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Expectations of a new eating disorder treatment and its delivery: Perspectives of patients and new therapists

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Abstract

Background: A significant number of people with bulimia nervosa (BN) or binge-eating disorder (BED) do not seek professional help. Important reasons include limited knowledge of eating disorders (EDs), feelings of shame, treatment costs, and restricted access to specialized healthcare. In this study, we explored if a novel therapy delivered in a primary care setting could overcome these barriers. We investigated factors such as motivation and expectations and included the patients' and newly trained therapists' perspectives.

Method: We interviewed 10 women with BN ($n = 2$) or BED ($n = 8$), enrolled in the Physical Exercise and Dietary therapy (PED-t) program, in a Healthy Life Center (HLC) located in a primary healthcare facility. Interview topics discussed were motivations for and expectations of therapy, and the treatment location. In addition, 10 therapists from HLC's were interviewed on their experiences with the PED-t training program and expectations of running PED-t within their service. The semi-structured interviews were analyzed using reflexive thematic analysis.

Results: Most patients had limited knowledge about EDs and first realized the need for professional help after learning about PED-t. Patients exhibited strong motivations for treatment and a positive perception of both the PED-t, the new treatment setting, and the therapists' competencies. The therapists, following a brief training program, felt confident in their abilities to treat EDs and provide PED-t. With minor operational adjustments, PED-t can seamlessly be integrated into national HLC service locations.

Conclusion: PED-t is an accessible therapeutic service that can be delivered in a primary care environment in a stepped-care therapy model.

Public Significance: This study investigates the views and experiences of patients and newly trained therapists of PED-t (Physical Exercise and Dietary therapy), a new program-led primary care therapy for binge-eating spectrum eating disorders. The treatment and the locations for the intervention, that is, local health care centers, were found to be highly acceptable to both patients and therapists, thus PED-t could easily be integrated as a first step into a step-care delivery model.

KEYWORDS
acceptability, binge-eating disorder, bulimia nervosa, eating disorders, expectations, healthy life center, motivation, PED-t, therapy, treatment seeking

1 | INTRODUCTION

Only one in five people with an eating disorder (EDs) seek professional treatment (Mond et al., 2007; Stokke et al., 2022). Reasons for this include limited capacity in specialized healthcare and limited knowledge of ED among health professionals (Ali et al., 2017, 2020; Regan et al., 2017). In addition, there are personal or psychological barriers to pursuing treatment, such as shame and an underestimation of the need for treatment (Ali et al., 2017, 2020; Regan et al., 2017). Moreover, access to ED treatment may be hindered by the fact that many individuals with EDs, such as those on the binge-eating spectrum (i.e., bulimia nervosa [BN] or binge-eating disorder [BED]), are more likely to consult health professionals for weight management than addressing their ED (Hart et al., 2011). The severity of ED pathology and the presence of purging behavior are identified as important facilitators for seeking treatment (Carrino et al., 2023; Regan et al., 2017). This may partly explain why people with BED seek treatment less frequently than those with other ED diagnoses (Ali et al., 2017, 2020). In addition, non-ED-related barriers to seeking ED treatment include cultural or socioeconomical factors, specifically reduced financial capacity and lack of knowledge on effective or available treatments (Regan et al., 2017).

We previously described Physical Exercise and Dietary Therapy (PED-t) as an acceptable and effective new treatment for EDs within the binge-eating spectrum (Bakland et al., 2019; Mathisen et al., 2020), including a beneficial effect on compulsive exercise (Mathisen et al., 2018). This treatment relies on professionally supervised and progressive resistance training, that is, an exercise program designed to increase maximal muscle strength by progressively adding resistance (external load) at regular intervals. The dietary treatment module focuses on improving eating behaviors, provides psychoeducation on nutrition, and invites participants to reflect on and discuss helpful or triggering aspects, and how their emotions affect their eating practices and behaviors (Mathisen et al., 2017, 2020). We also found that participants, who received PED-t, had high treatment motivation and expectations with the treatment (Pettersen et al., 2019) as well as positive experiences after completing it (Bakland et al., 2019; Pettersen et al., 2017). However, these findings may have been biased. For instance, participants' expectations were highly influenced by their admiration of the prestigious research university and its staff members where the treatment was conducted (Pettersen et al., 2019). In addition, findings may have been impacted by recall biases and treatment experiences, as the interviews were conducted retrospectively. Hence, the findings may not be necessarily transferrable or generalizable when transitioning PED-t from a research environment to a clinical application.

