, Berman, & Adachi-Mejia, 2017; Bacon & Aphramor, 2011) and extends it by pointing to possible underlying processes.

Strengths and Limitations

To our knowledge, this study is the first to take a systemic perspective on BED. Strengths include generating contextual and interactional understandings of BED and weight that involve other people and the surrounding society as active agents. Interactional understandings may help to lift shame and blame

of the affected people and point to additional pathways for change. More generally, systems theory enables intersectional inquiries of what arises when two categories of problems coexist, for instance psychiatric, medical, and social problems as is often the case in clinical reality. The study must be considered in light of limitations. Despite the study's emphasis on exploring contexts, the researcher only participated in the treatment setting. Similarly, the study touches on issues of embodiment which could also have benefited from participating in more lived life contexts.

Implications

The study raises concerns about the consequences of weight focus and body shaming as ways of preventing and solving weight problems. We argue that weight cannot be understood fully from a medical perspective, but also needs to be seen in relational and social terms and as a matter of identity. In light of poor long-term weight loss outcomes, a contested link between BMI and health, and the risks associated with food restriction for BED, alternative approaches to health must be explored. Addressing weight related prejudice and feelings of being wrong seems to encourage healthy eating and physical activity. It is imperative that health care providers who work with eating disorders and weight management are educated about the risks associated with individualizing weight.

Conclusion

The proposed concept of a relational weight problem offers a useful concept for approaching body and weight issues in BED beyond the individual's physical weight. The concept crosses borders between the individual and the outside world and between the eating disorder, body, and weight. Attention to social and relational aspects of weight could inspire to build practices that emphasize the involvement of close

relatives and awareness of social underpinnings of eating and weight problems. Contrary to critical claims that weight acceptance discourages people with obesity from engaging in weight loss efforts, we suggest that acceptance and a disentanglement of weight and identity are prerequisites for increased health for this group.

Acknowledgments

We greatly appreciate the possibility granted us by the participants in treatment for BED and the therapists, who allowed us to take part in the BED treatment. We are especially grateful for the generosity of the participants in sharing with us their experiences and wisdom about living with BED and finding pathways out of BED.

Declaration of Conflicting Interest

The authors had no conflicting interests and the funding party had no involvement in any part of the study or reported findings.

Funding

The study was funded by the Danish National Health Authority [j.nr.4-1613-26/2]

References

American Psychiatric Association (Ed.). (2013). *Diagnostic and statistical manual of mental disorders: DSM-5* (5th ed). Washington, D.C: American Psychiatric Association.

Andersen, T. (1987). The reflecting team: Dialogue and meta-dialogue in clinical work. *Family Process*, *26*(4), 415–428.

Anderson, H., & Goolishian, H. A. (1988). Human Systems as Linguistic Systems: Preliminary and Evolving Ideas about the Implications for Clinical Theory. *Family Process*, *27*(4), 371–393. https://doi.org/10.1111/j.1545-5300.1988.00371.x

Aphramor, L. (2005). Is A Weight-Centred Health Framework Salutogenic? Some Thoughts on Unhinging Certain Dietary Ideologies. *Social Theory & Health*, *3*(4), 315–340. https://doi.org/10.1057/palgrave.sth.8700059

Bacon, L. (2008). *Health at every size: the surprising truth about your weight*. Dallas, TX: BenBella Books.

Bacon, L., & Aphramor, L. (2011). Weight science: evaluating the evidence for a paradigm shift. *Nutrition Journal*, *10*(1), 9. https://doi.org/10.1186/1475-2891-10-9

Barnes, R. D., Blomquist, K. K., & Grilo, C. M. (2011). Exploring pretreatment weight trajectories in obese patients with binge eating disorder. *Comprehensive Psychiatry*, *52*(3), 312–318. https://doi.org/10.1016/j.comppsych.2010.06.011

Bateson, G. (1972). *Steps to an ecology of mind* (University of Chicago Press ed). Chicago: University of Chicago Press.

Bazeley, P., & Jackson, K. (2013). *Qualitative data analysis with NVivo* (Second edition). Los Angeles London New Delhi: SAGE.

Bombak, A. (2014). Obesity, health at every size, and public health policy. *American Journal of Public Health*, *104*(2), 60–67. https://doi.org/10.2105/AJPH.2013.301486

Bracken, P., Thomas, P., Timimi, S., Asen, E., Behr, G., Beuster, C., … Yeomans, D. (2012). Psychiatry beyond the current paradigm. *The British Journal of Psychiatry*, *201*(6), 430–434. https://doi.org/10.1192/bjp.bp.112.109447

Burgess, R. G. (1984). *In the field: an introduction to field research*. London ; Boston: Allen & Unwin.

Carels, R. A., Young, K. M., Wott, C. B., Harper, J., Gumble, A., Oehlof, M. W., & Clayton, A. M. (2009). Weight Bias and Weight Loss Treatment Outcomes in Treatment-Seeking Adults. *Annals of Behavioral Medicine*, *37*(3), 350–355. https://doi.org/10.1007/s12160-009-9109-4

Cena, H., Stanford, F. C., Ochner, L., Fonte, M. L., Biino, G., De Giuseppe, R., … Misra, M. (2017). Association of a history of childhood-onset obesity and dieting with eating disorders. *Eating Disorders*, *25*(3), 216–229. https://doi.org/10.1080/10640266.2017.1279905

Clark, A. L., Fonarow, G. C., & Horwich, T. B. (2014). Obesity and the Obesity Paradox in Heart Failure. *Progress in Cardiovascular Diseases*, *56*(4), 409–414. https://doi.org/10.1016/j.pcad.2013.10.004

Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed methods research* (2nd ed). Los Angeles: SAGE Publications.

Danish Health Authority. (2005). *Spiseforstyrrelser: Anbefalinger for organisation og behandling : Udarbejdet af en arbejdsgruppe under Sundhedsstyrelsen*. København: Sundhedsstyrelsen.

Day, J., Ternouth, A., & Collier, D. A. (2009). Eating disorders and obesity: two sides of the same coin? *Epidemiologia e Psichiatria Sociale*, *18*(02), 96–100. https://doi.org/DOI: 10.1017/S1121189X00000956

Dingemans, A. E., & van Furth, E. F. (2012). Binge eating disorder psychopathology in normal weight and obese individuals. *International Journal of Eating Disorders*, *45*(1), 135–138. https://doi.org/10.1002/eat.20905

Dollar, E., Berman, M., & Adachi-Mejia, A. M. (2017). Do No Harm: Moving Beyond Weight Loss to Emphasize Physical Activity at Every Size. *Preventing Chronic Disease*, *14*. https://doi.org/10.5888/pcd14.170006

Ferrari, M. (2011). Avoiding Conflicting Health Promotion Messages between Eating Disorders and Obesity Prevention. Can Systems Thinking Act as a Mediator, and How? *International Journal of Humanities and Social Science*, *December 2011*(1,19), 39–47.

Friedman, K. E., Reichmann, S. K., Costanzo, P. R., Zelli, A., Ashmore, J. A., & Musante, G. J. (2005). Weight stigmatization and ideological beliefs: relation to psychological functioning in obese adults. *Obesity Research*, *13*(5), 907–916.

Greenhalgh, S. (2016). Disordered Eating/Eating Disorder: Hidden Perils of the Nation's Fight against Fat: Disordered Eating/Eating Disorder. *Medical Anthropology Quarterly*, *30*(4), 545–562. https://doi.org/10.1111/maq.12257

Haines, J., & Neumark-Sztainer, D. (2006). Prevention of obesity and eating disorders: a consideration of shared risk factors. *Health Education Research*, *21*(6), 770–782. https://doi.org/10.1093/her/cyl094

Hilbert, A., Pike, K. M., Goldschmidt, A. B., Wilfley, D. E., Fairburn, C. G., Dohm, F.-A., … Striegel Weissman, R. (2014). Risk factors across the eating disorders. *Psychiatry Research*, *220*(1–2), 500–506. https://doi.org/10.1016/j.psychres.2014.05.054

Hudson, J. I., Hiripi, E., Pope, H. G., & Kessler, R. C. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. *Biological Psychiatry*, *61*(3), 348–358.

ICD-11 Beta Draft. (2017). Retrieved 29 September 2017, from http://apps.who.int/classifications/icd11/browse/f/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f1673294767

Kessler, R. C., Berglund, P. A., Chiu, W. T., Deitz, A. C., Hudson, J. I., Shahly, V., … Xavier, M. (2013). The Prevalence and Correlates of Binge Eating Disorder in the World Health Organization World Mental Health Surveys. *Biological Psychiatry*. https://doi.org/10.1016/j.biopsych.2012.11.020

Mann, T., Tomiyama, A. J., & Ward, A. (2015a). Promoting Public Health in the Context of the "Obesity Epidemic" False Starts and Promising New Directions. *Perspectives on Psychological Science*, *10*(6), 706–710.

Mann, T., Tomiyama, A. J., & Ward, A. (2015b). Promoting Public Health in the Context of the "Obesity Epidemic" False Starts and Promising New Directions. *Perspectives on Psychological Science*, *10*(6), 706–710.

Mann, T., Tomiyama, A. J., Westling, E., Lew, A.-M., Samuels, B., & Chatman, J. (2007). Medicare's search for effective obesity treatments: Diets are not the answer. *American Psychologist*, *62*(3), 220–233. https://doi.org/10.1037/0003-066X.62.3.220

McIver, S., McGartland, M., & O'Halloran, P. (2009). 'Overeating is Not About the Food': Women Describe Their Experience of a Yoga Treatment Program for Binge Eating. *Qualitative Health Research*, *19*(9), 1234–1245. https://doi.org/10.1177/1049732309343954

Mensinger, J. L., Calogero, R. M., Stranges, S., & Tylka, T. L. (2016). A weight-neutral versus weight-loss approach for health promotion in women with high BMI: A randomized-controlled trial. *Appetite*, *105*, 364–374. https://doi.org/10.1016/j.appet.2016.06.006

Mensinger, J. L., Calogero, R. M., & Tylka, T. L. (2016). Internalized weight stigma moderates eating behavior outcomes in women with high BMI participating in a healthy living program. *Appetite*, *102*, 32–43. https://doi.org/10.1016/j.appet.2016.01.033

Nardone, G. (2004). Advanced Brief Strategic Therapy: Knowing by changing. *Brief Strategic and Systemic Therapy European Review*, (1), 296–301.

Neumark-Sztainer, D. (2005). Can we simultaneously work toward the prevention of obesity and eating disorders in children and adolescents? *International Journal of Eating Disorders*, *38*(3), 220–227. https://doi.org/10.1002/eat.20181

Neumark-Sztainer, D. (2009). The interface between the eating disorders and obesity fields: Moving toward a model of shared knowledge and collaboration. *Eating and Weight Disorders - Studies on Anorexia, Bulimia and Obesity*, *14*(1), 51–58. https://doi.org/10.1007/BF03327795

Neumark-Sztainer, D., Bauer, K. W., Friend, S., Hannan, P. J., Story, M., & Berge, J. M. (2010). Family Weight Talk and Dieting: How Much Do They Matter for Body Dissatisfaction and Disordered Eating Behaviors in Adolescent Girls? *Journal of Adolescent Health*, *47*(3), 270–276. https://doi.org/10.1016/j.jadohealth.2010.02.001

Neumark-Sztainer, D., Wall, M., Larson, N. I., Eisenberg, M. E., & Loth, K. (2011). Dieting and Disordered Eating Behaviors from Adolescence to Young Adulthood: Findings from a 10-Year Longitudinal Study. *Journal of the American Dietetic Association*, *111*(7), 1004–1011. https://doi.org/10.1016/j.jada.2011.04.012

Puhl, R. M., & Brownell, K. D. (2012). Fight obesity, not the people. *The Atlanta Journal-Constitution*. Retrieved from Avaible at http://www.ajc.com/news/opinion/fight-obesity-not-the-people/2J8JayrYJCJSUox0RLDBzN/

Spark, A. (2001). Health at any size: the size-acceptance nondiet movement. *Journal of the American Medical Women*.

Sundhedsstyrelsen, (Fornavn), & (Danish Health Authority). (2015). Små skridt til vægttab - der holder. 5. udgave.

Vartanian, L. R., & Novak, S. A. (2011). Internalized Societal Attitudes Moderate the Impact of Weight Stigma on Avoidance of Exercise. *Obesity*, *19*(4), 757–762. https://doi.org/10.1038/oby.2010.234

Vocks, S., Tuschen-Caffier, B., Pietrowsky, R., Rustenbach, S. J., Kersting, A., & Herpertz, S. (2010). Meta-analysis of the effectiveness of psychological and pharmacological treatments for binge eating disorder. *International Journal of Eating Disorders*, NA-NA. https://doi.org/10.1002/eat.20696

Wansink, B., Latimer, L. A., & Pope, L. (2017). “Don’t eat so much:” how parent comments relate to female weight satisfaction. *Eating and Weight Disorders - Studies on Anorexia, Bulimia and Obesity*, *22*(3), 475–481. https://doi.org/10.1007/s40519-016-0292-6

Watzlawick, P., Weakland, J. H., & Fisch, R. (1974). *Change; principles of problem formation and problem resolution* (1st ed.). New York: Norton.

Weakland, J. H., Fisch, R., Watzlawick, P., & Bodin, A. M. (1974). Brief therapy: Focused problem resolution. *Family Process*, *13*(2), 141–168.

