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Cognitive-behavioural therapy for anorexia nervosa (CBT-AN-20): feasibility, acceptability, and preliminary effectiveness

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ABSTRACT

This study examined the feasibility, acceptability, and preliminary effectiveness of CBT-AN-20, a novel 20-session outpatient treatment for anorexia nervosa. A longitudinal case-series study (preregistration: <https://doi.org/10.17605/OSF.IO/S2WNY>) conducted in adult outpatient eating disorder services assessed CBT-AN-20's feasibility (eligible patients recruited who started treatment, retention, attendance), acceptability (suitability/confidence), and effectiveness (recovery rates, reliable change, outcome measures). Completer analyses indicated high feasibility (recruitment: 84.72%) and moderate-to-high acceptability (retention: 57.38%; session attendance: 84%). Both completer and Intention to Treat (ITT) analyses showed similar improvements in weight, eating pathology, anxiety and depression, all with large effect sizes. Pre-post treatment recovery rates for weight (64.29%) were broadly comparable to CBT-E studies, whereas rates for eating pathology (56.52%) were lower. There was reliable change for eating pathology (70.83%), anxiety (69.23%), and depression (56%). However, the attrition rate means that completer analyses were likely to be over-optimistic about recovery rates (relative to ITT analyses). Future developments should focus on enhancing retention for such patients. Results suggest that CBT-AN-20 may be a viable alternative treatment to CBT-E for some adult outpatients with anorexia nervosa. A fully powered study is needed to validate CBT-AN-20's effectiveness and to explore when change occurs, for whom, and its predictors.

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Anorexia nervosa; Cognitive-behaviour therapy; feasibility; acceptability; effectiveness

Anorexia nervosa is a serious, difficult-to-treat eating disorder with high mortality rates (Arcelus et al., 2011; Franko et al., 2013; Hoek, 2006) and poor treatment outcomes (de Rijk et al., 2024; Fichter et al., 2017; Khalsa et al., 2017). However, individuals can and do recover from this disorder, even after many years (Eddy et al., 2017). The UK National Institute for Health and Care Excellence (National Institute for Health and Care Excellence [NICE], 2017) recommends outpatient psychotherapy as a first-line treatment for adults with anorexia nervosa. Accessing effective treatment of this sort allows patients to be treated earlier in their disorder, reducing suffering and avoiding highly expensive intensive treatments (Guarda et al., 2017; van den Berg et al., 2022).

NICE (2017) recommends three first-line evidence-based psychotherapies for adult outpatients with anorexia nervosa: the Maudsley Anorexia Nervosa Treatment for Adults (MANTRA); Specialist Supportive Clinical Management (SSCM); and Cognitive-Behavioural Therapy for Eating Disorders (CBT-ED). Additionally, the American Psychiatric Association (American Psychiatric Association. [APA], 2023) guidelines suggest Focal Psychodynamic Therapy (FPT). However, all such therapies are broadly equivalent and have limited effectiveness (APA, 2023; Bulik et al., 2007; Byrne et al., 2017; Hay et al., 2015; NICE, 2017;

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Solmi et al., 2021). Furthermore, some require a long time to deliver [e.g. up to 40 sessions for Fairburn's (2008) Enhanced CBT (CBT-E)], making them expensive and hence less available (Egger et al., 2016; van den Berg et al., 2022).

NICE (2017) called for research into briefer yet effective therapies for eating disorders to enhance treatment availability and reduce care costs. One way to achieve this is to focus on improving the efficiency of CBT-ED, given the widespread use of cognitive-behavioural therapy (CBT) in the UK (NHS Digital [NHS], 2025) and its international standing as a leading psychotherapy (e.g. David et al., 2018). A briefer 10-session CBT-ED (CBT-T; Waller et al., 2019) for non-underweight eating disorders appears as effective as much longer therapy (Keegan et al., 2022; Paphiti & Newman, 2023; Tatham et al., 2020). Briefer therapy allows more patients to be treated sooner, reduces waiting lists, and can be delivered by junior therapists (under clinical supervision), thereby lowering costs (Waller et al., 2019).

This study's authors explored whether the same approach taken to CBT-T could be used to develop a more efficient CBT-ED for adults with anorexia nervosa—one that is as feasible, acceptable, and effective as existing evidence-based outpatient CBT. CBT-AN-20 (Waller et al., 2026) is a 20-session model of CBT that has been developed for outpatients with anorexia nervosa. At half the length of CBT-E (Fairburn, 2008), CBT-AN-20 has the potential to be a cost- and time-efficient alternative to existing NICE-recommended CBT-ED. Most importantly, CBT-AN-20 could provide faster access to briefer evidence-based CBT, enabling patients to treat their eating disorder and return to a better quality of life sooner.

Aims

The primary aim of this study was to ascertain the feasibility and acceptability of CBT-AN-20. Its secondary aim was to explore CBT-AN-20's preliminary effectiveness. Pre-registered plans to test whether early change in eating pathology predicts outcomes were not feasible because the dataset was insufficiently complete.

Method

Design

This study used a longitudinal case-series design to test the feasibility, acceptability, and preliminary effectiveness of CBT-AN-20 in a naturalistic setting. Therapists from two National Health Service (NHS) outpatient eating disorder services collected repeated-measures data from patients receiving CBT-AN-20 over an extended period (i.e. from assessment to follow-up or patients' last contact with the service) as part of routine clinical practice.

Ethical approval

According to NHS ethics guidance (Authority, n.d.), this study was an evaluation of routine practice and was therefore exempt from ethical review. Patients were fully informed of how their data would be used and had the opportunity to decline its use in this way. Ethical approval was obtained from the University of Sheffield (ref. 064046) to analyse this study's dataset. The study was preregistered (<https://doi.org/10.17605/OSF.IO/S2WNY>).