Healthy Life Centers (HLCs) are locally organized units that are part of the primary healthcare services in Norwegian municipalities. They are staffed by health professionals, such as exercise physiologists, dietitians, nurses, and physiotherapists. Residents often self-refer and are typically offered group-based activities that are focused on improving health and lifestyle, prevention of illness (improving diet, increasing physical activity, smoking cessation), and stress reduction. An HLC is a low-threshold service, affordable for most, socially accepted due to Norway's cultural appreciation of healthy living, and based on health service aspects that are arguably among the core interests of people with EDs (Hart et al., 2011; Mond et al., 2007). Therefore, HCL may be a suitable venue for providing eating disorder treatment like PED-t.

New therapies and delivery settings may have the potential to circumvent some of the challenges with identifying EDs and providing access to treatment. Thus, we aimed to explore the motivations for and expectations with PED-t in patients with BED or BN, as well as assess their opinions on the new setting for treatment at the HLC. In addition, we explored the expectations and readiness of HLC therapists who were trained in EDs and PED-t and their abilities to accept this new group of patients and treatment options into their service.

2 | METHOD

2.1 | Study context

This qualitative study was conducted as an implementation study design where the overall aim was to assess the acceptability, feasibility, and effectiveness of PED-t when it is used in a healthcare setting (the HLC), (Mathisen et al., 2023). Women with a diagnosis of BN or BED and between the ages of 18–40 years were included in this study. Pregnant women, those with manifested comorbid personality disorders or substance abuse, those outside the BMI range of 17.5–34.0 kg/m^2, and/or were competing athletes, were excluded from the study (Mathisen et al., 2020, 2023).

PED-t is run in a group format of 8–10 participants over 20 weekly sessions for 4 months. Each therapy session consists of a supervised exercise session and a dietary psychoeducational session including participants discussions. (Mathisen et al., 2017, 2020, 2023) (see supplementary file 3 for details).

2.2 | Participants recruited for the study

Patients were recruited to PED-t ($n = 10$) at one HLC location in 2021 (Mathisen et al., 2023), and were asked verbally or in writing whether they were willing to be interviewed before therapy about their motivations for and expectations of the treatment. All consented to participate.

The therapists ($n = 5$) from the HLC included in the study were trained in ED and PED-t. In addition, therapists in 10 HLCs that were designated by the authorities as research centers, were also invited to participate in the training. In total three additional HLCs, including 16 therapists, accepted participation. A total of 10 therapists provided informed consent to participate in interviews after training, on their readiness and expectations with opening their service to the new patient subgroup and treatment program (two therapists consented to be interviewed together).

2.3 | Ethical considerations

The project, from which this study emanates, was approved by the Norwegian Regional Committee for Medical and Health Research Ethics (REK) (ID no. June 25, 2019, reference number 2019/552 REK South-East B). In July 2019, it was approved according to GDPR by the Norwegian Centre for Research Data (ID no. 389139) and additionally registered in Clinical Trials (ID no. NCT04980781).

2.4 | Interviews

The individual interviews with therapists and patients were semi-structured, based on topic guides (see supplementary files 1 and 2, respectively), and were conducted either in person or digitally via Zoom, before the initiation of therapy. The mean (SD) duration of interviews was 21–25 min for patients and therapists.