White, M. (2007). *Maps of narrative practice* (1st ed). New York: W.W. Norton & Co.

Wilson, G. T., Wilfley, D. E., Agras, W. S., & Bryson, S. W. (2010). Psychological Treatments of Binge Eating Disorder. *Archives of General Psychiatry*, *67*(1), 94. https://doi.org/10.1001/archgenpsychiatry.2009.170

Paper 2

Reconnecting in Dialogical Spaces: How a Systemic and Narrative Group Intervention for Binge-Eating Disorder helps Patients Reconnect with Themselves and Other People

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Abstract

This study used Mikhail Bakhtin's dialogical theory to analyze participant observations and semi-structured interviews of a psychotherapy group for people affected by binge-eating disorder (BED). The participants' accounts revealed a profound sense of loss of self that emerged from years of believing that losing weight was necessary to be worthy of living. Using the therapeutic practices of externalizing, reflecting teams, and writing a food diary, the group treatment established different positions for speaking and listening which reflected Bakhtin's concepts of outsideness and otherness. This enabled participants to identify a myriad of voices that made up the eating disorder and critically evaluate them. Overall, treatment served to dialogize the eating disorder and enable the participants to move from closed monological states to living polyvocal spaces. The processes of change involved that the participants reconnected with a sense of self, with other people, and with a sense of belonging in the world. The study contributes to literature about the adverse effects of 'diet culture' and the potential associated with increasing patients' critical awareness of social and cultural influences in the treatment of BED.

Background

Eating disorders are severe psychiatric illnesses that greatly affect the individual's psychological, social, and physical health and well-being. Binge Eating Disorder (BED) is the most common of the eating disorders affecting 2 – 3 % of the population (Hudson, Hiripi, Pope, & Kessler, 2007; Kessler et al., 2013) and is characterized by episodes of binge-eating in the absence of recurrent compensator behavior (American Psychiatric Association, 2013). The individual eats a large amount of food within a short period of time accompanied by a sense of loss of control. People with BED often alternate between periods of binge-eating and strict dieting which drives their weight into dramatic fluctuations (Dingemans & van Furth, 2012) and an overall increase in weight over time (Hudson et al., 2007; Kessler et al., 2013). BED onset is between 15 and 27 years (Hudson et al., 2007; Kessler et al., 2013), but loss of control eating, body concerns and obesity are common even at a younger age (Tanofsky-Kraff, Faden, Yanovski, Wilfley, & Yanovski, 2005). What is often left out of mainstream psychological approaches to BED is that BED develops in a context of social ideation of thinness and a 'diet culture' that categorizes foods and body types into good/bad and right/wrong. This is perpetuated by a pervasive stigma towards obese bodies that links appearance with personality traits (Puhl & Heuer, 2009). Children as young as 3 years old show negative attitudes towards higher weight bodies (Cramer & Steinwert, 1998) and 8-year-olds exhibit dissatisfaction with their own bodies (Hughes et al., 2018). Also half of preadolescents want to be thinner and have engaged in dieting behavior (Maloney, McGuire, Daniels, & Specker, 1989; Schur, Sanders, & Steiner, 2000). Messages conveyed via mass media (Morris & Katzman, 2003) and social media (Meier & Gray, 2014) play an important part in the development of poor body image. Parents' comments about a child's eating, weight and shape (Hilbert et al., 2014; Neumark-Sztainer et al., 2010; Wansink, Latimer, & Pope, 2017), along with negative weight-talk and dieting in the family (Neumark-

Sztainer et al., 2010), and weight-related bullying by peers (Striegel-Moore, Dohm, Pike, Wilfley, & Fairburn, 2002) are strongly predictive of eating disorders and obesity. Thus, sociocultural voices seem to shape people's relationship with food and their body.

Traditionally, psychiatry relies on an 'internalizing' discourse to describe varieties of human suffering which locates problems in the individual's mind. In opposition to this, social constructionist-informed psychology emphasizes the embeddedness of problems in social and relational contexts, and narrative therapy specifically tries to externalize problems and see them as separate from the people who are affected by them (White, 2007).

Aims

The aim of this study was to explore processes of change in an integrative systemic and narrative psychotherapy intervention for BED. In a previous qualitative study (LB Meyer, Waaddegaard, Lau, & Tjørnhøj-Thomsen, 2018) we suggested *a relational weight problem* that emerged from an all-pervading focus on weight and weight loss in the participants' lives. We found that changes in the participants relationship to eating and bodily movement relied on a successful separation of identity and weight. An effectiveness study further found significant reductions in binge-eating, weight and shape concerns following this treatment (L Meyer et al., n.d.). What remain unanswered in these two studies, and what we intend to address here, are the processes that led to these changes. We used Mikhail Bakhtin's dialogical theory to conceptualize and analyze language usage and the influences of language in the participants' BED. Other studies have used Bakhtin to inquiry into therapeutic processes in individual therapy and in couples therapy (Penn & Frankfurt, 1994) and families (Olson, Laitila, Rober, & Seikkula, 2012; Seikkula, Laitila, & Rober, 2012). To our knowledge, no study has yet used Bakhtin to investigate a group psychotherapy setting. Deconstructing language and identifying influences that shape language

in eating disorders will expand the individualized conceptualizations of problems and solutions and inspire new points for awareness and intervention in treatment.

Method

Design

Data for this article were taken from a multimethod study that included a qualitative study and a quantitative single-group pre-post study of a two-phased treatment for BED. We used electronic questionnaires and Eating Disorder Examination interviews (EDE) to evaluate pre-post-treatment differences following integrative systemic and narrative treatment (Phase 1). We also conducted a qualitative ethnographic study of Phase 1 and Phase 2 (Weight Loss and Wellbeing) using in-depth interviews and participant observations (Meyer et al, 2018). The Weight loss and Wellbeing groups differed in that the first focused on making small adjustments in diet and physical movement with the aim of inducing weight loss and the second focused on increased self-acceptance through enjoyment of food and joyful movement.

The quantitative and qualitative data were analyzed separately in accordance with the specific methods (Creswell & Plano Clark, 2011). The findings presented here concern the integrative systemic and narrative treatment (Phase 1) but material and insights from the Weight loss and Well-being interventions are used to contextualize the understandings.

Setting and treatment

The study was conducted at a major out-patient eating disorder unit under the Mental Health Services in the Capital Region of Denmark. The eating disorder unit provides treatment for non-psychotic

adult patients with eating disorders. Treatment was multimodal and complied with recommendations from the Danish Health Authority (Danish Health Authority, 2005). A full BED treatment lasted 1 to 1 ½ years. The primary intervention consisted of 25 weekly sessions of integrative systemic and narrative group psychotherapy of which every five sessions were dietetic counseling. This was supplemented with support network sessions, multifamily meetings (Asen, 2002), body therapy, and mindfulness. Group sessions lasted 3 hours (including a 30-minute break) preceded by weight monitoring and followed by an unsupervised joint lunch. Groups had seven patients of mixed genders and were open to new patients as others finished. There were two trained psychotherapists. The treatment had cognitive behavioral elements (Fairburn, 1981): Patients were required to sign consent forms, keep a food diary, have individual goals, work towards normalizing eating patterns, and stabilize their weight within a +/- 5 – 7 kg margin (11 or 15.5 lbs.). Weight changes beyond these limits elicited extra dietetic guidance and a reflection period of three weeks during which patients were to reflect on the causes of weight change and decide whether to continue or terminate treatment.

Treatment was individual therapy in groups. One therapist interviewed each patient based on their diary entries, and group members and therapists provided feedback modelled on the Norwegian therapist, Tom Andersen's principles for reflecting teams (Andersen, 1987). Feedback included what had resonated and inspired the listeners and what came across as important to the interviewed patient. In systemic and narrative therapy, language is considered constitutive of reality rather than just descriptive; the way people and problems are articulated will foreground certain ways of thinking and acting, and psychological problems are understood as embedded in social, cultural, and relational contexts. The narrative method of externalizing (White, 2007) linguistically separates problems from persons based on the conviction that the person is not the problem; the problem is the problem. The therapist's role is to

facilitate a joint exploration of the norms, discourses and 'taken-for granted truths' that shape problems and how the problem impacts the patients' lives. The aim is to develop more preferred stories about the self that bring individuals closer to their own values, intentions, and hopes. Systemic questioning facilitates multiple, differing perspectives on problems and try to widen the 'contextual premises' of the problem and enable new ways of relating to the problem (Andersen, 1987).

Participants

The participants for this study were a subsample of participants included in a quantitative evaluation. A total of 111 participants entered Phase 1, 82 completed of which 35 continued in Phase 2 (19 participants in the Weight Loss intervention and 16 in Wellbeing intervention) of which 27 completed (Weight Loss 14, Wellbeing 13). Twenty-two participants who completed Phase 1 or 2 during a 6-month participant observation period were invited for in-depth interviews. Twenty accepted (Phase 1, n = 5; Weight Loss, n = 8 (of which one had dropped out); Wellbeing, n = 7). One participant (Wellbeing) declined due to work load and one (Phase 1) did not respond. Participants were three men and 17 women aged 22 to 58 (M = 34.8) with a BMI ranging from 28 to 55 (M = 39). Twelve were married or cohabiting, 11 had dependent children. Eleven were actively employed and nine were on sick leave. A large majority (27) had previously received more than five psychotherapy sessions, and five had previously been admitted to inpatient care. All but two had been affected by BED for more than 5 years. The majority (25) had experienced traumatic events before their 11th year. All 33 consented to the observational study (11 in each group). The eight participants cited in this article were given the pseudonyms Lise, Astrid, Tor, Ingrid, Ida, Eva, Andrea and Signe.

Data generation

We were interested in processes of change in an integrative systemic and narrative treatment and this rendered qualitative methods appropriate. For that purpose, I, the first author, used participant observations and in-depth interviews to generate data about lived experiences, interactions between participants, and therapeutic processes. Data were generated from November 2015 to May 2016.

Participant observations

I participated in a variety of treatment activities including group sessions, dietetic counseling, weight monitoring, and two multifamily meetings, and I did this concurrently in three different groups; a systemic and narrative psychotherapy group (Phase 1), a Weight Loss group and a Wellbeing group (Phase 2). Entering a therapy setting requires sensitivity of the researcher. I was presented by the therapists as 'a fly on the wall' and I made conscious efforts to not disturb the therapeutic processes. This involved sitting at a slight distance from the group and not facing them directly which allowed me to make detailed records of verbal exchanges as they occurred during therapy but limited my view of non-verbal interactions that could also have been important. During breaks, I participated more freely. I was approached by the participants sometimes as a researcher with knowledge about BED and sometimes just as a person. In the participant observations, the initial access to the groups went through the therapists. My hope was to lift any pressure to participate by not being present myself and to have the therapists stress that access to treatment was completely independent of the project. The participants had asked that I did not attend the unsupervised lunch as they wanted to speak freely about issues unrelated to treatment. Most often, participants were motivated to grant me access and to take part in interviews out of gratitude for being offered treatment. BED is not recognized as an independent diagnosis in

Denmark, and the participants hoped the study could raise awareness about BED. The participant observations provided intimate insights into the participants' work, the setting, and the practices and procedures that were necessary to develop relevant interview questions.

Interviews

Participants were invited for interviews in their homes, at the treatment facility, or over the phone. Interviews lasted between 30 minutes and 3 hours with interviews over the phone taking a shorter, more structured format than home visits (Whyte, 1979). All participants were asked to reflect on the same issues including their experiences of treatment and specific treatment elements and sequences from the observational study that had stood out to me as decisive.

Ethics

Referring to the committee law § 2, the National Committee on Health Research Ethics (DNVK) [40503] judged that the study could proceed without approval due to the nature of the methods used. Participants received oral and written information about the purpose of the interviews and participant observations and gave written consent to each separately. Participants could request that I leave therapy at any moment if they felt uncomfortable.

Data analysis

Interview material and field notes were transcribed and loaded into NVivo®-10 for organization and facilitation of analysis (Bazeley & Jackson, 2013). We used a previous coding of the material (LB Meyer et al., 2018) and adjusted it to align with the current dialogical focus. We selected material concerning systemic and narrative group therapy and the participants' lives before treatment, and used the remaining material and prior analytical insights to contextualize our analysis. The code *actors*

(subcoded for *internal*: the eating disorder, the critical voice, self, body, weight and *external*: relatives, strangers, group-members, therapists, health care professionals, and society) was used to identify voices present in the participants' speech, and the code *context* was used to locate these voices in time and space. We used *node trees* and *matrixes* to analyze the intermingling of voices in the participants' accounts and in the dialogical exchanges in treatment. To keep track of the analytical process, we used journaling and node memos. Coding, organization of data and processes of analyzes followed NVivo® guidelines (Bazeley & Jackson, 2013). We moved iteratively between theory and data to arrive at key theoretical concepts that could help us focus and structure our analysis.

Theoretical framework

The theoretical framework for the analysis was the Russian philosopher and linguist Mikhail Bakhtin's dialogical theory (Bakhtin, 1984) and his concepts *dialogue* and *monologue*. We found that Bakhtin was useful because he offered a way to track and map the sources of language that had influenced the participants. Even though the systemic and narrative treatment practices clearly draw on dialogical thinking, and a dialogical analysis, therefore, risks conflating with the therapeutic rationale, several core practices such as writing a food diary, eating regular meals, dietetic counseling, and keeping a stable weight were added from other treatment practices. Also, systemic and narrative therapies rely on a set of general principles and practices that are not manualized and are not directly aimed at eating disorder treatment. A detailed analysis of the language use in an integrative systemic and narrative therapy for BED could therefore provide valuable knowledge about how treatment is done in practice and how the different practices may be integrated.