Participants

Patients were recruited from two NHS services (see Figure 1). Data were collected between August 2022 and October 2025. Inclusion criteria were: aged ≥ 18 years; diagnosed (DSM-5 clinical interviews) with anorexia nervosa (any subtype); BMI = 15–19; low immediate physical and mental health risk; and any sex, gender identity, and ethnicity. Exclusion criteria were: physical risk (i.e. patients requiring more intense treatment, with active suicidality, or severe self-harm); BMI < 15; a formal autistic spectrum disorder (ASD) diagnosis; or currently receiving any other psychological treatment. Patients were not excluded for any other comorbidities, to test CBT-AN-20 with a clinically representative sample. Therapists recorded comorbidities disclosed by

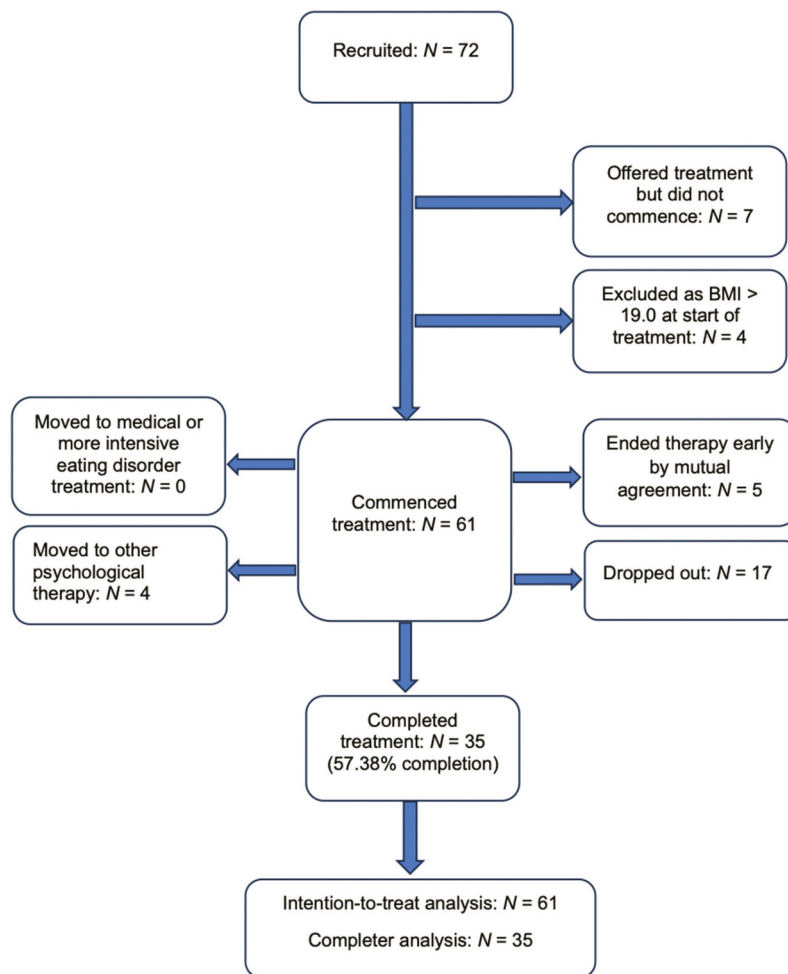


Figure 1. CONSORT (2010) Diagram.

patients at assessment or in Session 1 (see Table 1). Patients with atypical anorexia nervosa were not excluded from receiving CBT-AN-20 if therapists deemed it an appropriate treatment. However, post-registration, they were excluded from this study's analyses to conduct a more stringent test of CBT-AN-20. Patients in ongoing therapy were also excluded post-registration, so that only those who had the time to complete therapy (even if they ended treatment early) were included in this study's analyses. Physical risk was a removal criterion if patients deteriorated during treatment. Eligible patients who consented to receive CBT-AN-20 committed to up to 20 sessions plus follow-ups and were treated as part of routine services. Patients were not prohibited from receiving further psychological treatment after completing CBT-AN-20 but before the end of follow-up. No such cases were reported to the research team.

Therapists

CBT-AN-20 was designed for delivery by both junior and more experienced therapists under clinical supervision (Waller et al., 2026). Therapists ($N = 11$) were predominantly research assistants and assistant psychologists under the day-to-day supervision of clinical leads (HT and CR). All therapists received one full day of online training and weekly online clinical supervision from a qualified clinical psychologist (HT or GW), which focused on supporting therapists to deliver positive patient outcomes, with all cases discussed in each session. Therapists were given access to supporting materials (i.e. a PDF of the treatment protocol, including detailed descriptions of interventions, session-by-session checklists, and psychoeducational materials), because the manual (Waller et al., 2026) had not yet been published.

Table 1. Sample characteristics and between-group comparisons for CBT-AN-20 completers (N = 35) and non-completers (N = 26) at the start of treatment.

Characteristics	Completers		Non-completers		t-test	
	<i>n</i>	<i>M (SD)</i>	<i>n</i>	<i>M (SD)</i>	<i>t</i>	<i>d</i>
Age (years)	34	23.50 (6.99)	25	26.04 (9.78)	1.16	0.31
Duration of Disorder (years)	25	4.48 (4.94)	21	8.45 (8.40)	1.91	0.59
Weight (kg)	35	50.11 (4.45)	26	48.06 (6.23)	1.51	0.39
Body Mass Index (BMI)	35	17.77 (0.99)	26	17.35 (0.91)	1.72	0.44
Eating Disorder Examination (EDE-Q Total)	34	3.45 (1.27)	23	3.27 (1.41)	0.51	0.14
Anxiety (GAD-7 Total)	35	10.69 (5.52)	24	10.75 (5.31)	0.04	0.01
Depression (PHQ-9 Total)	34	11.50 (5.68)	24	13.13 (6.65)	1.00	0.27
Treatment Suitability (%)	18	77.50 (11.41)	15	60.93 (26.23)	2.27*	0.85
Confidence in Treatment (%)	18	70.28 (15.48)	16	55.94 (22.23)	2.16*	0.76
Self-Reported Gender						
Female	33	94.29%	22	84.62%		
Male	2	5.71%	2	7.69%		
Other reported gender identity	0	0.00%	2	7.69%		
Diagnosis						
Restrictive AN	29	82.86%	22	84.62%		
Binge-purge AN	6	17.14%	4	15.38%		
Identified Comorbidities						
Anxiety (any subtype)	4	11.43%	6	23.08%		
Attention-deficit hyperactivity disorder	0	0.00%	1	3.85%		
Chronic fatigue syndrome	1	2.86%	1	3.85%		
Depression and/or low mood	5	14.29%	4	15.38%		
Dissociative symptoms	0	0.00%	1	3.85%		
Emotional regulation difficulties	0	0.00%	1	3.85%		
Emotionally unstable personality disorder	1	2.86%	0	0.00%		
Interpersonal difficulties	0	0.00%	1	3.85%		
Myelodysplastic syndrome	0	0.00%	1	3.85%		
Obsessive-compulsive disorder	2	5.71%	3	11.54%		
Polycystic ovary syndrome	1	2.86%	0	0.00%		
Post-traumatic stress disorder	0	0.00%	1	3.85%		
Substance misuse	0	0.00%	1	3.85%		
Supraventricular tachycardia	1	2.86%	0	0.00%		
Participated in FREED	22	62.86%	11	42.31%		

Note. $p < .05$. Significance is indicated by an asterisk. Two-tailed p -values and absolute values for t and Cohen's d are reported.