2.5 | Analyses

All interviews were recorded and transcribed verbatim and analyzed groupwise with a deductive, semantic, and realistic approach by reflexive thematic analyses (Braun & Clarke, 2006, 2019). Following the suggested six steps in such an analytical procedure, the first author transcribed and familiarized herself with the data, generated initial data codes, identified, and reviewed themes by collated codes, named themes, and produced the final analytical report. The participants in the interviews were a convenience sample rather than a sample based on unlimited access to informants. Nevertheless, the authors were assured that the data collected had reached saturation during the evaluation period when generating codes and themes. During the final stage, rich extracts were chosen for the illustration of themes, and finally, a second author (GP) read the interviews and checked the allocation to the themes to ensure reliability (i.e., consistency and agreement). Through a collaborative, consensual, and iterative analytic process, we identified what we perceived as the most illustrative quotes to represent the themes. The findings are presented groupwise (patients and therapists, respectively) in the results, but discussed collectively to harness the potential for a more comprehensive understanding of the results.

3 | RESULTS

Demographic details of patients are given in Table 1. Participating therapists were five MSc exercise physiologists, four physiotherapists, and one dietitian. All but one therapist was female. All therapists and patients were Nordic by ethnicity.

3.1 | Interviews with PED-t participants

Following the analysis, three themes were identified from the interviews with the patients, that is, "To be recognized for the suffering," "lowering the barriers," and "aiming for coping tools and symptom reduction".

3.1.1 | To be recognized for the suffering

The sentiment most expressed by patients towards PED-t and the HLC was a feeling of being acknowledged for their ED. Most of the participants had never sought or received treatment for their ED. They said this resulted from a lack of understanding that their struggles with food consumption, emotional eating, thoughts about exercise, or difficulties with body weight reduction were caused by an ED, and not due to low self-discipline. In addition, many patients had found little ED knowledge among health personnel, as none had been presented with a possible diagnosis of ED or were offered any treatment options. Participants highlighted that the recruitment text, describing bulimic symptoms, had been an eye opener and contributed to their motivation to seek treatment at the HLC. They referred to the recruitment text as very informative, hence, vouching for the HLC's trustworthiness.

> The first thing I experienced [when reading the advertisement/recruitment text], was an enlightening moment. The advertisement spoke right to me and went straight to my head and heart at once, and that is something very different compared to what I have experienced previously. And this felt right, just like…

TABLE 1 Demographic details of patients.

	Patients ($n = 10$)
Patient age, years	32.9 (5.2)
Patients EDE-Q, global score	3.6 (1.0)
Patients self-reported the duration of illness, years	14.3 (8.3)
Patients with BN, *n* (%)	4 (40%)
Patients with BED, *n* (%)	6 (60%)

Note: Numbers are mean (standard deviation) or number (percentage) as indicated. EDE-Q, Eating Disorder Examination Questionnaire (Fairburn & Beglin, 2008); BN, bulimia nervosa; BED, binge-eating disorder.

> you know, it's like when you fall in love, you just feel it. That it's this. This is what I'm going to do.
>
> Woman with BED, 39 years.

Because the participants with a BED-diagnosis had been unaware of their condition, they had blamed themselves for their lack of motivation and inability to make sustained behavioral changes. Such feelings of shame and hopelessness were affirmed in meetings with their general practitioner (GP), as the participants said GPs only suggested help with weight management. Whether the GPs were aware of the underlying diagnosis or not, is not known.

> I haven't received any treatment, and no, I haven't requested it either, except for the fact that I've talked to the doctor about it and been told, "Yes, but I believe in you, you can do it!" …with a pat on the shoulder as well.
>
> Woman with BED, 22 years.