Dialogue and monologue

Bakhtin was critical of the idea of a single truth and a single unified self and instead proposed *dialogue* as a model of the world. Bakhtin's ideas about the self thereby moved from describable inner structures to everchanging dialogical encounters between people and voices.

> "Life by its very nature is dialogic. To live means to participate in dialogue: to ask questions, to heed, to respond, to agree and so forth. In this dialogue a person participates wholly and throughout his whole life: with his eyes, lips, hands, soul spirit, with his whole body and deeds. He invests his entire self in discourse and this discourse enters into the dialogic fabric of human life, into the world symposium" (Bakhtin, 1984, p. 293)

Bakhtin claimed that the natural state of the world is messy and made up of events that are governed by two competing forces. *Centripetal forces* constantly work towards order, agreement and unity with the aim of upholding stability. *Centrifugal forces* try to disrupt order and seek difference and newness. According to Bakhtin, both forces are necessary. Life, selves and all other social entities are 'oscillating field[s] of force lines' (Morson & Emerson, 1990, p. 56). If left unchallenged, centripetal forces will monopolize all voices and merge them into one single monological truth. Monologues are detrimental to life and to the upholding of a self because they are closed, unresponsive, and unchallengeable; they pretend to be the ultimate word and appear to "come from God or nowhere' (Bakhtin, 1984, p. 293).

The dialogical self

To Bakhtin, the self is dialogical in that it is unfinalized and always coming into being in dialogical encounters with others. A *dialogical self* comprises a *repertoire of voices* that are shaped by culture, history, social communities, and lived experiences of the individual. Bakhtin argued that words

and voices are half others and half one's own as, each time individuals use language, what they say will have traces of other people's usage and value judgments about the same topic. Bakhtin described that it was an ethical responsivity of the individual to evaluate and assimilate these many voices and that this would move the voices along a continuum from authoritative voices to innerly persuasive voices.

> [The word] becomes 'one's own' only when the speaker populates it with his [her] own intention, his [her] own accent […] it exists in other people's mouths, in other people's contexts, serving other people's intentions: it is from there one must take the word and make it one's own (Bakhtin 1981, 293-94).

A dialogical self comprises a constantly changing polyvocal choir of voices that exist on this continuum of authoritative to innerly persuasive (Morson & Emerson, 1990). According to Bakhtin, purely authoritative voices are uncontestable and monological and can be disliked, disobeyed or treated with hostility but can never be challenged. Bakhtin argued that selfhood relies on the ability to render all finalizing definitions of the self untrue (Morson & Emerson, 1990, pp. 91–92) and a psyche made up of only authoritative voices is finalized and closed.

Outsideness and otherness

The dialogical conception of self is that it is *in-selfsufficient*; the self can never fully see or understand itself except through the eyes of the other. Bakhtin used *otherness* (the citation below) and *outsideness* to describe this outside position.

> "I achieve self-consciousness, I become myself only by revealing myself to another, through the another and with another's help. The most important acts, constitutive of self-consciousness, are

> determined by their relation to another consciousness (a "thou"). Cutting oneself off, isolating oneself, closing oneself off, those are the basic reasons for the loss of self" (Bahtin, 1984, appendix cited in Todorov & Godzich, 1984, p. 96)

The dialogical nature of the self carries an inherent need to be heard that, in the absence of any immediate listener, Bakhtin operates with an ever-present, invisible listener (*a superaddressee*) who promises to understand in 'just the right way' (Morson & Emerson, 1990).

Findings

Applying Bakhtin's dialogical concepts to the empirical data, we came to understand the problem of BED as a monological state of opposing forces that kept the participants trapped and disconnected from a sense of self and a sense of belonging in the world. The participants shared inner closed discussions centering on a seemingly undisputable truth about having to lose weight to be worthy of living. An equally strong drive was to eat which was partly related to the weight loss project and partly to manage emotions. Overall, treatment introduced *outsideness* and *otherness* which created options for dialogizing the inner discussions of the participants. Decisive changes arose as the therapeutic conversations simultaneously created a position of evaluation for the participants.

We start by presenting excerpts that illustrate this monological state of living with the eating disorder.

Trapped in a monological battlefield

Without exception, the participants described their lives with the eating disorder as complete chaos and constant battles between trying to lose weight and eating uncontrollably. In interviews,

participants shared vivid accounts of feeling completely out of control and in the hands of an eating disorder that they feared would eventually take their lives. Some used phrases like “I was dying”, “It was killing me mentally and physically, “I felt I had vanished”, “There was nothing left of me”, “The eating disorder had taken over completely” and “I was hanging off a cliff”. Participants also said that things had escalated and worsened over time in that they ate more and felt increasingly out of control, hopeless, worthless, and isolated. Using Bakhtin’s dialogical concepts, we tried to understand what created and sustained this chaotic state, and why it was so difficult for the participants to find ways to escape. The participants also struggled to understand it, and, Lise, a woman in her late thirties, described her daily battles like this:

> Lise: So, I had this idea that ‘tomorrow it’s over’. And I would wake up with that every day and it would be the last thought on my mind going to bed, that ‘tomorrow it’s over’. ‘Tomorrow, I’ll stop’.
>
> Researcher: stop eating? (laughs)
>
> Lise: (laughs) yeah precisely, I didn’t have a clue what I had to do to get out of this eating pattern that I had worked up. It was just pendulating more and more out of control. (…) I felt awful. I woke up every day desperate over my situation and yet saw myself, every night, spinning out in exactly the same behavior.

Lise shares her continued, failed, attempts to “pull herself together” and stop eating but finding herself pendulating to the other extreme of binge-eating. This pattern was common across the accounts with some participants describing days or even months of strict dieting followed by massive waves of binge-eating. Opposed to Bakhtin’s idea of the world as governed by oscillating fields of competing forces that push for order or disruption of order, it seemed that the participants instead were trapped in

two separate monological force fields. In one, they were desperately trying to take control and lose weight and in the other, they would lose control and eat excessively. To fully understand the depth of this battlefield, we looked at each "force" separately.

Forces pushing for weight loss

In the interview, Lise also explained what had kept her trying to lose weight:

> I knew that I said 'no' to things because I didn't want to meet people, so they could see that I had gotten fat. But I didn't know that I deep down didn't believe that I deserved to have a life. I didn't feel that I deserved to go on holiday, I wasn't doing anything before I had lost weight. And that's not right, is it. Then I felt more and more isolated and then you don't have that and then you get sad about that.

Lise believed that she had to lose weight to be worthy of living and she put her life on hold until she had lost weight. This was a common theme in the participants' stories. Many added that they believed everything would be good when they lost weight; they would get a job, find love and happiness, and they would be able to love themselves and enjoy life. Likewise, every time they gained weight or for a moment did not control their eating, they felt hopeless and useless which would lead them further into their binge-eating. Like Lise, many said that the eating disorder wanted to keep them isolated. It would convince them that it was safer to stay home or make them feel too ashamed to leave the house. In an interview in the therapy group, Susan, a woman in her late twenties, said that her weight had made her feel like she entered social settings with a huge minus compared to others. She always had to be happy and agreeable, never object to anything or say no, and when she entered therapy, she said she could not feel what she

liked or what she wanted. A treatment goal for her was to stay true to herself but she also feared there was nothing left of her if the eating disorder was gone.

> I want to be better at knowing what I feel like doing and stay true to that. I feel so wrong. What if there's nothing behind it?

There was a profound sense of loss of self in all the accounts. The participants' stories about their lives with the eating disorder almost always revealed years or decades of weight loss attempts. In the analysis, we also found that these stories were populated with numerous voices of mothers, peers, doctors, bullies, and dieticians who had all been concerned about the participants' weight. Many of the participants called themselves 'experts' in the area of food, referring to the extensive knowledge they had accumulated from being on 'all the diets in the world' and trawling through the internet for 'miracle cures' and 'scientific secrets' about weight loss. Quite a few had also trained as dieticians or nutritional counselors. The excerpts from field notes and the interview below describe how this quest for weight loss had once seemed so convincing but, after entering treatment, suddenly appeared to border the absurd. Five participants were sat in soft chairs waiting to be weighed prior to treatment. Three of them were speaking:

> Astrid, Signe and Eva were laughing and joking and talking about this new thing that Astrid had read where you can lose weight by eating frozen foods. The three entered a complicated and amusing discussion about how they could melt white and not brown fat tissue by subjecting themselves to cold temperatures while also eating cold foods. They jointly fabricated a perfect scenario for eating *and* losing weight where they would drive an ice-cream van in a bikini while eating frozen nougat mice.

In an interview after treatment, Astrid was asked about the story of her weight and she came to think about the episode above and added that it showed how desperate the whole weight loss project had been:

> I think many of us have exactly the same story with endless crazy weight loss projects that, when you take a meta view of it and look down on what you have subjected yourself to of really weird stuff, then... Well, like when we were talking about that thing about driving an ice cream van in a bikini and eating frozen nougat mice, well you can laugh about it, can't you, but when you're stuck in a desperate situation, you think, well, heck, it might just work.

Like Bakhtin's concern about monologism, it seemed that the many voices and experiences with weight loss that the participants had accumulated from society, people around them, and personal history had gravitated toward one thing: having to lose weight at any cost. This 'truth' seemed to have come so intensely loaded with value judgements that participants could do nothing but abide.

Dialogically, failing to engage with monologues and such authoritative voices means succumbing to one definition of the self which in Bakhtin's view was detrimental. In this case, *weight loss* seemed to have become a project of selfhood, so much so, that the participants believed they were not entitled to have a life if they were unable to lose weight.

This example also shows that the participants, at this point in treatment, were challenging these ideas. Part of this was done through humor and laughter which, according to Bakhtin, has the power to evade authority (Bakthin in Morson & Emerson, 1990).

Forces pushing for binge-eating

We explored the many forces pushing for binge-eating. One participant said in treatment that she discovered that eating could be her response to anything; feeling happy, celebrating, feeling relief, sadness, tired, bored and so on. Another participant replied that he discovered that his eating disorder would make him eat and then turn around and laugh at him for doing so. Eating was also described as *a break* from having to defend or explain themselves for looking the way they did and for eating what they were eating. Eating could also be a habit, and many described their episodes of eating as 'shifting to autopilot'. On autopilot, there was no chaos, no inner dialogues or conflicts, just silence and calm – for a while. Dialogically, however, this silence also made it impossible to change or do something new. As we will se later, simply being conscious of the eating disorder created an option for acting differently in treatment.

In a variety of ways, the participants described a momentary comfort when eating. Eric described his binge-eating as crawling into a shell where he was alone and protected, eating was *an immune system* that left him unaffected by what people said or did. He was never really happy but never really unhappy, except when he had finished eating. Similarly, Ingrid called her eating disorder *a protective shield*. In excerpt of an interview below, Ida shared how she, at an early age, had discovered that eating allowed her to not deal with her feelings.

> I kept it all inside. I ate my feelings. That's what I've been doing all my life; I eat my feelings. I keep it inside. I discovered that, yeah, this helps me: If I'm sad then I just need to eat something, then I don't have to react to it (Ida)

Turning to Bakhtin, eating could be understood as a superaddressee, an intimate voice who offered protection and understanding. Tina said that binge-eating had helped her avoid looking at difficult feelings from her childhood.

> That's what I've been too scared to look at. So, I've just thought I'm going to close that down right now, how do I do that? I do that by eating a strawberry cake, or something. So I'd eat so much that I would feel so full, so uncomfortable that (…) the only thing I could manage was to lie on the couch and then when I woke up I would be more worried about , 'oh, aren't you bad, how nasty, disgusting and ugly and stupid you've been because you've eaten and now you better do some exercise'. Then, I didn't have to think about it [the difficult feelings] till the next time.

From that perspective, binge-eating and the weight loss project kept the participants away from engaging in the inner and outer dialogues that were necessary to come to know themselves and to develop a sense of self. More importantly, it seemed that the sense of chaos and the oscillations between extremes led the participants to believe that there were no exits, no hopes; that they could only lie back and surrender to the eating disorder.

In a dialogically framework, this illustrates the detrimental effects of not being heard, of not having a voice that can challenge the conversations that define you, and of leaving the dialogical world that gives shape to selves and connects people. Bakhtin argued that monologues are closed to change because they pretend to come from nowhere, with no sender to argue with, and did not acknowledge the voice of the receiver. In that sense, the voices about body and weight that the participants shared in their talk were often inherited through generations or were fragments accumulated across social and cultural contexts which concealed that these voices came from somewhere and communicated something that was possible to respond to or even oppose to.

Reconnecting in dialogical spaces

Looking back, many participants were surprised that the eating disorder had taken up so much energy and seeped into so many areas of their lives without them knowing about it? Many said that being conscious of the eating disorder, i.e. knowing that they had an eating disorder and it was not poor self-discipline, and beginning to see it at work in their lives, had helped them work against the eating disorder. In an interview, Lise described treatment as one big Aha! Moment where knowing made it possible to act.