Intervention

CBT-AN-20 is a 20-session evidence-based CBT for outpatients with anorexia nervosa (Waller et al., 2026). Its key stages are:

- **Phase 1:** Early dietary change and weight regain to maximise outcomes (Chang et al., 2021) and to fast-track patients' learning through exposure.
- **Progress review (Session 6–8):** At this point, the decision is taken as to whether to continue therapy or encourage the patient to engage more fully, depending on progress. CBT-AN-20 is ended early if patients are unwilling or unable to engage in its non-negotiables (i.e. eating more to regain weight, including open weighing and dietary tracking) at this time. If therapy is ended early, the therapist emphasises that neither the patient nor the therapy has failed; it is simply not the right time for this patient to be in this therapy. Patients are encouraged to try CBT-AN-20 again when ready to commit to its non-negotiables or are directed to alternative treatments.
- **Phase 2:** Behavioural experiments (particularly weight maintenance and addressing beliefs behind patients' fears of specific foods).
- **Phases 3 and 4:** Addressing emotional triggers and body image work, respectively.
- **Phase 5:** Ending treatment well and relapse prevention.

Throughout CBT-AN-20, therapists manage risk and address therapy-interfering behaviours, engagement, and motivation, and measure patients' weekly progress and outcomes.

To understand how CBT-AN-20 differs from other CBT-ED for anorexia nervosa, it is helpful to draw comparisons with CBT-E (Fairburn, 2008). While CBT-AN-20 incorporates many of the evidence-

based cognitive and behavioural components of CBT-E, its content differs in the following ways. First, exposure is a key element of CBT-AN-20 but not of CBT-E. CBT-AN-20 encourages patients to face and overcome their fears of eating more and gaining weight, using experiences of change to build motivation through positive reinforcement. This approach to exposure is underpinned by inhibitory learning principles (Cardi et al., 2019; Craske et al., 2014), where by patients are encouraged to experience maximum tolerable anxiety levels to optimise their learning. Inhibitory learning principles can accelerate the learning process when treating food-related fears and may prevent relapse (Steinglass et al., 2011). In contrast, CBT-E is slower than CBT-AN-20 to engage patients in behavioural change, working first on motivation and only addressing monitoring and changing eating patterns from around Session 3 or 4 (Fairburn, 2008). Second, early change is an expectation in CBT-AN-20, assessed and responded to around Sessions 6–8, whereas such early change is less clearly a focus of CBT-E. This expectation of early change might itself act as a motivator for faster change in CBT-AN-20. Finally, CBT-AN-20 and CBT-E take a different approach to tackling body image issues. Both therapies include cognitive restructuring and behavioural experiments. However, CBT-E focuses more on cognitive restructuring (e.g. identifying and exploring over-evaluation of weight/shape, enhancing other forms of self-evaluation - Fairburn, 2008), whereas CBT-AN-20 includes a wider range of behavioural experiments (e.g. testing beliefs by experimenting with different clothing and with checking and comparison behaviours) and uses exposure (e.g. mirror/screen exposure). It also integrates recent treatment innovations, such as working with the “anorexic voice” (Burnett-Stuart et al., 2024; Pugh & Waller, 2017), body image surveys (Giles & Waller, 2026), and body neutrality (Pellizzer & Wade, 2023). CBT-AN-20’s wider range of CBT-based techniques may allow for more precise, individualised targeting of the mechanisms that maintain negative body image.

Measures

To evaluate the feasibility, acceptability, and preliminary effectiveness of CBT-AN-20, pre-registered criteria and benchmarks were estimated from previous CBT-E studies (Fairburn et al., 2013; Jenkins et al., 2019). These studies were chosen for comparison because CBT-E (Fairburn, 2008) is the closest therapeutic model to CBT-AN-20, and they delivered therapy to similar samples (adults with anorexia nervosa) in similar settings (outpatient clinics).

Feasibility and acceptability

Feasibility was measured as the number of patients recruited and eligible to receive CBT-AN-20 who started treatment ($\geq 60\%$ = high feasibility, 40–59% = moderate feasibility, $< 40\%$ = low feasibility). This measure was refined post-registration to improve precision. It was also measured by retention levels over a full course of treatment ($\geq 60\%$ = high feasibility, 40–59% = moderate feasibility, $< 40\%$ = low feasibility). Post-registration, an additional measure was included: session attendance rates for patients completing a full course of treatment ($\geq 75\%$ = high feasibility, 50–75% = moderate feasibility, $< 50\%$ = low feasibility). As a measure of acceptability, at the start of treatment, therapists asked patients to rate CBT-AN-20’s suitability (i.e. “How suitable do you believe this therapy is for you?”) and their confidence in CBT-AN-20 (i.e. “How confident do you feel that this treatment will be effective?”) on a scale of 0% (not suitable/confident at all) to 100% (completely suitable/confident).

Effectiveness

The following self-report measures were used to collect data for the effectiveness analyses. All are commonly used in clinical practice and have established psychometric properties (Berg et al., 2012; Kroenke et al., 2010; Mond et al., 2004, 2006; Tatham et al., 2015). Measures were collected at the start of treatment, Session 6 (to explore early change), at the end of treatment (Session 20 or earlier if patients completed treatment sooner), and at follow-up (at one-, three-, and six-months post-treatment).