3.1.2 | Lowering the barriers

Practical and mental barriers to seeking treatment were evident when patients talked about the beneficial aspects of the HLC. Accessing PED-t in the local HLC was seen as making therapy accessible. This was deemed crucial for this group of adult women trying to juggle treatment with their other responsibilities, such as work and family obligations. Another important statement was the need to destigmatize the treatment of a mental disorder. The women expressed that the PED-t reduced their stress levels as they realized they had an illness and needed professional help. Having psychotherapy as the only option in a specialized healthcare service was seen as a barrier for treatment seeking due to the perception of it being a medical intervention and thus provoked fear in some to further pursue. One participant spoke of her motivation for accessing PED-t in an HLC, rather than being treated in a specialist center when she finally realized that she had an illness:

> I think it is…about making it less serious. That you feel kind of ill in a healthier way, and that you do not feel so categorized, perhaps. To me at least, it feels more suitable this way… because you do realize that it is about your mental health, but… It is much scarier, the alternative [psychotherapy].
>
> Woman with BED, 39 years.

3.1.3 | Aiming for coping tools and symptom reduction

Motivation and expectations of PED-t and the HLC were related to the practical focus of PED-t, as the therapy implemented a step-by-step approach to support behavioral change that did not focus primarily on discussing personal reflections from one's past, and also included an opportunity for physical activity. A shared recognition by most of the women was that they were motivated to try something new, that was different from what they had done previously. For some, there was a desire for an alternative therapy to psychotherapy, while others felt a need to address their long-held negative experiences with physical activity. Finally, some perceived that group therapy could be beneficial as opposed to intimidating.

> Even as I find it very strange to say this, as it contradicts everything I have previously believed, I think it [the PED-t] was the perfect combination—a combination of something physical and theoretical. I'd never imagined that I'd say this, because just thinking of participating in a group setting, and doing something physically with others in a group, is very far from what I've found comfortable. Still, this time it became a part of my motivation.
>
> Woman with BED, 37 years.

Motivation with PED-t and the HLC was related also to participants' hopes for a positive treatment outcome, and in particular, a desire to feel a sense of control and mastery over food intake and physical activity, which are the key aspects of BED which PED-t addresses.

> A good result to me will be that I do not lose control when dining out… because I often do that when I eat, or when I binge-eat or simply eat, because I binge-eat a lot. I actually binge-eat every time I eat, because I have a tight training schedule, and as such I can always compensate with exercise the next day. So, a good result to me, would be that I could rather exercise by pure joy, and not only motivated by guilt.
>
> Woman with BN, 29 years

> I wish that I could better control [my eating]. When I get overwhelmed by emotions, I get this urge to… a craving arises to binge-eat to alleviate the discomfort, and I wish to reduce that impulse. I wish I could experience that urge a little less intense, and that is my main motivation.
>
> Woman with BN, 38 years.

Interestingly, modest hopes regarding treatment outcomes were communicated, as no participant specifically mentioned remission. Five women openly admitted a desire to lose body weight.

> Yes, well what is a good result? The first thing I come to think about, is that I could perhaps lose a little weight, but still—this isn't the main focus.
>
> Woman with BN, 38 years.

Most were not optimistic about achieving remission, especially those who had been marginally aware of having an illness and who had been suffering for a long time, or those who had received treatment earlier but without remission. However, all had expectations for obtaining better control and coping strategies to reduce the frequency or extent of binge-eating episodes.

> I have a few goals on my mind, but related to this specifically [the treatment outcome], my goal is ….to get well. But then I start to think that is too unrealistic, and as such, I think that my goal will be to get a better control of my illness. And that I want to become a better version of myself, both in psychological and physiological terms. (-) Because–I do not know how it is to be completely recovered–I find it difficult to understand when one is defined as recovered. I mean, I have been suffering since I was about 12 years of age.
>
> Woman with BED, 39 years.

3.2 | Interviews with PED-t therapists

Four of ten therapists reported having briefly learned about EDs during their professional studies, one had focused on EDs in her MSc thesis, and one had personal experience with a family member who had an ED. In terms of readiness and expectations to run a new service like PED-t in the HLC, the results from interviews fell into three themes; "enhanced understanding," "theoretically prepared" and "service challenged by diagnoses".