> Yes, Phase 1 [systemic and narrative group therapy] was one big aha moment. Suddenly understanding that my eating disorder wasn't just me that couldn't stop myself eating at night for instance, it was a large network of sleep problems, food problems and psychological problems (…) It was a huge relief, really, just to find out that there was something quite concrete that could be done about it.

The narrative aim of separating the person and the problem seems tap onto the dialogical position of *outsideness.* In Bakhtin's view, creating this distance would cast a *slight shadow of objectification* over the eating disorder which meant that it became open to be evaluated by the participants.

In field notes we saw that the therapists consistently talked about the eating disorder in this externalizing manner as did the participants. Some even had a name for their eating disorder and could describe what it looked like and its position. In feedback from the therapists and the group members, the ability to separate the self and the eating disorder was talked about as a marker of progress.

Reconnecting with a sense of self

The participants extended the strategy of giving voice to problems and creating a distance between them and their problems to other practices in the treatment.

One therapeutic practice was to write a food diary and note down food and emotions. In an interview, Astrid told me that writing the diary had helped her see connections between her meals and what she understood as a suppressed sadness from her childhood. It also made her aware of situations and encounters with others that upset her and how eating helped her manage that.

Another strategy was to say things out loud; Asta, had discovered that simply sharing her thoughts minimized the power of her eating disorder.

> And the things that hurt the very most they have to be said out loud. Because that's been my only way to battle the eating disorder, saying it out loud. And when I've said it out loud and have talked about it then it becomes a little bit smaller. Something will probably pop up again at a later time because it's not like it's solved by that one time, but when things are said out loud they don't get to stay and disturb for a long time.

For another participant, Tor, it was even helpful to speak to himself in front of a mirror. Simply getting words out of the mind and onto paper or into the word and into conversations with others were strategies for change for the participants. This also illustrates the dialogical need to live in dialogue.

In the aggregated field notes of a group session presented below, we see how the therapists used different strategies to create a dual move away from the eating disorder and towards a position of an evaluative self.

After turn, each patient was asked to select a day in their diary that they wanted to talk about and give a reason for why they had chosen that particular day. One of the therapists read the diary entries out load, always starting with the food and times of eating. The therapist typically asked, 'what are your thoughts about the menu that day?' This could elicit many different responses from the participants along a continuum of being pleased or displeased with themselves. For instance, Eva replied that she was happy that she had managed to get all her meals even though she had had a busy day at work. Another participant, Andrea, commented 'I managed to eat a little bit of 'human food' [not a powdered diet], whereas Signe just said; 'It was okay'. The patients' reply most often led to a therapist-led talk about who was speaking and the intentions of that speaker. If the patients reply was positive, the therapist would explore their response in terms of its significance for the patient and how it had been possible; 'what did you do to make it possible to take that step', 'what was your intention or plan with doing that', 'what were you fighting for', 'was this a step against the eating disorder?'. If the reply was more self-critical or about how it had been difficult to eat in accordance with what they wanted or there had been set-backs, for instance, 'I did not get enough veggies' or 'it was not the healthiest food', or 'I should have...' the therapists would continue with questions like; 'compared to what' or 'says who' or 'is this the eating disorder/the critical voice speaking' or 'does it have a share in this', 'what do you think it [the eating disorder or the critical voice] wants', 'are you in a position where you agree'. Sometimes, when there was not a lot of food entries or the opposite, if food had been scarce, the therapist would involve the dietician's voice; 'what do you think [the dietician] would say?'

The therapists probed subjects like good/bad and right/wrong and this often revealed hidden health ideologies or detached truth statements. Words or fragments would surface from the past, from parents, bullies or someone unknown to the participants and some of these voices had accompanied the participants for years without having been questioned. Dialogically, these voices may have survived

because they gravitated towards this single truth. The monological forces might also mean that alternative voices that had perhaps been more validating and kinder were not remembered by the participants. The therapists seemed alert to such fragmented statements and questioned where they came from and participants' thought about them today. It was extraordinary that the participants often remembered the exact wording but could not remember the person who had spoken them, or they disliked the person or disagreed with everything else about the person. Dialogically, putting a face to the statements and asking the participants to respond opened these statements to change. Sometimes the participants said they still agreed with a critical statement which put the therapists in a somewhat difficult position as the narrative move is to encourage resistance to oppressive forces. However, in dialogical terms, simply evaluating words, voices, and intentions will make them part of the inner, polyphonic and mature psyche.

The dietician in the group interviewed the participants in a manner similar to the therapists but she only focused on the food entries. Many participants revealed to me that they had initially been nervous and afraid of exposing their 'poor eating habits' to a dietician or they thought it was a waste of time because they already knew everything. What many found was that the dietician offered 'a counterargument to the eating disorder'. The analysis showed that the dietician invited two voices into the conversations about food: one was a biophysiochemical voice about the functions of food and the needs for nutrients of all bodies and other was the participants'; 'what do you like to eat', 'what choices do you want to make?', 'what fits in with your life'. The dietician even commented on a diary entry that 'lasagna is a perfectly fine food to have for breakfast'. Eva later explained that being offered a position to eat according to her own needs and preferences made a lot of the food she would normally binge on 'uninteresting'. A change happened for her because all foods were allowed. Bakhtin stated that it is impossible to disagree with monological truths but it is possible to disobey them. Following from that,

the act of eating uncontrollably and eating "forbidden foods" could be understood as acts of disobedience in the absence of any real option to disagree with having to lose weight. The dietitian's project was not about weight loss or health. She had a completely different outset: she worked to change the participants' relationship to food. Thinking in terms of forces pushing for order and disruption of order, the dietician seemed to help the participants to move beyond controlled-uncontrolled eating by encouraging them to make the voices about food their own.

Overall, 'truths' about weight and eating were challenged and reevaluated in the different treatment settings. Lise described these changes like this:

> Another thing that's been important in this treatment is - all the stuff you hear on the news and the entire culture that we live in, which is all part of that outside picture I was talking about - and to understand how great an influence that has, you know, what that does to people to live in a society like the one we've created. And then to somehow find a counterargument to that, an alternative mindset, which is also important for all of us who have children to teach them to have a different focus than on how you look.

Lise talked about understanding the influence of the outside picture and, later in the interview, she said that she had come to realize that these voices did not fit in with who she was.

> It was around that time that it began to dawn on me that it actually was not a part of who I am to think like that. And that I needed to get those thoughts out and to get counter-answers. To get some different thoughts in, you know.

This illustrates the closed discussions that characterized the eating disorder and how change became possible as new voices were introduced in treatment. In a similar vein, many said that they could not always identify if the critical voices about them came from the outside world or from their minds.

After she finished treatment, Ingrid reflected on how she reacted to such critical voices about her weight, now:

> Where, before, I wouldn't have questioned it, I just took it in and thought 'yeah, well they're probably right', because 'yeah, yeah, I am fat and stupid' and all of those things the eating disorder would tell me. But now, I thought 'what are you saying and what do you mean?' But it's not like it's gone, just because I'm free of my eating disorder. It's still there, my ears just hear it in a different way now.

Being free of her eating disorder let her hear the voices differently and she found that she did not agree.

Reconnecting with others

Another strategy to create a shift in perspective was hearing one's own words in the speech of the other group members in the feedback. Lise said in an interview:

> I think it was informative to hear the others' stories about their thought prisons [in Danish "tankefængsler"]. And then, on some points, they were very alike and on others they weren't, but it gave me a good picture of what it does to people to live with a bunch of restrictive thoughts. And then it was easy, when you hear others, to kind of see that it doesn't do any good.

Through what Bakhtin called otherness, the participants came to see themselves more clearly and navigated in these multiple voices. As the eating disorder was dismantled and the participants came to know it, it also became something that could be shared in other conversations: The dialogical field expanded. It seemed that a sense of belonging followed from this connection with the group and with

people in their lives which also created another distinction between inner voices:

> Maybe I don't look so different from everyone else. (…) But I am extremely vigilant of what is what. What is the eating disorder? Because some things are just natural. Other people have that too. It's not just because I have an eating disorder. I still need to think about that.

What about weight?

Considering the importance of weight in the participants accounts, we found that the exploration of 'weight' in treatment was substantially different from the therapeutic exploration of 'the eating disorder'. Weight was confined to the weekly practice of weighing which many participants said they struggled to see the point of: It did not make sense to be asked to leave the weight loss project behind and not ascribe meaning to weight and be asked to see the weight. Andrea said that 'I think we all just needed a break from all that'.

In the field notes, I described the atmosphere in the weighing room as 'strangely silent'. The therapist's comments about weight were limited to 'If you look here, you can see that your weight is stable over time', or 'what are your thoughts?', which was then followed by 'does the eating disorder have an opinion about this?' or, if the weight went up, the participants were offered to see the dietician or they were asked if they had had episodes of binge eating. While weighing did seem to dismantle some of the participants' fears about eating and weight, the speech surrounding the topic only acknowledged the presence of two voices; the oppressive voice of the eating disorder and a voice that claimed to be unaffected by weight. Most participants also had a voice of concern for their physical health, and old inner conversations about easting and not eating that would start on the day leading up to weighing. These voices were not unfolded in treatment. Even among the participants themselves, weight was never

discussed. When participants returned to the others in the waiting area after being weighed, they did not share their weight or the feelings the weighing had given rise to.

From a dialogical perspective, the scarcity of voices and positions on 'weight' left the topic less open to change and less open for the participants to make their own.

Reflecting on entering treatment, Astrid remarked that she had not been convinced that the treatment strategies would work but thought 'what I have been doing the past 50 years hasn't helped so I might as well do what they say'. Overall, treatment offered a new set of rules that the participants were to follow in place of the eating disorder's rules. They even had to sign consent forms agreeing to eat regular meals, eat all types of food, write a food diary, and *not* try to lose weight. The field notes of therapy, however, showed that the therapeutic work was about getting the participants to 'try on' these new rules and make them their own. While Astrid felt great changes in her eating disorder, the issue of weight was never fully resolved for her. She explained that treatment had become her 'substitute mother', a new authority that had temporarily given her permission to *not* lose weight. When she finished treatment, she was no longer 'protected' and felt obligated to reengage in the weight loss project.

Discussion

The present study explored processes of change in an integrative systemic and narrative psychotherapy group for BED with the aim of inspiring new understandings of BED and ways of creating change in treatment. Using excerpts from participant observations of therapy, we demonstrated how externalizing practices, reflecting teams, and writing a food diary helped the participants disconnect from their eating disorder and reconnect with a sense of self and with other people. Processes of change involved moving problems from inner, closed monologues to conversations with themselves and with

other people. From being submerged in the problem, participants found ways of stepping outside and seeing it as an eating disorder. In so doing they learned about the eating disorder but also came to know themselves and the contexts that had shaped the eating disorder.

The findings underline the dialogical emphasis on evaluation as a way to develop a coherent and mature self, as well as the importance of engaging in multiple voices. The systemic and narrative methods clearly made use of dialogical principles for change in that the therapists probed for hidden voices in the patient's speech and invited the patients to take an evaluative stance towards them. What was interesting and new, was that the participants utilized these strategies in relation to other treatment elements such as writing the diary, saying things out loud (even to themselves) and hearing the other group members speak.

The treatment group itself, with the different participants and therapists and treatment elements, created new constellations of speaking and listening, or even a mini-dialogical world of voices that the participants could engage in. The analysis also showed that therapists were oriented to people outside the therapy room, to discourses and received truth claims in society which moved the dialogical field beyond the individuals in treatment. For the participants, the therapeutic probe for hidden voices instilled a critical ear and an awareness of who is speaking that helped them navigate outside of treatment.

Dialogical understandings of BED

Governed by the convincing uncontestable truth about weight loss, we found that the participants' experiences, their thoughts, and their encounters with other people were colonized by weight concerns. This, to such an extent that weight loss had become a life project. Through the dialogical analysis, the

contours of the eating disorder appeared, not as one thing, but as a collection of instances and manifestations of the disorder. The eating disorder comprised many voices from society and other people that had all gravitated towards a center concerning weight loss. In that sense, change occurred in therapy as the core ideas about weight were questioned and the voices were identified and challenged. This process did not end with treatment but the participants continued to try to identify when the eating disorder was speaking and which external voices it responded to. Recovery was about being able to argue with whatever inner or outer voices presented themselves and say, 'I agree' or 'I disagree'.

All the participants agreed that they needed to lose weight but they did not agree that it was the most important thing in their lives. The conversations were monologic in nature and reflected findings by other dialogical analyses of therapy (Olson et al., 2012; Penn & Frankfurt, 1994).

Generally, a context developed that enabled the participants to decide for themselves. We conclude from this that involving other people in treatment, including having a group format, and encouraging multiple perspectives on problems are important in working with BED.

Limitations and future directions

To our knowledge, this is the first study to explore BED and group therapy from a dialogical perspective. The strengths include generating understandings of often individualized problems that include relational, social, and cultural influences. The therapeutic attention to the traces of voices that are discernable in the patients' speech offers other ways of creating change than traditional cognitive restructuring of maladaptive thoughts. The difference lies especially in the consequent positioning of the participants not

as people with deficits who must change but as people who can break free if they are supported in a meaningful manner. Limitations include the narrow analytical focus on language, as Bakhtin was also highly concerned with embodied communication. A broader focus on bodily responsiveness could have expanded the therapeutically universe beyond its current limits of language.

References

American Psychiatric Association (Ed.). (2013). *Diagnostic and statistical manual of mental disorders: DSM-5* (5th ed). Washington, D.C: American Psychiatric Association.