Weight. Height (cm) and weight (kg) were measured at the start of therapy to calculate objective BMI. Weight was measured weekly to monitor progress.

Eating Disorder Examination Questionnaire (EDE-Q v.6; Fairburn & Beglin, 2008): Twenty-two items measure the overall severity of eating disorder psychopathology over the past 28 days. Higher EDE-Q global scores indicate more severe eating disorder psychopathology. Four cognitive subscales measure restraint, eating concerns, shape concerns, and weight concerns.

Eating Disorder-15 (ED-15; Tatham et al., 2015). Fifteen items (10 attitudinal, five behavioural) measure eating disorder symptoms over the past seven days. There are two attitudinal subscales (weight and shape concerns; eating concerns) and an overall attitudinal score (mean of the 10 attitudinal items). Higher scores indicate a greater prevalence of eating disorder symptoms.

Patient Health Questionnaire-9 (PHQ-9; Kroenke et al., 2001). Nine items measure depression severity over the past 14 days. Higher scores indicate more severe depression symptoms.

Generalised Anxiety Disorder Questionnaire (GAD-7; Spitzer et al., 2006). Seven items measure anxiety symptoms over the past 14 days. Higher scores indicate higher anxiety levels.

Recovery rates. Pre- to post-treatment completer recovery rates were measured as the percentage of patients who started treatment within a clinically unhealthy range of scores for weight (BMI) and eating pathology (EDE-Q global scores) who then ended treatment within a healthy range. Pre-registered benchmarks based on previous studies' recovery rates (e.g. Byrne et al., 2011, 2017; Kessler et al., 2022; Waller, 2016) were not applied because the criteria for their application were not specified. Instead, CBT-AN-20 recovery rates were contextualised by comparison with outcomes from CBT-E studies (Fairburn et al., 2013; Jenkins et al., 2019).

Data were not collected using the pre-registered Clinical Impairment Assessment (CIA; Bohn et al., 2008). Treatment fidelity and protocol adherence were informally monitored through clinical supervision.

Primary and secondary outcomes of interest

This study's primary outcomes were: feasibility—the percentage of eligible patients starting CBT-AN-20; acceptability—retention and session attendance rates; and preliminary effectiveness—intention to treat (ITT) analyses, completer analyses, and completer recovery rates for the primary outcomes of weight (BMI) and eating pathology (EDE-Q global scores). ITT and completer analyses were also conducted for the secondary outcomes of depression (PHQ-9 total scores) and anxiety (GAD-7 total scores), and for the secondary measure of eating pathology (ED-15 overall attitudinal and subscale scores).

Data analysis

Data were analysed using SPSS (v.29.0.2.0). Sample characteristics were calculated separately for CBT-AN-20 completers and non-completers at the start of treatment. Independent samples *t*-tests were used to compare patient groups and identify any baseline differences. **Feasibility** rates were calculated as: the percentage of patients recruited and eligible to receive CBT-AN-20 who started treatment; retention rates = the percentage of patients who completed a full course of treatment; and session attendance rates = the mean percentage of sessions attended by patients who completed a full course of treatment. **Acceptability** was measured using the patients' self-ratings of confidence and suitability.

Preliminary treatment **effectiveness** was analysed in three ways: a) ITT analyses; b) completer analyses; and c) calculating pre- to post-treatment CBT-AN-20 completer recovery rates and comparing them with outcomes from CBT-E studies (Fairburn et al., 2013; Jenkins et al., 2019).

ITT and completer analyses were used to compare patient scores at the start of treatment, Session 6, end of treatment, and at two follow-up periods (at one-month post-treatment, and at the latest available time point). For the ITT analyses, Generalised Linear Mixed Models (GLMM) were used, allowing for the use of all available data across the five time points. For the completer analyses, repeated-measure ANOVAs were conducted for the same time points, and effect sizes were estimated using partial eta-squared (0.01 = small, 0.06 = medium, ≥ 0.14 = large).

Reliable change indices (RCI; using completer data for the start and end of therapy) were calculated for eating pathology (EDE-Q global scores), anxiety (GAD-7 total scores), and depression (PHQ-9 total scores), to assess whether observed changes in completers were statistically reliable (Jacobson & Truax, 1991). RCI analyses were not conducted for the ED-15, as this was a secondary measure of eating pathology, and had not been used by Fairburn et al. (2013) or Jenkins et al. (2019). Therefore, RCI was only comparable for the EDE-Q scores (see Table 4). Furthermore, RCI analyses could not be conducted for BMI (as BMI does not have the psychometric properties needed to calculate RCI—particularly internal consistency). RCI used the standard deviation of patients' baseline scores and Cronbach's alpha, and was computed using Evans (2023) calculator. The number and percentages of patients showing reliable improvement ($\geq$ RCI), deterioration ($<$ start of treatment) and no change (i.e. did not meet the threshold for reliable change) between the start and end of treatment were calculated.

Completer recovery rates for the primary outcome variables of BMI and EDE-Q global scores were calculated from the start to the end of treatment in three ways: 1) BMI scores only; 2) EDE-Q global scores only; and 3) combined BMI and EDE-Q global scores. Recovery rates were calculated as percentages, using data from Tables S5 and S6 (Supporting Information B) at two different cutoff points for BMI (BMI = 19, BMI = 18.5). The BMI = 19 cutoff was used to calculate recovery rates that reflect this study's inclusion criteria and clinical practice, as it is commonly used by therapists to allow for fluctuation in patients' weights between assessment and starting treatment. BMI $<$ 19 was considered underweight if there were accompanying clinical starvation features (Keys et al., 1950), and BMI $\geq$ 19 was considered within the healthy weight range. The BMI = 18.5 cutoff was used to calculate recovery rates for comparison with those of CBT-E studies (Fairburn et al., 2013; Jenkins et al., 2019), which used this diagnostic cutoff. An EDE-Q global score cutoff of 2.77 was used by all three studies, as it is considered indicative of clinical levels of eating pathology (Fairburn, 2008; Fairburn et al., 2013; Jenkins et al., 2019), with a score of $<$ 2.77 considered within the healthy range.