3.2.1 | Enhanced understanding

This theme describes therapists' experiences and learning outcomes from the training program, hence, their readiness to meet new clients in their service. The therapists appreciated that the program concentrated on understanding EDs within the binge-eating spectrum. The combination of self-directed learning (digital and printed learning tools) and workshops was positively acknowledged. All indicated that they had gained substantial knowledge about EDs, much more detailed than expected, and this was something they really felt a need for.

> I previously did not know much about BED, hence, I was not able to identify it among our users. This gives me a kind of shameful feeling, or at least a feeling like; "oh, and we pushed messages about exercise, healthy eating and weight regulation, and then it turns out you actually had an illness you hadn't told us about". So, the training has been a wake-up experience to me [by gaining this knowledge on ED].
>
> Therapist, interview 6
>
> I would definitely say that this training program has made me more confident in working with individuals with EDs. What I might have missed a bit previously in my academic studies is that the education on EDs has been very theoretical. It's like… this is eating disorders, and that's it, whereas here you get a bit more insight into how things work in practice.
>
> Therapist, interview 3.

After being trained in PED-t and EDs, the therapists reflected on what necessary basic competences one needed to benefit from the training and to qualify as a skilled therapist. While participants frequently argued that it was important to have competencies in exercise physiology, all found it important to have experience in leading groups to effectively run the new therapy.

> I think, it is important to have a profession within healthcare, and to have experience in working with individuals that are trying to attain changes in their life, but of course, knowledge about exercise and nutrition is important. And-it is important to have experience in supervising different groups in exercise.
>
> Therapist, interview 6.

Having experience in leading groups of individuals was specifically mentioned as something the HLC therapists would benefit from, as this is a core factor in the services offered in their organization. Being skilled with group therapy is not simply about leading several people in exercise programs or psychoeducation, but rather being able to see each individual's needs while in a group, to allow for all voices and experiences to be heard, and to manage the group dynamics while some participants express their specific difficulties. Overall, the therapists reported an experience of an in-depth training program, which increased their understanding and knowledge about EDs.

3.2.2 | Theoretically prepared

Even though the therapists discussed having acquired an increased understanding of EDs, they also expressed eagerness to gain further practical experience with this patient group to feel more competent.

> I feel very confident after the training, and I think that I will become even more confident when we have started implement the PED-t… As you get to apply your knowledge in practice, then you will gain the necessary experience.
>
> Therapist, interview 5.

Some therapists mentioned they would appreciate more practical experience such as an internship in an established service while a few expressed concern about whether they were competent enough to treat people with EDs after the *theoretical* PED-t training. Finally,

some stated an increase in self-efficacy from the knowledge gained from the training or they utilized their tacit knowledge from previous experiences with different patients.

> My expertise will evolve with each new patient I encounter. While theoretical study provides a foundation, the true refinement comes from real-world consultations. Although I have a solid fundamental understanding, practical experience enhances and refines my skills further.
>
> Therapist, interview 4.

3.2.3 | Service challenged by diagnoses

This theme describes the controversy that emerged when a diagnosis-based service was to be included in a primary healthcare unit that focused on the prevention of illnesses. Some therapists described the strongly held tradition in the HLC of including all individuals in their group activities, irrespective of diagnosis or health status. They spoke of a focus on seeing the individuals behind the symptoms of illness or health challenges, rather than focusing on the exact diagnosis. Still, after the PED-t training, they reported having realized that they have many service users that may have an ED and therefore needed to provide a tailored intervention.

> I find that several come here to reduce weight. They want to change their body…specifically those with a large body and then we address it like "lifestyle and healthy living," but it may be so much more complex. I personally experience this as very challenging; that we have not had any appropriate services or any specific competence to address this [the ED].
>
> Therapist, interview 1.

After being trained in ED and PED-t, the therapists began to find this therapy suitable and well adapted to the needs of persons with EDs within the binge-eating spectrum. They found the psychoeducation and the practical experience with the healthy ways of exercising were important for the patients and perceived it as an effective way of building patients' sense of mastery and self-efficacy. Moreover, they found the "feed forward" focus in PED-t beneficial, that is, helping patients to focus on how to cope with future challenges, rather than focusing on past challenges.