Andersen, T. (1987). The reflecting team: Dialogue and meta-dialogue in clinical work. *Family Process*, *26*(4), 415–428. https://doi.org/10.1111/j.1545-5300.1987.00415.x

Asen, E. (2002). Multiple family therapy: An overview. *Journal of Family Therapy*, *24*(1), 3–16.

Bakhtin, M. M. (1984). *Problems of Dostoevsky's poetics* (C. Emerson, Trans.). Minneapolis: University of Minnesota Press.

Bazeley, P., & Jackson. (2013). *Qualitative data analysis with NVivo* (Second edition). Los Angeles London New Delhi: SAGE.

Cramer, P., & Steinwert, T. (1998). Thin is good, fat is bad: How early does it begin? *Journal of Applied Developmental Psychology*, *19*(3), 429–451. https://doi.org/10.1016/S0193-3973(99)80049-5

Creswell, J. W., & Plano Clark. (2011). *Designing and conducting mixed methods research* (2nd ed). Los Angeles: SAGE Publications.

Danish Health Authority. (2005). *Eating Disorders: Recommendations for organisations adn treatment [Iin Danish: Spiseforstyrrelser: Anbefalinger for organisation og behandling]*. København: Sundhedsstyrelsen.

Dingemans, A. E., & van Furth. (2012). Binge eating disorder psychopathology in normal weight and obese individuals. *International Journal of Eating Disorders*, *45*(1), 135–138. https://doi.org/10.1002/eat.20905

Fairburn, C. (1981). A cognitive behavioural approach to the treatment of bulimia. *Psychological Medicine*, *11*(04), 707. https://doi.org/10.1017/S0033291700041209

Hilbert, A., Pike, Goldschmidt, Wilfley, Fairburn, Dohm, … Striegel Weissman. (2014). Risk factors across the eating disorders. *Psychiatry Research*, *220*(1–2), 500–506. https://doi.org/10.1016/j.psychres.2014.05.054

Hudson, J. I., Hiripi, Pope, & Kessler. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. *Biological Psychiatry*, *61*(3), 348–358. https://doi.org/10.1016/j.biopsych.2006.03.040

Hughes, E. K., Mundy, L. K., Romaniuk, H., Sawyer, S. M., Wake, M., Williams, J., … Patton, G. C. (2018). Body Image Dissatisfaction and the Adrenarchal Transition. *Journal of Adolescent Health*, *63*(5), 621–627. https://doi.org/10.1016/j.jadohealth.2018.05.025

Kessler, R. C., Berglund, Chiu, Deitz, Hudson, Shahly, … Xavier. (2013). The Prevalence and Correlates of Binge Eating Disorder in the World Health Organization World Mental Health Surveys. *Biological Psychiatry*. https://doi.org/10.1016/j.biopsych.2012.11.020

Maloney, M. J., McGuire, J., Daniels, S. R., & Specker, B. (1989). Dieting behavior and eating attitudes in children. *Pediatrics*, *84*(3), 482–489.

Meier, E. P., & Gray, J. (2014). Facebook Photo Activity Associated with Body Image Disturbance in Adolescent Girls. *Cyberpsychology, Behavior, and Social Networking*, *17*(4), 199–206. https://doi.org/10.1089/cyber.2013.0305

Meyer, L, Waaddegaard, M., Poulsen, S., Ersbøl, A. K., Davidsen, A. H., & Lau, M. E. (n.d.). Effectiveness of an integrative systemic and narrative group psychotherapy for adult patients with binge-eating disorder. *Unpublished Manuscript*.

Meyer, LB, Waaddegaard, M., Lau, M. E., & Tjørnhøj-Thomsen, T. (2018). (Dis-)solving the Weight Problem in Binge-Eating Disorder: Systemic Insights From Three Treatment Contexts With Weight Stability, Weight Loss, and Weight Acceptance. *Qualitative Health Research*, 1–12. https://doi.org/10.1177/1049732318764874

Morris, A. M., & Katzman, D. K. (2003). The impact of the media on eating disorders in children and adolescents. *Paediatrics & Child Health*, *8*(5), 287–289.

Morson, G. S., & Emerson, C. (1990). *Mikhail Bakhtin: creation of a prosaics*. Stanford, Calif: Stanford Univ. Press.

Neumark-Sztainer, D., Bauer, Friend, Hannan, Story, & Berge. (2010). Family Weight Talk and Dieting: How Much Do They Matter for Body Dissatisfaction and Disordered Eating Behaviors in Adolescent Girls? *Journal of Adolescent Health*, *47*(3), 270–276. https://doi.org/10.1016/j.jadohealth.2010.02.001

Olson, M. E., Laitila, A., Rober, P., & Seikkula, J. (2012). The shift from monologue to dialogue in a couple therapy session: Dialogical investigation of change from the therapists' point of view. *Family Process*, *51*(3), 420–435.

Penn, P., & Frankfurt, M. (1994). Creating a participant text: Writing, multiple voices, narrative multiplicity. *Family Process*, *33*(3), 217–231.

Puhl, R., & Heuer, C. (2009). The Stigma of Obesity: A Review and Update. *Obesity*, *17*(5), 941–964. https://doi.org/10.1038/oby.2008.636

Schur, E. A., Sanders, M., & Steiner, H. (2000). Body dissatisfaction and dieting in young children. *The International Journal of Eating Disorders*, *27*(1), 74–82.

Seikkula, J., Laitila, A., & Rober, P. (2012). Making Sense of Multi-Actor Dialogues in Family Therapy and Network Meetings. *Journal of Marital and Family Therapy*, *38*(4), 667–687. https://doi.org/10.1111/j.1752-0606.2011.00238.x

Striegel-Moore, R., Dohm, F.-A., Pike, K. M., Wilfley, D. E., & Fairburn, C. G. (2002). Abuse, bullying, and discrimination as risk factors for binge eating disorder. *American Journal of Psychiatry*, *159*(11), 1902–1907.

Tanofsky-Kraff, M., Faden, D., Yanovski, S. Z., Wilfley, D. E., & Yanovski, J. A. (2005). The perceived onset of dieting and loss of control eating behaviors in overweight children. *International Journal of Eating Disorders*, *38*(2), 112–122.

Todorov, T., & Godzich, W. (1984). *Mikhail Bakhtin: the dialogical principle*. Manchester: Manchester Univ. Press.

Wansink, B., Latimer, & Pope. (2017). “Don’t eat so much:” how parent comments relate to female weight satisfaction. *Eating and Weight Disorders - Studies on Anorexia, Bulimia and Obesity*, *22*(3), 475–481. https://doi.org/10.1007/s40519-016-0292-6

White, M. (2007). *Maps of narrative practice* (1st ed). New York: W.W. Norton & Co.

Whyte, W. F. (1979). On Making the Most of Participant Observation. *The American Sociologist*, *14*(1), 56–66.

Effectiveness of an integrative systemic and narrative group psychotherapy for adult patients with binge-eating disorder

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ABSTRACT

Systemic and narrative (SN) methods are widely used in the treatment of eating disorders (ED), but few studies have examined SN treatments for binge-eating disorder (BED). This naturalistic cohort study evaluated the effectiveness of an Integrative SN (I-SN) group intervention for adults with BED (N =111) at an outpatient ED unit in Denmark. Results showed a completion rate of 74% and significant improvements in BED symptoms and general psychopathology post-treatment with pre-post effect sizes (Cohen's *d)* ranging from 1.11 to 2.00. More than half of the full sample achieved full recovery, indicating an effect of I-SN for adults with BED.

INTRODUCTION

Eating disorders (EDs) have a serious effect on the individual's psychological and physical health and well-being (Hudson, Hiripi, Pope, & Kessler, 2007). Binge-eating disorder (BED) is the most prevalent of the eating disorders with 2-3% of the population affected (Hudson et al., 2007; Kessler et al., 2013). The BED diagnosis is defined by recurrent episodes of binge-eating in the absence of regular compensatory behaviors (American Psychiatric Association, 2013). Approximately 75% of people with BED have co-occurring lifetime psychiatric disorders (Grilo, White, & Masheb, 2009), including anxiety and major depression (Javaras et al., 2008; Kessler et al., 2013), and more than 2/3 become overweight or develop obesity (Hudson et al., 2007).

EDs are considered biopsychosocial problems because of their complex and multifactorial etiology (Culbert, Racine, & Klump, 2015). For BED, the social context of idealization of thinness and pervasive weight stigma is especially pertinent. Weight stigma exist in a variety of institutional and interpersonal contexts (Puhl & Heuer, 2009) and are associated with disturbed eating (Mensinger, Calogero, & Tylka, 2016), poor body image, high body mass index (BMI), and poor physical and mental health and well-being (Puhl & Suh, 2015; Tomiyama et al., 2018). Compared weight matched controls, BED patients are found to be more sensitive to stigmatizing experiences and are more likely to internalize weight stigma, i.e. believing that their worth depends on their weight. People with BED who internalize weight stigma also tend to show higher levels of weight and shape concerns, including greater overvaluation of weight and shape,(Pearl, White, & Grilo, 2014), depression, and lower self-esteem (Durso et al., 2012) compared to people with BED who have not internalized weight stigma.

A number of psychotherapeutic approaches for BED have been shown to reduce binge-eating and weight and shape concerns and lead to weight stabilization (Vocks et al., 2010). A meta-analysis

including 39 randomized controlled trials of various psychotherapeutic approaches and modalities for BED, reported a total weighted mean recovery rate of 50.9 % for completers and 45.1 % in intention-to-treat analyses (Linardon, 2018). While interpersonal therapy (IPT) appears to have the highest average recovery rate (63,1 % post-treatment), several other well-established psychotherapeutic approaches, including dialectic behavior therapy (DBT), cognitive behavior therapy (CBT), psychodynamic interpersonal psychotherapy, and behavioral weight loss treatment (BWLT), also yield recovery rates above 40 % post-treatment. A recent meta-analysis including 35 randomized clinical trials (RCTs) (18 trials included participants with BED) indicated that all psychotherapies meeting Wampold et al.'s (Wampold et al., 1997) definition of a bona fide treatment are equally effective when treating EDs (Grenon et al., 2018).

The fact that approximately only half of patients with BED fully recover (Linardon, 2018), indicates that the continued development of effective treatments for BED is imperative. Furthermore, a recent study (Dakanalis, Colmegna, Riva, & Clerici, 2017) showed that recovery rates were highly associated with symptom severity, ranging from 98.5 % in mild cases to only 7 % in cases with extreme severity of BED. Thus, there is a specific need for new and improved treatments for severe and extremely severe cases of BED.

The most prominent approaches in BED treatment, CBT and IPT, are based on intrapsychic theoretical models. While CBT focuses on dietary restrains and acknowledges that poor body image is widespread in the general population and a core feature of EDs, the social and cultural norms and social interactions concerning these issues are not explicitly addressed in therapy (Fairburn, Cooper, Shafran, et al., 2008). Likewise, while IPT-BED addresses constricted social functioning associated with shame-producing experiences (bullying) and negative emotions concerning weight, the focus is on improving

the *patient's* ability to ask for social support irrespective of such weight-shaming experiences (D. Wilfley, Frank, Welch, Spurrell, & Rounsaville, 1998). Thus, both CBT and IPT tend to frame interpersonal problems as deficits of the individual that can be alleviated through prescribed behavioral or psychological changes, rather than acknowledging the profound impact of cultural norms and expectations. An exception is a family-based IPT (FB-IPT), developed for preadolescents with loss-of-control eating (LOC-eating) and overweight/obesity. FB-IPT explicitly addresses the patterns of communication between parents and children that contribute to problematic eating, i.e. taking into account the reciprocity of social interaction. Compared to a family-based health education, FB-IPT significantly reduced disordered eating attitudes and lowered the odds of LOC-eating (Shomaker et al., 2017). Similar methods have not yet been applied in psychotherapy for adults with BED.

One possible way to improve outcome of psychotherapy for BED is to focus more specifically on weight stigma and the idealization of thinness inherent in Western culture. Taking such a contextual perspective may help us expand these intrapsychic theoretical models and develop more inclusive psycho-social models that better capture the complexity of lived lives and cooccurring BED and obesity.

The current study examines a systemic and narrative (SN) treatment for BED. SN is founded in postmodernism and sees reality as co-constructed between people and shaped by cultural and social contexts. SN treatment thus relocates psychiatric problems to an interactional arena. The primary aim of narrative therapy is to develop more preferred stories about the self by explicating constricting self-narratives shaped by dominating discourses (White, 2007). A fundamental therapeutic stance is that 'the person is not the problem; the problem is the problem' which is directly practiced through the narrative method of externalizing. Externalizing linguistically separates the patient and the problem, which invites a joint exploration of how the problem impacts the patient's life and how the person can take steps against

it (White, 2007). Systemic therapy focuses on interpersonal interactional networks (Watzlawick, Weakland, & Fisch, 1974), which are thought to give rise to and sustain the problems. Long-term problems are believed to reflect a system that continuously tries to solve the problems with unhelpful solutions. Change is initiated through identifying the attempted solutions that maintain the problem and by facilitating multiple, differing perspectives on the problem. The therapist is not an expert but a facilitator that uses his or her knowledge to explore new ways of thinking and doing that are meaningful to the patient.