Results

Sample characteristics

Table 1 compares the characteristics of the CBT-AN-20 completers and non-completers at the start of treatment. The mean number of sessions attended by completers ($N = 35$) was 16.80 ($SD = 3.97$; including follow-up sessions - $M = 18.09$, $SD = 4.64$). For non-completers ($N = 26$), the mean number of sessions attended was 8.73 ($SD = 4.21$).

Feasibility

Figure 1 shows the recruitment, retention, and attrition of patients in this study. Sixty-one (84.72%) of the 72 patients eligible for and offered CBT-AN-20 started treatment, which met the criterion for high feasibility. Of the 61 patients who commenced treatment, 35 (57.38%) completed it. This retention rate met the criterion for moderate feasibility. The session attendance rate for treatment completers was 84%, which met the criterion for high feasibility.

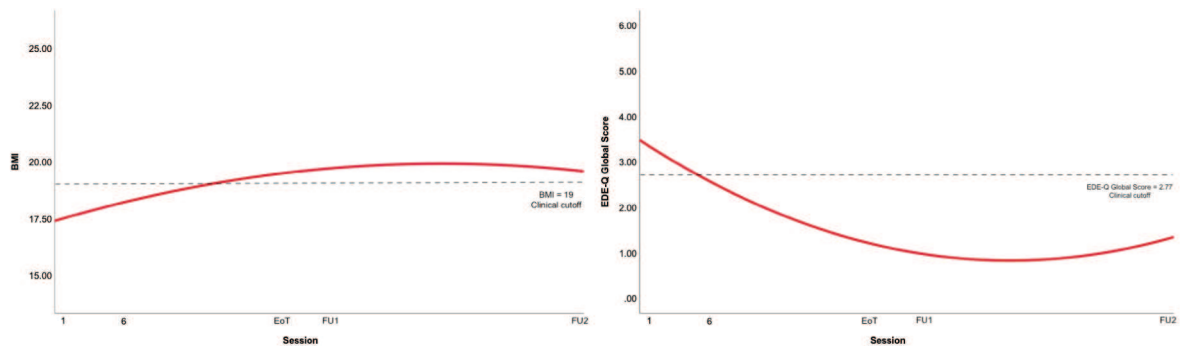
Acceptability

Table 1 shows that, at Session 1, completers rated the suitability of and their confidence in CBT-AN-20 higher than non-completers, indicating that patients' ratings of acceptability predict therapy completion. There were no other significant between-group differences at the start of treatment.

Table 2. Intention to treat analyses (N = 61) using GLMM estimated mean scores for body Mass index (BMI) and eating disorder examination questionnaire (EDE-Q) scores over the course of CBT-AN-20.

	M (95% CI)					GLMM		Pairwise Comparisons t (95% CI)				
	SoT	S6	EOt	FU1	FU2	F (df)	p	SoT - EOt	SoT - S6	S6 - EOt	EOt - FU1	EOt - FU2
BMI	17.59 (17.35–17.84)	18.14 (17.82–18.47)	19.45 (18.87–20.03)	19.86 (18.95–20.77)	19.55 (18.66–20.45)	15.72 (4,187)	<.001	5.84* (–2.49 – –1.23)	2.67* (–0.96 – –0.14)	3.90* (–1.98 – –0.65)	0.74 (–1.48 – 0.67)	0.18 (–1.16 – 0.97)
EDE-Q (Global)	3.40 (3.06–3.74)	2.32 (1.86–2.79)	1.30 (0.89–1.71)	1.00 (0.69–1.31)	1.32 (0.92–1.73)	31.67 (4,145)	<.001	7.76* (1.56–2.63)	3.68* (0.50–1.65)	3.25* (0.40–1.64)	1.15 (–0.21 – 0.81)	0.07 (–0.60 – 0.56)
EDE-Q (Restraint)	3.11 (2.68–3.55)	1.63 (1.19–2.06)	0.84 (0.43–1.25)	0.49 (0.21–0.77)	0.96 (0.47–1.45)	26.80 (4,146)	<.001	7.46* (1.67–2.88)	4.76* (0.87–2.10)	2.59* (0.19–1.39)	1.37 (–0.15 – 0.85)	0.38 (–0.76 – 0.52)
EDE-Q (Weight concerns)	3.44 (3.04–3.84)	2.40 (1.87–2.93)	1.36 (0.91–1.81)	0.99 (0.68–1.30)	1.30 (0.91–1.68)	26.98 (4,146)	<.001	6.84* (1.48–2.69)	3.10* (0.38–1.71)	2.95* (0.34–1.74)	1.34 (–0.18 – 0.92)	0.22 (–0.53 – 0.66)
EDE-Q (Eating concerns)	3.08 (2.74–3.42)	2.09 (1.60–2.58)	1.08 (0.66–1.51)	0.89 (0.49–1.28)	1.17 (0.70–1.64)	24.25 (4,144)	<.001	7.29* (1.46–2.54)	3.28* (0.39–1.59)	3.05* (0.35–1.66)	0.67 (–0.38 – 0.78)	0.28 (–0.72 – 0.54)
EDE-Q (Shape concerns)	4.07 (3.68–4.45)	3.12 (2.57–3.67)	1.97 (1.50–2.45)	1.65 (1.19–2.11)	1.86 (1.45–2.28)	24.05 (4,146)	<.001	6.77* (1.48–2.70)	2.80* (0.28–1.61)	3.12* (0.42–1.87)	0.97 (–0.34 – 0.99)	0.34 (–0.52 – 0.74)

Note. $p < .05$. Significance is indicated by an asterisk. SoT = start of treatment, S6 = Session 6, EOt = end of treatment (i.e. Session 20 or sooner if completed treatment early), FU1 = one-month follow-up, FU2 = latest available follow-up data (one, three, or six months post-treatment).



(a) GLMM analysis showing changes in BMI by CBT-AN-20 session

(b) GLMM analysis showing changes in EDE-Q global scores by CBT-AN-20 session

Figure 2. Intention to treat analyses (N = 61) using GLMM estimated mean scores for body Mass index (BMI) and eating disorder examination questionnaire (EDE-Q) global Scores. GLMM analysis showing changes in EDE-Q global scores by CBT-AN-20 session ($y = 3.65 - 0.18x + 2.94E-3x^2$, $R^2 = 0.37$). Note. Session 1 = start of treatment, EOt = end of treatment (i.e. Session 20 or sooner if completed treatment early), FU1 = one-month follow-up, FU2 = latest available follow-up data (one, three, or six months post-treatment).