> You [as the participant] kind of say to yourself: "okay, I can do this. I can actually focus on these things," like turning this behavior to something better, without getting lost in what really went wrong in the past, rather, you look forward and focus on "yes, I'm going to do these things, that will be beneficial to me, and improve my health."
>
> Therapist, interview 4.

Because the HLC service is based on a diagnosis-neutral approach, the thought of offering a diagnosis-specific service was perceived as challenging. The therapists were concerned about the demand that such a diagnosis-specific service would make on their operations, like the screening procedure, and the number of staff needed to be involved in one treatment group. Because their services are rooted in the municipality's primary healthcare service, funded by local budgets, many HLC's do not accept patients across municipality borders.

> I find this service [the PED-t] demanding. For example, like here in our service, if we need to be three therapists to run this new service, and if one needs to be skilled in nutrition… We are only two physiotherapists here, and as such I think this concept will demand too much of the service, at least considering how it is run in smaller municipalities.
>
> Therapist, interview 2.

However, the therapists argued a need for cooperation across such borders especially for smaller municipalities if they were to be able to feasibly run this service. They did not foresee such cooperation as difficult to establish as some of their services already had such arrangements.

4 | DISCUSSION

In this study, we aimed to explore the motivation and expectations persons with BN and BED have with PED-t that was implemented at the HLC. Second, we aimed to explore the expectations and readiness of HLC therapists trained to provide PED-t for individuals with EDs as a new group therapy in their health service.

We found that individuals with BN or BED expressed PED-t as trustworthy and they were motivated by the practical and future-oriented focus with PED-t. Further, patients expressed high hopes and expectations for symptom reduction and improved coping and functioning. In parallel, therapists felt competent in delivering the PED-t, after appropriate training, and highlighted the relevance of the approach to the specific patient group. They perceived the PED-t as allowing them to provide a more tailored service offer. Some organizational challenges were also highlighted but primarily related to manpower and financial constraints.

4.1 | PED-t rests on participants' interests and therapists' competence

Based on the present findings, it is evident that patients place trust in ED treatments that are provided outside the conventional clinical setting. In addition, the study suggests that avenues beyond psychotherapy may offer a sense of hope and support. Patients were interested in PED-t because it provided them with an understanding of their coping mechanism (binge-eating) and promised "tools" to better

control impulses to binge-eat. Another important facet was the positive endorsement of meeting at an HLC, rather than at a clinic. By being offered in an accessible primary care setting and with the therapy being focused on socially desirable elements (i.e., healthy eating and regular exercise), patients may have experienced diminished barriers to seeking PED-t.

With regards to the therapists, results from the present study show that the training program equipped them with improved competence, which helped them better understand some of the users they saw utilizing their services. Providing training to healthcare professionals who work with diverse service users, and helping them leverage and build on their existing subject matter competence (here: exercise and nutrition), may have helped them to increase their self-efficacy in acquiring new skills. This is an important aspect when aiming for the efficient and effective implementation of new service offerings. While the PED-t seems similar to the services within the HLC context (i.e., healthy eating courses and exercise groups), it is a more tailored program that is more focused on the cognitive and emotional aspects of people's challenges.

4.2 | Improved ED knowledge in primary healthcare may increase the detection rate

Both participants and therapists possessed limited ED knowledge, which reduced the opportunity for early detection and effective intervention (Ali et al., 2017, 2020; Regan et al., 2017), which could increase the risk of harmful intervention efforts. Also, people with BED often seek treatment due to physical complications, and healthcare practitioners need to be aware of this (Reas, 2017). Through the ED training program, the HLC therapists were given in-depth knowledge not normally offered in the regular professional study programs. This led them to feel more confident and better equipped to properly address ED symptoms in their consultations. This is similar to findings from other studies, where training healthcare professionals in EDs and the treatment they provided improved access to care in community settings (Johnson et al., 2022; Pehlivan et al., 2022). Specifically, studies suggest that upskilling primary care clinicians or health professionals in diagnosis and stepped-care models may help reduce stigmatization, and improve detection rates and treatment access (Pehlivan et al., 2022). Thus, HLC has strong potential for facilitating early detection of people with EDs and subsequent prompt initiation of therapy.