Compared to other treatments, psychotherapeutic interventions founded in postmodernism have not been extensively studied. These interventions, however, are widely used in treating EDs (von Sydow, Beher, Schweitzer, & Retzlaff, 2010; von Sydow, Retzlaff, Beher, Haun, & Schweitzer, 2013), and have been shown to be effective in reducing binge eating, weight, and global functioning in people with EDs (Jackson, Pietrabissa, Rossi, Manzoni, & Castelnuovo, 2018). Narrative family therapy has successfully improved outcomes for children and parents struggling with diverse, treatment-resistant psychiatric and behavioral problems, including EDs (Jørring & Gjessing-Jensen, 2018). An RCT, carried out in the same outpatient clinic as the present study, compared I-SN and a feedback-informed I-SN and found no differences in outcome between the two treatment arms, but reported overall reductions in ED and general psychopathological symptoms for a transdiagnostic eating disorder sample (Davidsen et al., 2017).

The aim of the present study was to evaluate the effectiveness of an integrative systemic and narrative (I-SN) group therapy for adult patients with BED in an outpatient eating disorder service in Denmark. Using a naturalistic cohort design, we examined treatment outcomes for the full sample and across different BED severity levels in terms of recovery rate, severity of ED symptomatology, general psychological distress, level of psychosocial functioning, weight management, and quality of life.

METHOD

PARTICIPANTS

The sample comprised of treatment-seeking adult patients (age ≥ 18), referred by their general practitioner to a public outpatient ED unit in Denmark in the period November 2013 to February 2016. To be eligible for the study, patients were required to have BED according to DSM-IV-TR research criteria (American Psychiatric Association, 1994) and a Body Mass Index (BMI) ≥ 27. Excluded were patients unable to communicate in Danish, in acute suicidal risk, suffering from current psychosis, having an ongoing substance abuse, who were pregnant, in concomitant psychotherapeutic or psychiatric treatment outside the facility.

Treatment

The I-SN intervention was multimodal and complied with official Danish recommendations and guidelines for eating disorder treatment (Danish Health Authority, 2005). Treatment was managed by an interdisciplinary team and administered according to an unpublished treatment guide. Within the study period, a total of 10 therapists participated; two psychologists, three physiotherapists, two social workers, (all were experienced SN therapists), two dieticians and one physician. The entire team received supervision by a certified SN-supervisor for 1½ hours twice a month. There were four parallel groups, each with seven patients of both genders, two therapists, and one dietician attached. New patients entered as others finished.

Prior to treatment, patients attended two psychoeducational sessions and a preparatory session with an assigned group therapist. Group treatment consisted of 25 weekly systemic and narrative psychotherapy sessions of 210 minutes. Every fifth session revolved around/was based on nutritional guidance led by a dietician, and with a therapist present to secure transitions into therapy. Patients were instructed to keep a food diary with the aim of exploring relations between eating behavior and thoughts, emotions and activities in their everyday life. A stable weight, +/- 5–7 kilos (ll-15.5 lbs.) depending on BMI, was requested during treatment to underline the point that weight loss attempts are part of the problem rather than the solution. The treatment team consistently spoke about eating disorder-related thoughts, feelings, and behaviors, as well as self-criticism and hopelessness (*the eating disorder* and *the critical voice* respectively) in an externalizing manner.

The treatment format was individual therapy in groups. In therapy sessions, each patient was interviewed about their diary entries followed by feedback from reflecting teams (Andersen, 1987), first by group members, then by therapists. The purpose was to inspire new ways of seeing and relating to problems through the opinions/attitudes/stories of experts with lived experiences of BED and professional experts in BED. Over the course of treatment, there were two multi-family meetings (Asen, 2002) that facilitated dialogues across their social network.

Nutritional counseling included individual interviews, nutritional education, and group discussions. Sessions worked to deconstruct socially derived, eating disordered convictions about food, and encourage patients to eat for enjoyment and nourishment. The aim was to establish structured and regular eating patterns based on patient preferences, reduce BE, and reestablish signals of hunger/satiety.

According to patients' needs, the group treatment could be augmented with up to 3 sessions of, e.g., individual psychotherapy, nutritional guidance, social, medical or couples counseling, Basic Body Awareness Therapy, and mindfulness.

Measures

Eating Disorder Examination interview (EDE): We used EDE version 12, with the Binge Eating Disorder module from version 16 (Fairburn, Cooper, & O'Connor, 2008), to assess DSM-IV-R criteria for BED. EDE is a semi-structured, investigator-based interview that measures eating pathology, including the frequency and duration of binge-eating over the past 6 months. In addition to the diagnostic items, the EDE contains four subscales (Restraint, Eating Concern, Shape Concern, and Weight Concern), the mean score of which provides a Global score (GS). BED severity level was determined according to DSM-5 (American Psychiatric Association, 2013) definitions, based on frequency of binge-eating episodes in the past 28 days: Mild (1 - 3 episodes/week), moderate (4 - 7 episodes/week), severe (8 - 13 episodes/week), and extreme (14 or more episodes/week). A high degree of inter-rater reliability, internal consistency, and discriminant validity has been reported for Danish samples (Clausen & Rokkedal, 2010).

Body Mass Index (BMI) Body weight and height were measured to compute BMI (kg/m^2).

The Mini International Neuropsychiatric Interview 5.0. (MINI) The Mini International Neuropsychiatric Interview 5.0. (MINI) is a short, structured diagnostic interview aligned with the diagnostic criteria of the International Classification of Diseases (ICD-10) and the DSM-IV (Sheehan et al., 1998). We added modules from version 6.0 to assess current psychosis, depression, suicidal risk, and substance misuse. Studies have shown good sensitivity, specificity, reliability, and validity (Sheehan et al., 1998).

The Symptom Checklist-90-Revised (SCL-90-R) The Symptom Checklist-90-Revised (SCL-90-R) is a multidimensional, 90-item self-report questionnaire measuring general psychopathology (psychological and affective distress) (Derogatis, Lipman, & Covi, 1973; Derogatis, Rickels, & Rock, 1976). The 90 items are rated on a scale from 0 (not at all) to 4 (very much). The Global Severity Index (GSI) is the mean score of the 90 items. Internal validity has been found acceptable for all subscales except psychoticism (Derogatis et al., 1976).

Sheehan Disability Scale (SDS) Sheehan Disability Scale (SDS) is a self-rated measure of functional impairment within the domains of work/school, social, and family life. SDS uses three items rated on a scale from 0 to 10, the sum of which provides a global score ranging from 0 (unimpaired) to 30 (highly impaired) (Sheehan, Harnett-Sheehan, & Raj, 1996). Studies show acceptable reliability, sensitivity to change and construct validity of the SDS (Sheehan & Sheehan, 2008).

The WHO-Five Well-being Index (WHO-5) The WHO-5 uses five items to measure psychological well-being over the past two weeks, concerning positive mood (feeling in good spirits and feeling relaxed), vitality (being active and waking up fresh and rested), and being interested in things (Bech, 2004). A total score is calculated by multiplying the sum score by 4. A score of 0 represents the worst possible and 100 represents the best possible quality of life (Bech, 2004). The measure has shown good reliability and excellent validity (McDowell, 2010), and is recommended as a patient-reported outcome measure (Bech, Austin, & Lau, 2018).

Outcome measures

Primary outcome

The primary outcome was full recovery of binge-eating, defined as zero binge-eating episodes the previous 28 days according to the EDE. Full recovery is of clinical importance for BED as sub-clinical levels of binge-eating post-treatment have been found predictive of poorer long-term outcomes (Fischer, Meyer, Dremmel, Schlup, & Munsch, 2014).

Secondary outcomes

The secondary outcomes were frequency of binge-eating episodes, EDE global score (GS) and subscale scores on restriction, eating concern, weight concern, and shape concern (EDE), BMI, scores on SCL-90-R (GSI), SDS and WHO-5, and treatment completion defined as at least 75 % attendance of group psychotherapy.

Procedure

The study was non-invasive to the usual practice of the treatment facility. EDE interviews were incorporated as part of the clinical assessment/evaluation routine and were performed by research assistants (psychologists and final year psychology students) trained by the leading psychologist in EDE assessment in Denmark, Loa Clausen, and supervised by the first and sixth author. Psychiatrists and a psychiatrist in training performed the MINI interviews. MINI and EDE interviews were conducted at baseline (mean weeks before treatment 14.9, SD 8.2) and EDE was performed again at post-treatment (mean weeks 1.8, SD 3.1). At baseline and post-treatment, patients received a link to various electronic questionnaires (SCL-90R, SDS, WHO-5). Questionnaires were re-administered pre-treatment if treatment started more than 6 weeks after baseline (n = 76). Access to data was granted by the Capital Region of Denmark [I-Suite no: 01193, ID no: RHP-2011-02]. Referring to the committee law § 2, the National Committee on Health Research Ethics (DNVK) [40503] decided that the study could proceed without approval.

STATISTICAL ANALYSES

Descriptive statistics (means ± SD) were performed to describe baseline characteristics of the full sample. For comparative analyses on selected baseline measures of completers and non-completers, we performed Fischer's exact test (categorical variables) and paired samples t-tests (continuous variables). Effect sizes were calculated using Cohen's *d* (Cohen, 1988). All analyses were two-tailed with a significance level of $p < .05$.

Recovery rates were calculated for the full sample and for the four severity groups separately. Changes in eating-related psychological and functional symptoms, from baseline to post-treatment, were evaluated through analysis of variance. Multiple imputation was used to replace missing values with imputed values (Raghunathan, 2004). There were missing observations in post-treatment outcome measures of SDS ($n = 45$), WHO-5 and SCL-90-R ($n = 25$), EDE ($n = 20$), and BMI ($n = 11$). A total of ten imputed data sets were derived. In each data set, missing values were replaced by values generated randomly according to a linear regression model using a fully conditional specification method. Each imputed data set was analyzed using an analysis of variance, testing changes from baseline to post-treatment for each symptom variable. The mean changes from baseline to post-treatment were calculated by combining the parameter estimates from the analyses of the ten imputed data sets. The analysis was performed using the MI, MIXED and MIANALYZE procedures in the Statistical Analysis System (SAS, version 9.4).

RESULTS

Two-hundred and nine patients were assessed for treatment within the study period. Of these, 98 (46.9 %) did not enter the study, primarily because they had no BED diagnosis according to DSM-IV criteria (n = 38). Twenty-four were offered non-I-SN BED treatment at the centre, 16 declined treatment, 2 were pregnant, and 18 patients did not participate for other reasons. The full sample thus included 111 patients whose baseline characteristics can be seen in Table 1.

Table 1. Baseline characteristics of the full sample (*N* = 111)

Variable	
Age, mean (SD), range	35.8 (10.3), 18-69 years
BMI, mean (SD), range	41.7 (8.2), 28-69 kg/m2
Females, (*n*) (%)	99 (89.2)
Married or co-habiting, (*n*) (%)	52 (46.8)
School education: 10+ years, (*n*) (%)§	70 (63.1)
University degree, (*n*) (%)§	13 (11.7)
Employed or full-time studying, (*n*) (%)	54.1 (60)
Prior psychotherapy, (*n*) (%)	85 (76.6)
Duration of ED symptoms > 5 years, (*n*) (%)*	103 (92.8)
Childhood sexual abuse, (*n*) (%)	11 (9.9)
Co-morbidity; mood or anxiety disorders (*n*) (%)#	54 (51.9)
Co-morbid mood disorders (MINI), (*n*) (%)#	41 (39.4)
Co-morbid anxiety disorders (MINI), (*n*) (%)#	34 (32.7)

Most participants were females in their mid-thirties with a BMI of around 40 kg/m^2. Approximately half were married/co-habiting, and half were in paid employment or enrolled in

education. Almost all the participants had been affected by BED for more than 5 years, and three-quarters had previously attended psychotherapy. Half had psychiatric co-morbidity in terms of either mood or anxiety disorders. Based on the frequency of BE episodes at assessment, 35.1 % of the full sample was categorized with mild, 33.3 % moderate, 25.5 % severe, and 9 % extreme severity of BED.

Treatment completion

Of the 111 included patients, 82 (73,9 %) completed treatment. No differences were found between completers and non-completers on any of the baseline demographic or psychiatric characteristics. Twenty-nine patients discontinued I-SN. Of these, 6 were offered individual or motivational treatment, 9 discontinued treatment due to changes in life circumstances (pregnancy, serious illness, moving) and 3 wished to pursue weight loss. An additional 11 participants dropped out for other reasons. Completion rate ranged from 82 % for mild cases to 64 % for severe cases (see table 2).

Recovery and secondary outcomes

The recovery rate (i.e. reporting zero binge-eating episodes the previous 28 days) of the intention-to-treat (ITT) sample was 55 % and 58.5 % for completers. As presented in Table 2, recovery rates in the ITT sample fluctuated depending on BED severity; 48 % for extreme cases and 62.3 % for mild cases. In the completer sample, patients with severe BED symptoms had the highest recovery rate (71.9 %).