Preliminary effectiveness

Weight and eating pathology

Table 2 and Figure 2 show the results of ITT analyses (N = 61) for the primary outcome variables of BMI and EDE-Q global scores. Table 2 shows significant improvements over time for both BMI [$F(4,187) = 15.72$, $p < .001$] and EDE-Q global scores [$F(4,145) = 31.67$, $p < .001$]. Figure 2a shows a curvilinear increase in BMI over the course of CBT-AN-20 to one-month follow-up. Figure 2b shows a curvilinear decrease in EDE-Q global scores over the course of treatment to one-month follow-up. EDE-Q subscale scores (Table 2 and Figure S1, Supporting Information A) follow a similar pattern to the global scores, with reductions across all time points until the end of treatment.

Pairwise comparisons (Table 2) confirm significant increases in BMI from the start to the end of treatment, from the start to Session 6, and from Session 6 to the end of treatment. Subsequent changes in BMI were not significant. There were significant pairwise decreases in EDE-Q global scores from the start to

the end of treatment, from the start to Session 6, and from Session 6 to the end of treatment. Subsequent changes in EDE-Q global scores were not significant.

Completer analyses ($N = 35$; Table 3) for BMI and EDE-Q global scores broadly reflect those of the ITT analyses. There were significant changes in BMI [$F(1.37, 26.09) = 20.67$, $p < .001$, $\eta^2_p = 0.52$] and EDE-Q global scores [$F(2.12, 23.31) = 28.82$, $p < .001$, $\eta^2_p = 0.72$] with large effect sizes. These changes were significant for both variables and for the EDE-Q subscale scores at all time points until the end of treatment.

Analyses for ED-15 scores broadly reflect those of the EDE-Q. ITT analyses (Figure S3, Supporting Information A; Table S1, Supporting Information B) show significant decreases in ED-15 scores from the start to the end of treatment, from the start to Session 6, and from Session 6 to the end of treatment for overall attitudinal scores [$F(4, 178) = 20.02$, $p < .001$], for the attitudinal subscales of weight/shape concerns and eating concerns, and for the number of times per week patients restricted and binged. Completer analyses (Table S2) show significant decreases in ED-15 scores from the start to the end of treatment, from the start to Session 6, and from Session 6 to the end of treatment for overall attitudinal scores [$F(2.09, 37.58) = 26.60$, $p < .001$, $\eta^2_p = 0.60$] with large effect sizes, and for the attitudinal subscales of weight/shape concerns and eating concerns. There were also significant decreases in the number of times per week patients restricted and exercised hard from the start to the end of treatment, and from the start to Session 6.

Anxiety and depression

ITT analyses ($N = 61$; Figure S2, Supporting Information A; Table S3, Supporting Information B) show significant improvements over time for both anxiety [GAD-7 total scores; $F(4, 136) = 11.56$, $p < .001$] and depression [PHQ-9 total scores; $F(4, 135) = 9.36$, $p < .001$]. Figure S2 shows a curvilinear decrease in both GAD-7 and PHQ-9 total scores over the course of CBT-AN-20 to one-month follow-up. Pairwise comparisons (Table S3) show significant decreases in GAD-7 and PHQ-9 total scores from the start to the end of treatment and from Session 6 to the end of treatment. Changes between all other time points were not significant.

Completer analyses ($N = 5$; Table S4, Supporting Information B) broadly reflect the outcomes of the ITT analyses. There were significant changes with large effect sizes in GAD-7 [$F(4, 16) = 11.75$, $p < .001$, $\eta^2_p = 0.75$] and PHQ-9 [$F(4, 16) = 13.02$, $p < .001$, $\eta^2_p = 0.77$] scores. These changes were significant for both variables from the start to the end of treatment, from the start to Session 6, and from Session 6 to the end of treatment.

Table 3. Completer analyses for changes in body Mass index (BMI) and eating disorder examination questionnaire (EDE-Q) scores over the course of CBT-AN-20.

		M (SD)		ANOVA ^a					t-test ^b <i>t</i> (<i>n</i>), <i>d</i>					
	<i>N</i>	SoT	S6	EoT	FU1	FU2	<i>F</i> (<i>df</i>)	<i>p</i>	η^2_p	SoT - EoT	SoT - S6	S6 - EoT	EoT - FU1	EoT - FU2
BMI	20	17.67 (1.20)	18.57 (1.51)	19.62 (1.97)	19.72 (2.06)	19.59 (2.12)	20.67 (1.37, 26.09)	<.001	0.52	6.39* (34), 1.10	6.01* (35), 1.02	4.90* (34), 0.84	0.71 (21), 0.15	0.21 (21), 0.05
EDE-Q (Global)	12	3.30 (1.40)	2.29 (1.29)	1.05 (0.78)	1.01 (0.72)	1.31 (0.99)	28.82 (2.12, 23.31)	<.001	0.72	9.95* (24), 2.03	4.95* (19), 1.14	6.35* (18), 1.50	0.24 (15), 0.06	1.42 (19), 0.33
EDE-Q (Restraint)	12	2.87 (1.89)	1.37 (1.04)	0.48 (0.73)	0.55 (0.63)	0.95 (1.20)	15.80 (1.87, 20.59)	<.001	0.59	7.01* (24), 1.43	4.74* (20), 1.06	4.06* (18), 0.96	0.65 (15), 0.17	1.55 (19), 0.36
EDE-Q (Weight concerns)	13	3.57 (1.73)	2.34 (1.18)	1.17 (0.79)	1.00 (0.72)	1.20 (0.81)	26.44 (1.48, 17.74)	<.001	0.69	7.81* (25), 1.56	4.26* (20), 0.95	5.97* (18), 1.41	1.14 (15), 0.30	0.82 (19), 0.19
EDE-Q (Eating concerns)	12	2.80 (1.56)	2.37 (1.67)	0.77 (0.83)	0.99 (0.90)	1.30 (1.21)	15.63 (4.00, 44.00)	<.001	0.59	8.59* (24), 1.75	2.49* (19), 0.57	4.07* (17), 0.99	0.82 (14), 0.22	1.37 (18), 0.32
EDE-Q (Shape concerns)	13	4.16 (1.16)	3.11 (1.32)	1.69 (1.07)	1.39 (0.88)	1.63 (0.98)	33.95 (2.40, 28.78)	<.001	0.74	8.33* (25), 1.67	4.53* (20), 1.01	6.68* (18), 1.57	0.84 (15), 0.22	0.25 (19), 0.06

Note. $p < .05$. SoT = start of treatment, S6 = Session 6, EoT = end of treatment (Session 20 or sooner if completed treatment early), FU1 = one-month follow-up, FU2 = latest available follow-up data (one, three-, or six-months post-treatment).

a Bonferroni corrections were applied to the one-way repeated-measures ANOVA. All reported p -values are corrected.

b Significance is indicated by an asterisk. Two-tailed p -values and absolute values for t and Cohen's d are reported.