4.3 | Strength and limitations

The strengths of this study are its prospective design and the concurrent evaluation of both therapists' and patients' perspectives of PED-t and its implementation. An important limitation is that the same person who held the training course for therapists also conducted the interviews and analyses on perceived learnings from the course. Such blended roles may have biased the participants to provide more favorable perspectives. However, the interviewer's in-depth knowledge of the training might also have facilitated more in-depth discussions and supported the interpretation of the findings. Importantly, the demographic diversity of the sample is limited, as is typical for the population of Norway. Hence further studies of the acceptability and feasibility of the PED-t should be conducted in more diverse samples, including different genders, ethnicities, and ages.

5 | CONCLUSION

Patients expressed motivation for participating in the PED-t in the local HLC and experienced the treatment venue as positive and the therapists as professional and competent. The therapists felt competent in EDs and the PED-t after a brief training program and saw the PED-t as fitting for their service. As such the PED-t could be an accessible therapy with the potential of being applied further into the primary healthcare environment as the first step in a stepped-care treatment model.

AUTHOR CONTRIBUTIONS

Therese Fostervold Mathisen: Conceptualization; data curation; formal analysis; funding acquisition; investigation; methodology; project administration; software; validation; writing – original draft; writing – review and editing. **Gunn Pettersen:** Conceptualization; investigation; methodology; writing – review and editing. **Jan H. Rosenvinge:** Conceptualization; writing – review and editing. **Ulrike Schmidt:** Investigation; resources; validation; writing – review and editing. **Jorunn Sundgot-Borgen:** Conceptualization; funding acquisition; investigation; methodology; resources; supervision; writing – review and editing.

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CONFLICT OF INTEREST STATEMENT

The authors have no financial conflict to declare.

DATA AVAILABILITY STATEMENT

Data from this research is not available for sharing.

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REFERENCES

Ali, K., Farrer, L., Fassnacht, D. B., Gulliver, A., Bauer, S., & Griffiths, K. M. (2017). Perceived barriers and facilitators towards help-seeking for eating disorders: A systematic review. *International Journal of Eating Disorders*, *50*(1), 9–21. https://doi.org/10.1002/eat.22598

Ali, K., Fassnacht, D. B., Farrer, L., Rieger, E., Feldhege, J., Moessner, M., Griffiths, K. M., & Bauer, S. (2020). What prevents young adults from seeking help? Barriers toward help-seeking for eating disorder symptomatology. *International Journal of Eating Disorders*, *53*(6), 894–906. https://doi.org/10.1002/eat.23266

Bakland, M., Rosenvinge, J. H., Wynn, R., Sundgot-Borgen, J., Fostervold Mathisen, T., Liabo, K., Hanssen, T. A., & Pettersen, G. (2019). Patients' views on a new treatment for bulimia nervosa and binge eating disorder combining physical exercise and dietary therapy (the PED-t). A Qualitative Study. *Eating Disorders*, *27*(6), 503–520. https://doi.org/10.1080/10640266.2018.1560847

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Carrino, E., Flatt, R., Pawar, P., Sanzari, C., Tregarthen, J., Argue, S., Thornton, L., Bulik, C., & Watson, H. (2023). Sociodemographic and clinical characteristics of treated and untreated adults with bulimia nervosa and/or binge-eating disorder recruited for a large-scale Research study. *Journal of Eating Disorders*, *11*, 126. https://doi.org/10.21203/rs.3.rs-2899349/v1

Fairburn, C., & Beglin, S. (2008). Eating disorder examination questionnaire (EDE-Q 6.0). In C. Fairburn (Ed.), *Cognitive behavior therapy and eating disorders* (pp. 309–313). Guildford Press.