Table 2. Recovery rate for full sample and completers across DSM-5 severity groups

	Mild (*n* = 39)	Moderate (*n* = 37)	Severe (*n* = 25)	Extreme (*n* = 10)	Total (*n=111)*
Completers, (*n*) (%)	32 (82.1)	27 (73.0)	16 (64.0)	7 (70.0)	82 (73.9)
Recovery of completers, *n* (%)	20 (64.4)	15 (55.9)	11 (71.9)	3 (42.9)	49 (59.8)
Recovery of full sample, *n* (%)	24 (62.3)	18 (50.0)	15 (59.6)	4 (48.0)	61 (55.0)

The results of the primary and secondary outcome variables are shown in Table 3. A statistically significant improvement was observed on both the primary outcome and most of the secondary outcome measures following the I-SN treatment. A significant reduction in binge-eating frequency was seen from baseline to end-of-treatment with a large effect size (Cohen's *d* = 2.0). The global EDE-score and the four EDE subscales also showed high effect sizes, ranging from *d* = 1.11 for weight concern, to *d* = 1.79 for eating concern. Attending the treatment caused no reduction in BMI, but the level of general psychological distress decreased significantly (*d* = 0.67*),* and the quality of life increased (*d* = 0.41*)*.

Table 3. Changes in eating-related, affective, and functional symptoms from baseline to post-treatment (*N*=111)

Variable	Baseline	Post-treatment	Effect size	95% CI	*p*-value
	mean (*SD*)				
EDE- Binge eating frequency (days) previous 28 days, mean, (SD)	16.85 (8.17)	2.43 (6.03)	2.00	-2.46; -1.55	<0.001
EDE - Global score	3.69 (1.16)	1.46 (1.21)	1.88	-2.33; -1.44	<0.001
EDE – Dietary restraint	2.11 (1.38)	0.42 (0.78)	1.50	-1.93; -1.09	<0.001
EDE - Eating concern	3.34 (1.41)	0.97 (1.24)	1.79	-2.23; -1.35	<0.001
EDE - Weight concern	4.75 (2.95)	2.08 (1.71)	1.11	-1.51; -0.71	<0.001
EDE - Shape concern	4.56 (1.15)	2.45 (1.87)	1.30	-1.77; -0.95	<0.001
SDS – Sum score	11.91 (8.44)	9.17 (16.01)	0.21	-0.59; 0.16	0.24
SCL-90R, GSI-score	1.18 (0.62)	0.74 (0.70)	0.67	-1.05; -0.28	0.004
WHO-5-score	37.26 (19.85)	47.93 (30.85)	0.41	0.04; 0.79	0.048
BMI (kg/m2)	41.66 (8.24)	43.31 (8.19)	0.20	-0.17; 0.57	0.16

DISCUSSION

In this study, we aimed to evaluate the effectiveness of an I-SN treatment for adult patients with BED in an outpatient ED unit in Denmark. Effectiveness was evaluated in terms of recovery from BED and severity of ED symptomatology, general psychological distress, level of psychosocial functioning, weight management, and quality of life. The sample resembled participants included in other clinical trials in terms of age range, gender ratio, comorbidity, BED duration, and childhood trauma and abuse (Linardon, 2018; Welch et al., 2016). Results showed a completion rate of 74 %, which is lower than reported in RCTs for CBT (88.3 %) (Peterson, Mitchell, Crow, Crosby, & Wonderlich, 2009) and IPT (93 %) (D. E. Wilfley et al., 2002), but high compared to the generally high dropout rates found in naturalistic studies of ED outpatients (29 % to 73 %) (Fassino, Pierò, Tomba, & Abbate-Daga, 2009). Dakanalis et al. reported higher and equal completion rate across all severity groups (mild: 98.5 %, moderate: 97.1 %, severe: 90.3 % and extreme: 93.3 %) (Dakanalis et al., 2017) In the present study, the severe group turned out to have the lowest completion rate (64 %) but the highest recovery rate (71.9 %) among those who completed treatment.

Recovery

More than half of the full sample (55 %) reached full recovery, indicating an effect of I-SN for adults with BED. Compared to other studies and RCTs of clinician-led group psychotherapy with the same definition and assessment of recovery as this study, our study showed a recovery rate well within the range of CBT (Linardon, 2018); 41 % (Munsch et al., 2007); 44.4 % (Grilo, Masheb, Wilson,

Gueorguieva, & White, 2011); 48.9 % (Tasca et al., 2006); 51.7 % (Peterson et al., 2009); 63.3 % (Dingemans, Spinhoven, & van Furth, 2007); 79 % (D. E. Wilfley et al., 2002), but lower than DBT, 64 % (Safer & Jo, 2010), and IPT, 73 % (D. E. Wilfley et al., 2002).

In contrast to a severity-dependent treatment response as found in the study of CBT by Dakanalis et al. (mild, 98.5 %, moderate, 66.7 %, severe, 38.7 %, and extreme, 6.7 %) (Dakanalis et al., 2017), the present study showed more consistent recovery rates across severity groups (mild, 62.3%, moderate, 50 %, severe 59.6%, and extreme, 48 %). This finding could indicate that I-SN is more effective than CBT with more severely ill BED-patients.

Reduction in BE and related symptoms

The outcomes of the present study were at least similar to well-established psychotherapeutic approaches for BED. There were significant improvements in both BE and general ED psychopathology post-treatment with large effect sizes (Cohen's *d*). Compared to a meta-analysis conducted by Vocks et al. (2010), the effect sizes were higher in our study - both in reduction of days with BE and in the EDE sub-scales (dietary restraint and eating, weight-, and shape concerns). Meyer et al. compared to Vocks et al. (2010) in terms of effect sizes: Days with BE, d =2.00 / 1.81; Dietary restraint, d = 1.50 / 0.36; Eating concern, for, d = 1.79 / 1.34; Weight concern, d = 1.11 / 0.98; Shape concern d = 1.30 / 1.10.

The Davidsen et al. (Davidsen et al., 2017) RCT of I-SN for a transdiagnostic ED sample found overall reductions in eating behavior and psychopathology similar to the present study. Exceptions were SDS global scores where the present study had a non-significant reduction, possibly due to the high number of missing observations. Conversely, we found a larger reduction than the Davidsen study in the

EDE global score, which could be due to the fact that treatment of BED patients may generally yield larger effect sizes than treatment of other EDs. Thus, two meta-analyses evaluating abstinence rates in BN (Linardon & Wade, 2018) and BED treatments (Linardon, 2018) found better overall response to treatment for BED patients.

Changes in weight

Like other psychotherapy interventions for BED (Vocks et al., 2010), we found a slight, but non-significant, increase in weight despite significant reductions in BE and weight and shape concerns. This indicates that recovery from BED is independent of weight reduction. Since BED patients often have a steep weight trajectory leading up to treatment (Barnes, Blomquist, & Grilo, 2011) and the long-term results of weight loss treatments in the general population are typically poor (Mann et al., 2007), it may be fair to reconsider if weight loss should remain a treatment focus and, consequently, if BMI is a meaningful outcome measure.

Core aspects of the I-SN treatment resemble elements in the CBT-E and IPT models of BED treatment; normalizing eating patterns, addressing interpersonal difficulties, as well as common factors of therapy such as disclosure and validation by peers. What was unique to the I-SN was the therapeutic stance towards problems (the patient is not the problem; the problem is the problem) and the deliberate therapeutic aim of deconstructing oppressive discourses. As weight stigma is negatively associated with eating (Araiza & Wellman, 2017), physical movement (Vartanian & Shaprow, 2008), weight loss (Wott & Carels, 2010), and overall health and well-being (Puhl & Suh, 2015), a treatment that successfully addresses societal and relational issues concerning weight may lead to overall increases in health. Two

qualitative studies of the I-SN treatment in BED, that included the same patients as this study, found that the patients' experiences of recovery were associated with increased acceptance by self and others irrespective of weight (L. B. Meyer, Waaddegaard, Lau, & Tjørnhøj-Thomsen, 2018; L. Meyer, Waaddegaard, Lau, & Tjørnhøj-Thomsen, n.d.). All in all, addressing overvaluation of shape and weight along with issues pertaining to weight stigma could prove to be a productive road to increase BED recovery.

Strengths and limitations

There are several strengths to this study. First, the inclusion of a sample that varied in age, gender, BMI, and severity level, is an advantage in terms of the clinical relevance of the study, i.e. the naturalistic features of this study resemble real clinical practice. Secondly, we used absolute abstinence from binge eating as the primary outcome, which can be considered the most desirable outcome, since binge eating is one of the core symptoms of BED. A benefit of the within-group analysis is that it provided an absolute recovery percentage rather than odds or risk ratios which is useful for practitioners and policy makers (Linardon, 2018).

These results, however, need to be considered in the context of certain limitations. Most significantly, the present study was not randomized and did not include a control group. Due to a Danish law ensuring a short waiting period for psychiatric outpatient treatment, it was not possible to use waiting list patients as controls. Thus, the recovery from BED cannot be directly attributed to the intervention, and it is possible that the obtained outcomes were due to other factors such as the group environment or

expectancy effects. Furthermore, as symptoms were measured directly after the intervention, the present study provides no indication of the long-term impact of the intervention on ED symptoms or weight.

Despite attempts to keep the EDE-assessors blinded, this was not possible in the clinical context of this study as patients clearly exhibited treatment experience in the post-treatment EDE interviews. Patients received varying amounts of body therapy, social network interventions, and individual counseling. Larger scale, controlled studies are needed to clarify the relative impact of the individual interventions on the overall outcome and to determine what characterizes patients who do or do not benefit.

Despite the notable limitations, the study provides promising evidence for the effectiveness of an I-SN treatment for BED, particularly for those with severe and extreme levels of BED who are found to benefit the least from standard treatments such as CBT.

CONCLUSION

The study provides preliminary support for the effectiveness of a 25-week integrative systemic and narrative group intervention for patients with BED and BMI > 27. This is evident in the high recovery and remission rates, the significant reduction of binge-eating and improved general and BED psychopathology, and quality of life from baseline to post-treatment. The completion and recovery rates found in the present study were comparable to findings reported elsewhere on controlled studies of BED treatment (Linardon, 2018). Overall, the findings suggested benefits of an integrative systemic and narrative group psychotherapy for the treatment of BED that included nutritional counseling, psychoeducation, mind-body interventions, and inclusion of the support network. I-SN treatment has a

particular focus on social, relational and contextual factors which are rarely attended to in other psychotherapy treatments (Holmes, 2017).

By actively involving society and the surrounding network in the description and alleviation of problems, I-SN constitutes a contextual approach that mirrors clinical practice and lived lives. Focusing on social and relational factors rather than individual deficits may give inspiration to more holistic BED treatment models and new views on pathways for changes, and even raise questions about which outcome measures reflect BED recovery the best.

REFERENCES

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders: DSM-IV*. Washington, DC: American Psychiatric Association.

American Psychiatric Association (Ed.). (2013). *Diagnostic and statistical manual of mental disorders: DSM-5* (5th ed). Washington, D.C: American Psychiatric Association.

Andersen, T. (1987). The reflecting team: Dialogue and meta-dialogue in clinical work. *Family Process*, *26*(4), 415–428. https://doi.org/10.1111/j.1545-5300.1987.00415.x

Araiza, A. M., & Wellman, J. D. (2017). Weight stigma predicts inhibitory control and food selection in response to the salience of weight discrimination. *Appetite*, *114*, 382–390. https://doi.org/10.1016/j.appet.2017.04.009

Asen, E. (2002). Multiple family therapy: An overview. *Journal of Family Therapy*, *24*(1), 3–16.

Barnes, R. D., Blomquist, & Grilo. (2011). Exploring pretreatment weight trajectories in obese patients with binge eating disorder. *Comprehensive Psychiatry*, *52*(3), 312–318. https://doi.org/10.1016/j.comppsych.2010.06.011

Bech, P. (2004). Measuring the Dimension of Psychological General Well-Being by WHO-5. *Quality of Life Newsletter*, *32*, 15–16.

Bech, P., Austin, S. F., & Lau, M. E. (2018). Patient reported outcome measures (PROMs): examination of the psychometric properties of two measures for burden of symptoms and quality of life in patients with depression or anxiety. *Nordic Journal of Psychiatry*, *72*(4), 251–258. https://doi.org/10.1080/08039488.2018.1451918

Clausen, L., & Rokkedal, K. (2010). Assessment measures in eating disorders [Danish: Undersøgelsesinstrumenter ved spiseforstyrrelser]. In S. Lunn, K. Rokkedal, & B. Rosenbaum (Eds.),

Eating disorders illustrated clinically and culturally [Danish: Fråsog faste Spiseforstyrrelser i klinisk og kulturel belysning]. (pp. 491–505). Virum: Dansk psykologisk Forlag.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed). Hillsdale, N.J: L. Erlbaum Associates.

Culbert, K. M., Racine, S. E., & Klump, K. L. (2015). Research Review: What we have learned about the causes of eating disorders - a synthesis of sociocultural, psychological, and biological research. *Journal of Child Psychology and Psychiatry*, *56*(11), 1141–1164. https://doi.org/10.1111/jcpp.12441

Dakanalis, A., Colmegna, F., Riva, G., & Clerici, M. (2017). Validity and utility of the DSM-5 severity specifier for binge-eating disorder: DAKANALIS et al. *International Journal of Eating Disorders*, *50*(8), 917–923. https://doi.org/10.1002/eat.22696

Danish Health Authority. (2005). *Eating Disorders: Recommendations for organisations adn treatment [Iin Danish: Spiseforstyrrelser: Anbefalinger for organisation og behandling]*. København: Sundhedsstyrelsen.