Reliable change

Analyses showed a reliable change (≥ 1.4 reduction) in EDE-Q global scores for 17 (70.83%) of the 24 completers for whom scores were available at the start and end of CBT-AN-20. None deteriorated and seven (29.17%) showed no change. There was also reliable change (≥ 2.99 reduction) in GAD-7 total scores for 18 (69.23%) of the 26 completers. One (3.85%) completer deteriorated, and seven (26.92%) showed no change. Lastly, there was a reliable change (≥ 4.23 reduction) in PHQ-9 total scores for 14 (56%) of the 25 completers. One (4%) completer deteriorated, and ten (40%) showed no change. To summarise, no patients deteriorated in terms of eating pathology, one patient deteriorated in terms of anxiety, and another patient deteriorated in terms of depression over the course of treatment.

Completer recovery rates

Eight (34.78%) of the 23 patients who started CBT-AN-20 with both unhealthy BMI and EDE-Q global scores (BMI < 19 and EDE-Q global score ≥ 2.77) finished with both scores in the healthy (BMI ≥ 19 and EDE-Q global scores < 2.77) range (Table S5, Supporting Information B). Of these 23 patients, nine (39.13%) ended treatment with at least one score in the healthy range, and six (26.09%) ended treatment with both scores in the unhealthy range. To summarise, 17 (73.91%) of the 23 patients who started CBT-AN-20 with both severity markers for BMI and EDE-Q global scores met at least one criterion for significant improvement by the end of treatment. Table 4 shows the recovery rates for BMI and EDE-Q global scores separately at the BMI = 19 cutoff.

Comparison of CBT-AN-20 and CBT-E outcomes

Table 4 compares CBT-AN-20 outcomes (BMI = 18.5 cutoff) with CBT-E outcomes reported in Fairburn et al. (2013) and Jenkins et al. (2019). Similar levels of eligible patients started treatment across the three samples (68.25–74.63%). All three samples also had similar retention rates (54.90–62%). However, the proportion of sessions attended was higher in the CBT-AN-20 sample than in Jenkins et al. (2019) [data not available for Fairburn et al. (2013)]. All three samples had large pre- to post-treatment effect sizes for BMI

Table 4. Comparison of CBT-AN-20 outcomes relative to those for Fairburn et al. (2013, UK sample) and Jenkins et al. (2019).

	CBT-AN-20	Fairburn et al. (2013)	Jenkins et al. (2019)
Number of patients recruited and eligible for treatment	72	67	63 ^c
Number of patients who started treatment (% of recruited and eligible)	51 (70.83%) 61 (84.72%)	50 (74.63%)	43 (68.25%)
SoT BMI < 18.5 SoT BMI < 19			
Number of treatment completers (% retention rate)	28 (54.90%) 35 (57.38%)	31 (62%)	24 (55.81%)
SoT BMI < 18.5 SoT BMI < 19			
Number of sessions (full course of treatment)	20	40	40
Number of sessions completed (% of full course)	84% $M = 16.80$ $SD = 3.97$	Not reported	57.75% $M = 23.1$ Range = 3–61
Completer pre- to post-treatment effect sizes			
BMI	$\eta^2_p = 0.52$	$g = 0.91^b$	$d = 1.72$
EDE-Q GS	$\eta^2_p = 0.72$	$g = -1.02^b$	$d = 1.46$
Completer recovery rates (%) ^a			
BMI	18/28 (64.29%) 17/35 (48.57%)	22/31 (71%)	23/34 (67.6%) ^c
EoT BMI ≥ 18.5 EoT BMI ≥ 19			
EDE-Q GS (%)	13/23 (56.52%) 13/23 (56.52%)	28/31 (90.3%)	25/34 (73.5%) ^c
EoT BMI ≥ 18.5 EoT EDE-Q GS ≥ 19			

Note. SoT = start of treatment, EoT = end of treatment, GS = global score. Data are reported to either whole numbers, the number of decimal places reported by the studies' authors, or to 2 d.p. if calculated by this paper's authors.

a CBT-AN-20 recovery rates were calculated from data in Tables S5 and S6, Supporting Information B, as the percentage of patients who started CBT-AN-20 with scores in an unhealthy clinical range and completed treatment with scores in a healthy range. The CBT-E studies' percentage recovery rates were calculated as the number of patients who completed treatment with scores in a healthy range, divided by the total completer sample.

b Taken from Duggan et al. (2026).

c Results are reported for both patients with anorexia nervosa and atypical anorexia nervosa as completer data were not presented separately by diagnosis.

and EDE-Q global scores. The BMI recovery rates for completers were broadly similar across the three samples (64.29–71%), whereas the CBT-AN-20 completers had lower EDE-Q global score recovery rates than in either CBT-E sample. Comparisons were not possible for RCI or for combined BMI and EDE-Q global score recovery rates, as these outcomes were not reported in the CBT-E studies.

Discussion

This study aimed to ascertain the feasibility and acceptability of CBT-AN-20, and to explore its preliminary effectiveness as a novel treatment for adult outpatients with anorexia nervosa. Results showed that CBT-AN-20 was feasible, acceptable, and effective for some such patients. Comparisons with CBT-E case series (Fairburn et al., 2013; Jenkins et al., 2019) contextualise these results.