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

Johnson, C., Cook, L., Cadman, K., Andersen, T., Williamson, P., & Wade, T. D. (2022). Evaluating an implementation model of evidence-based therapy for eating disorders in non-specialist regional mental health settings [article]. *Journal of Eating Disorders*, *10*(1), 1–11. https://doi.org/10.1186/s40337-022-00695-7

Mathisen, T. F., Bratland-Sanda, S., Rosenvinge, J. H., Friborg, O., Pettersen, G., Vrabel, K. A., & Sundgot-Borgen, J. (2018). Treatment effects on compulsive exercise and physical activity in eating disorders. *Journal of Eating Disorders*, *6*(1), 43. https://doi.org/10.1186/s40337-018-0215-1

Mathisen, T. F., Pettersen, G., Rosenvinge, J. H., Schmidt, U., & Sundgot-Borgen, J. (2023). Effectiveness and acceptability of the physical exercise and dietary therapy in a healthy life center. *International Journal of Eating Disorders*, *56*, 1931–1940. https://doi.org/10.1002/eat.24020

Mathisen, T. F., Rosenvinge, J. H., Friborg, O., Vrabel, K., Bratland-Sanda, S., Pettersen, G., & Sundgot-Borgen, J. (2020). Is physical exercise and dietary therapy a feasible alternative to cognitive behavior therapy in treatment of eating disorders? A randomized controlled trial of two group therapies. *International Journal of Eating Disorders*, *53*(4), 574–585. https://doi.org/10.1002/eat.23228

Mathisen, T. F., Rosenvinge, J. H., Pettersen, G., Friborg, O., Vrabel, K., Bratland-Sanda, S., Svendsen, M., Stensrud, T., Bakland, M., Wynn, R., & 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), 180. https://doi.org/10.1186/s12888-017-1312-4

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

Pehlivan, M. J., Miskovic-Wheatley, J., Le, A., Maloney, D., Research Consortium, N. E. D., Touyz, S., & Maguire, S. (2022). Models of care for eating disorders: Findings from a rapid review. *Journal of Eating Disorders*, *10*(1), 166. https://doi.org/10.1186/s40337-022-00671-1

Pettersen, G., Rosenvinge, J. H., Skomakerstuen, T., Sordal, S., Mathisen, T. F., & Sundgot-Borgen, J. (2019). Patient expectations of a new treatment for eating disorders combining guided physical exercise and dietary therapy: An interview study of women participating in a randomised controlled trial at the Norwegian School of Sport Sciences. *BMJ Open*, *9*(4), e025344. https://doi.org/10.1136/bmjopen-2018-025344

Pettersen, G., Sørdal, S., Rosenvinge, J. H., Skomakerstuen, T., Mathisen, T. F., & Sundgot-Borgen, J. (2017). How do women with eating disorders experience a new treatment combining guided physical exercise and dietary therapy? An interview study of women participating in a randomised controlled trial at the Norwegian School of Sport Sciences. *BMJ Open*, *7*(12), e018588. https://doi.org/10.1136/bmjopen-2017-018588

Reas, D. L. (2017). Public and healthcare Professionals' knowledge and attitudes toward binge eating disorder: A narrative review. *Nutrients*, *9*(11), 11267. https://doi.org/10.3390/nu9111267

Regan, P., Cachelin, F. M., & Minnick, A. M. (2017). Initial treatment seeking from professional health care providers for eating disorders: A review and synthesis of potential barriers to and facilitators of "first contact". *International Journal of Eating Disorders*, *50*(3), 190–209. https://doi.org/10.1002/eat.22683

Stokke, O., Karttinen, E., Halvorsen, C., Vinter, C., & Skogli, E. (2022). The societal value of preventing eating disorders. *Economics* https://nettros.no/wp-content/uploads/2022/03/Samfunnsverdien-av-a%CC%8A-forebygge-spiseforstyrrelser_januar-2022-1.pdf

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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