Davidsen, A. H., Poulsen, S., Lindschou, J., Winkel, P., Tróndarson, M. F., Waaddegaard, M., & Lau, M. (2017). Feedback in group psychotherapy for eating disorders: A randomized clinical trial. *Journal of Consulting and Clinical Psychology*, *85*(5), 484–494. https://doi.org/10.1037/ccp0000173

Derogatis, L. R., Lipman, R. S., & Covi, L. (1973). SCL-90: An Outpatient Psychiatric Rating Scale - Preliminary Report. *Psychopharmacological Bulletin*, *9*, 13–28.

Derogatis, L. R., Rickels, K., & Rock, A. F. (1976). The SCL-90 and the MMPI: a step in the validation of a new self-report scale. *The British Journal of Psychiatry*, *128*(3), 280–289.

Dingemans, A. E., Spinhoven, P., & van Furth, E. F. (2007). Predictors and mediators of treatment outcome in patients with binge eating disorder. *Behaviour Research and Therapy*, *45*(11), 2551–2562. https://doi.org/10.1016/j.brat.2007.06.003

Durso, L., Latner, J. D., White, M. A., Masheb, R. M., Blomquist, K. K., Morgan, P. T., & Grilo, C. M. (2012). Internalized weight bias in obese patients with binge eating disorder: Associations with eating disturbances and psychological functioning: Internalized Weight Bias in Bed. *International Journal of Eating Disorders*, *45*(3), 423–427. https://doi.org/10.1002/eat.20933

Fairburn, Cooper, Z., & O'Connor, M. (2008). Eating Disorder Examination (16.0D). In *Cognitive Behavior Therapy and Eating Disorders.* Guilford Press.

Fairburn, Cooper, Z., Shafran, R., Bohn, K., Hawker, D., Murphy, R., & Straebler, S. (2008). Enhanced cognitive behavior therapy for eating disorders: the core protocol. In *Cognitive behavior therapy and eating disorders* (pp. 45–193). New York: Guilford Press.

Fassino, S., Pierò, A., Tomba, E., & Abbate-Daga, G. (2009). Factors associated with dropout from treatment for eating disorders: a comprehensive literature review. *BMC Psychiatry*, *9*(1). https://doi.org/10.1186/1471-244X-9-67

Fischer, S., Meyer, A. H., Dremmel, D., Schlup, B., & Munsch, S. (2014). Short-term Cognitive-Behavioral Therapy for Binge Eating Disorder: Long-term efficacy and predictors of long-term treatment success. *Behaviour Research and Therapy*, *58*, 36–42. https://doi.org/10.1016/j.brat.2014.04.007

Grenon, R., Carlucci, S., Brugnera, A., Schwartze, D., Hammond, N., Ivanova, I., … Tasca, G. A. (2018). Psychotherapy for eating disorders: A meta-analysis of direct comparisons. *Psychotherapy Research*, 1–13. https://doi.org/10.1080/10503307.2018.1489162

Grilo, C., Masheb, R. M., Wilson, G. T., Gueorguieva, R., & White, M. A. (2011). Cognitive–behavioral therapy, behavioral weight loss, and sequential treatment for obese patients with binge-eating disorder: A randomized controlled trial. *Journal of Consulting and Clinical Psychology*, *79*(5), 675–685. https://doi.org/10.1037/a0025049

Grilo, C., White, M. A., & Masheb, R. M. (2009). DSM-IV Psychiatric Disorder Comorbidity and Its Correlates in Binge Eating Disorder. *The International Journal of Eating Disorders*, *42*(3), 228. https://doi.org/10.1002/eat.20599

Holmes, S. (2017). The role of sociocultural perspectives in eating disorder treatment: A study of health professionals. *Health:*, 136345931771577. https://doi.org/10.1177/1363459317715778

Hudson, J. I., Hiripi, Pope, & Kessler. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. *Biological Psychiatry*, *61*(3), 348–358. https://doi.org/10.1016/j.biopsych.2006.03.040

Jackson, J. B., Pietrabissa, G., Rossi, A., Manzoni, G. M., & Castelnuovo, G. (2018). Brief strategic therapy and cognitive behavioral therapy for women with binge eating disorder and comorbid obesity: A randomized clinical trial one-year follow-up. *Journal of Consulting and Clinical Psychology*, *86*(8), 688. https://doi.org/10.1037/ccp0000313

Javaras, K. N., Pope, H. G., Lalonde, J. K., Roberts, J. L., Nillni, Y. I., Laird, N. M., … Hudson, J. I. (2008). Co-occurrence of binge eating disorder with psychiatric and medical disorders. *The Journal of Clinical Psychiatry*, *69*(2), 266–273.

Jørring, N. T., & Gjessing-Jensen, K. (2018). Treatment efficacy of narrative family therapy for children and adolescents with diverse psychiatric symptomatology. *Scandinavian Journal of Child and Adolescent Psychiatry and Psychology*, *6*, 1–8. https://doi.org/10.21307/sjcapp-2018-012

Kessler, R. C., Berglund, Chiu, Deitz, Hudson, Shahly, … Xavier. (2013). The Prevalence and Correlates of Binge Eating Disorder in the World Health Organization World Mental Health Surveys. *Biological Psychiatry*. https://doi.org/10.1016/j.biopsych.2012.11.020

Linardon, J. (2018). Rates of abstinence following psychological or behavioral treatments for binge-eating disorder: Meta-analysis. *International Journal of Eating Disorders*. https://doi.org/10.1002/eat.22897

Linardon, J., & Wade, T. D. (2018). How many individuals achieve symptom abstinence following psychological treatments for bulimia nervosa? A meta-analytic review. *International Journal of Eating Disorders*. https://doi.org/10.1002/eat.22838

Mann, T., Tomiyama, Westling, Lew, Samuels, & Chatman. (2007). Medicare's search for effective obesity treatments: Diets are not the answer. *American Psychologist*, *62*(3), 220–233. https://doi.org/10.1037/0003-066X.62.3.220

McDowell, I. (2010). Measures of self-perceived well-being. *Journal of Psychosomatic Research*, *69*(1), 69–79. https://doi.org/10.1016/j.jpsychores.2009.07.002

Mensinger, J. L., Calogero, & Tylka. (2016). Internalized weight stigma moderates eating behavior outcomes in women with high BMI participating in a healthy living program. *Appetite*, *102*, 32–43. https://doi.org/10.1016/j.appet.2016.01.033

Meyer, L. B., Waaddegaard, M., Lau, M. E., & Tjørnhøj-Thomsen, T. (2018). (Dis-)solving the Weight Problem in Binge-Eating Disorder: Systemic Insights From Three Treatment Contexts With Weight Stability, Weight Loss, and Weight Acceptance. *Qualitative Health Research*, 104973231876487. https://doi.org/10.1177/1049732318764874

Meyer, L., Waaddegaard, M., Lau, M. E., & Tjørnhøj-Thomsen. (n.d.). Reconnecting in Dialogical Spaces: How an Integrative Systemic and Narrative Group Intervention for Binge-Eating Disorder helps Patients Reconnect with Themselves and Other People. *Unpublished Manuscript*.

Munsch, S., Biedert, E., Meyer, A., Michael, T., Schlup, B., Tuch, A., & Margraf, J. (2007). A randomized comparison of cognitive behavioral therapy and behavioral weight loss treatment for overweight individuals with binge eating disorder. *International Journal of Eating Disorders*, *40*(2), 102–113. https://doi.org/10.1002/eat.20350

Pearl, R. L., White, M. A., & Grilo, C. M. (2014). Overvaluation of shape and weight as a mediator between self-esteem and weight bias internalization among patients with binge eating disorder. *Eating Behaviors*, *15*(2), 259–261.

Peterson, C. B., Mitchell, J. E., Crow, S. J., Crosby, R. D., & Wonderlich, S. A. (2009). The Efficacy of Self-Help Group Treatment and Therapist-Led Group Treatment for Binge Eating Disorder. *American Journal of Psychiatry*, *166*(12), 1347–1354. https://doi.org/10.1176/appi.ajp.2009.09030345

Puhl, R., & Heuer, C. (2009). The Stigma of Obesity: A Review and Update. *Obesity*, *17*(5), 941–964. https://doi.org/10.1038/oby.2008.636

Puhl, R., & Suh, Y. (2015). Health Consequences of Weight Stigma: Implications for Obesity Prevention and Treatment. *Current Obesity Reports*, *4*(2), 182–190. https://doi.org/10.1007/s13679-015-0153-z

Safer, D. L., & Jo, B. (2010). Outcome from a randomized controlled trial of group therapy for binge eating disorder: comparing dialectical behavior therapy adapted for binge eating to an active comparison group therapy. *Behavior Therapy*, *41*(1), 106–120.

Sheehan, Harnett-Sheehan, K., & Raj, B. (1996). The measurement of disability. *Int Clin Psychopharmacol*, *11*(3), 98–95.

Sheehan, K. H., & Sheehan, D. V. (2008). Assessing treatment effects in clinical trials with the Discan metric of the Sheehan Disability Scale. *International Clinical Psychopharmacology*, *2008*, 70–83.

Sheehan, Lecrubier, Sheehan, Amorim, P., Janavs, Weiller, E., … Dunbar, G. C. (1998). The Mini-International Neuropsychiatric Interview (M.I.N.I.): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *The Journal of Clinical Psychiatry*, *59 Suppl 20*, 22-33;quiz 34-57.

Shomaker, L. B., Tanofsky-Kraff, M., Matherne, C. E., Mehari, R. D., Olsen, C. H., Marwitz, S. E., … Yanovski, J. A. (2017). A randomized, comparative pilot trial of family-based interpersonal psychotherapy for reducing

psychosocial symptoms, disordered-eating, and excess weight gain in at-risk preadolescents with loss-of-control-eating. *International Journal of Eating Disorders*. https://doi.org/10.1002/eat.22741

Tasca, G. A., Ritchie, K., Conrad, G., Balfour, L., Gayton, J., Lybanon, V., & Bissada, H. (2006). Attachment scales predict outcome in a randomized controlled trial of two group therapies for binge eating disorder: An aptitude by treatment interaction. *Psychotherapy Research*, *16*(1), 106–121. https://doi.org/10.1080/10503300500090928

Tomiyama, A. J., Carr, D., Granberg, E. M., Major, B., Robinson, E., Sutin, A. R., & Brewis, A. (2018). How and why weight stigma drives the obesity 'epidemic' and harms health. *BMC Medicine*, *16*(1). https://doi.org/10.1186/s12916-018-1116-5

Vartanian, L. R., & Shaprow. (2008). Effects of Weight Stigma on Exercise Motivation and Behavior: A Preliminary Investigation among College-aged Females. *Journal of Health Psychology*, *13*(1), 131–138. https://doi.org/10.1177/1359105307084318

Vocks, S., Tuschen-Caffier, Pietrowsky, Rustenbach, Kersting, & Herpertz. (2010). Meta-analysis of the effectiveness of psychological and pharmacological treatments for binge eating disorder. *International Journal of Eating Disorders*, NA-NA. https://doi.org/10.1002/eat.20696

von Sydow, K., Beher, S., Schweitzer, J., & Retzlaff, R. (2010). The Efficacy of Systemic Therapy With Adult Patients: A Meta-Content Analysis of 38 Randomized Controlled Trials. *Family Process*, *49*(4), 457–485. https://doi.org/10.1111/j.1545-5300.2010.01334.x

von Sydow, K., Retzlaff, R., Beher, S., Haun, M. W., & Schweitzer, J. (2013). The Efficacy of Systemic Therapy for Childhood and Adolescent Externalizing Disorders: A Systematic Review of 47 RCT. *Family Process*, *52*(4), 576–618. https://doi.org/10.1111/famp.12047

Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K., & Ahn, H. (1997). *A Meta-Analysis of Outcome Studies Comparing Bona Fide Psychotherapies: Empirically, "All Must Have Prizes."* 13.

Watzlawick, P., Weakland, & Fisch. (1974). *Change: Principles of Problem Formation and Problem Resolution*.

Welch, E., Jangmo, A., Thornton, L. M., Norring, C., von Hausswolff-Juhlin, Y., Herman, B. K., … Bulik, C. M. (2016). Treatment-seeking patients with binge-eating disorder in the Swedish national registers: clinical course and psychiatric comorbidity. *BMC Psychiatry*, *16*(1). https://doi.org/10.1186/s12888-016-0840-7

White, M. (2007). *Maps of narrative practice* (1st ed). New York: W.W. Norton & Co.

Wilfley, D. E., Welch, R. R., Stein, R. I., Spurrell, E. B., Cohen, L. R., Saelens, B. E., … Matt, G. E. (2002). A Randomized Comparison of Group Cognitive-Behavioral Therapy and Group Interpersonal Psychotherapy for the Treatment of Overweight Individuals With Binge-Eating Disorder. *Archives of General Psychiatry*, *59*(8), 713. https://doi.org/10.1001/archpsyc.59.8.713

Wilfley, D., Frank, M., Welch, R., Spurrell, E., & Rounsaville, B. (1998). Adapting Interpersonal Psychotherapy to a Group Format (IPT-G) for Binge Eating Disorder: Toward A Model for Adapting Empirically Supported Treatments. *Psychotherapy Research*, *8*(4), 379–391. https://doi.org/10.1080/10503309812331332477

Wott, C. B., & Carels, R. A. (2010). Overt Weight Stigma, Psychological Distress and Weight Loss Treatment Outcomes. *Journal of Health Psychology*, *15*(4), 608–614. https://doi.org/10.1177/1359105309355339