Measures of feasibility were broadly comparable across all three samples (Table 4), with Fairburn et al. (2013) retention rates being slightly higher than those of CBT-AN-20 and Jenkins et al. (2019). This may be due to differences in research conditions. Fairburn et al. (2013) study was carried out under more controlled conditions, whereas this study and Jenkins et al. (2019) study were conducted in routine clinical practice. Alternatively, CBT-AN-20's push for early change in eating behaviours could have contributed to slightly lower retention rates. A parallel thematic analysis of patients' experiences of CBT-AN-20 (Duggan et al., 2025) suggests that some patients (particularly those with prior experience of other therapies that had not required early change) were discouraged by the early focus on food. This could explain why some patients left therapy around the review point (Sessions 6–8; $M = 8.73$, $SD = 4.21$) if they felt unable or unwilling to commit to its non-negotiables. On the other hand, Duggan et al. (2025) found that patients who remained in CBT-AN-20 also experienced anxiety about the early need to eat differently and regain weight, but tolerated that fear long enough to see the benefits of doing so, and experience wider benefits (e.g. body image improvement, better quality of life). These latter patients' experiences were reflected in the qualitative subtheme of “difficult but worthwhile”. A key question for future research is how to retain more patients in CBT-AN-20 during its early stages and support them to complete a full course of treatment, as the present study's results suggest it is possible for some patients to achieve good outcomes. Early psychoeducation material has been added to the treatment manual (Waller et al., 2026) to raise patients' awareness of the potential value of remaining in therapy and engaging in early change.

Preliminary ITT and completer analyses support the further exploration of CBT-AN-20's effectiveness. Its large pre- to post-treatment effect sizes for the primary outcome measures for weight (BMI) and eating pathology (EDE-Q global scores) are comparable with those of CBT-E studies (Fairburn et al., 2013; Jenkins et al., 2019; Table 4), and with outpatient CBT for adults with anorexia nervosa more broadly (Duggan et al., 2026). Additionally, CBT-AN-20's completer recovery rates for BMI were comparable to those of CBT-E samples (64.29–71%; Table 4). These findings are supported by previous research (e.g. Radunz et al., 2020; Vall & Wade, 2015), which suggests that patient outcomes for weight and eating pathology are not associated with the duration of eating disorder treatment. The similar level of weight regain across 20-session CBT-AN-20 to that observed in 40-session CBT-E might also be due to CBT-AN-20's early push for change in patients' eating behaviours from Session 1 onward (see Interventions), as early change predicts better treatment outcomes in eating disorders (Chang et al., 2021), and BMI change has been shown to be unrelated to treatment duration for patients with anorexia nervosa (Bell et al., 2017).

In contrast, completer recovery rates for EDE-Q global scores were lower for CBT-AN-20 (56.52%; Table 4) than for CBT-E samples (90.3% for Fairburn et al., 2013; 73.5% for; Jenkins et al., 2019). Methodological differences in recovery rate calculations might account for some of this difference. This study calculated CBT-AN-20 recovery rates as a percentage of those patients who started treatment with unhealthy scores (≥ 2.77) who ended treatment with a healthy score (< 2.77), whereas it was unclear whether all patients included in the recovery rate calculations for the CBT-E studies started treatment with unhealthy scores. Recalculating the CBT-AN-20 recovery rate for EDE-Q global scores using the entire completer sample, regardless of baseline EDE-Q global scores (using data from Tables S5 and S6, Supporting Information B), results in 65.71% (23/35) of patients ending treatment with healthy scores. This percentage is still slightly lower than that of Jenkins et al. (2019) and notably lower than that of Fairburn et al. (2013), which might indicate that changes in eating pathology will benefit from longer active therapy. However, conclusions

cannot be drawn as it is not yet known whether these differences persist over time (i.e. whether outcomes at 40 weeks from baseline would be comparable), given this study's limited follow-up data. Furthermore, it is unclear whether patients would consider the additional improvements in eating pathology worth spending twice as long in therapy.

Strengths and limitations

This study is the first to explore the feasibility, acceptability, and preliminary effectiveness of CBT-AN-20. Its key strengths include preregistration and adherence with Open Science principles (Center for Open Science, [n.d.](#)), and enhanced ecological validity from conducting this study in a naturalistic setting. However, this study also has limitations.

- It was not fully powered to determine effectiveness. Therefore, conclusions regarding CBT-AN-20's effectiveness are preliminary, and results must be interpreted cautiously.
- As expected in busy clinical practices, not all planned outcome measures were consistently recorded, resulting in missing data and lower completion rates, and preventing the planned assessment of the impact of early change. Notably, results for anxiety and depression must be interpreted cautiously, given the limited sample size. Also, some patients were lost to follow-up, meaning outcomes at this time point must be interpreted cautiously.
- There was a lack of detailed recruitment data to assess CBT-AN-20's generalisability [e.g. numbers of patients screened for eligibility, excluded (ineligible), offered treatment, chose treatment over alternatives].
- Lower-weight (BMI < 15) patients were excluded from participating, meaning treatment effectiveness cannot be assumed for these patients.
- While excluding patients with atypical anorexia nervosa from this study's analyses increased comparability with Fairburn et al.'s sample (2013), this decision could have decreased comparability with Jenkins et al.'s sample (2019), which contained some atypical cases and reported some combined outcomes (Table 4). Overall, however, it was considered worthwhile to exclude patients with atypical anorexia nervosa at this stage because it enabled more stringent testing of CBT-AN-20 as an intervention for anorexia nervosa.
- Although no cases were reported, patients were not prohibited from starting new treatments during follow-up. If any such additional treatments took place unknowingly, this could have affected this study's results.
- Patients were not pre-screened for comorbidities (e.g. personality disorders), which could have affected engagement and treatment outcomes.
- Patients were not demographically diverse, limiting the generalisability of this study's results.
- There was no formal measure of treatment fidelity or protocol adherence, meaning the quality and completeness of CBT-AN-20's delivery is unknown.
- There were no measures of quality of life, meaning the broader impact of this therapy is unknown.
- GLMM models only account for data missing at random, which is unlikely to be the case for dropouts. Therefore, ITT results must be interpreted cautiously as they likely overestimate patient outcomes and underestimate the extent of treatment non-response.

Future directions

The following recommendations are made for future research:

- Conduct a fully-powered study to validate and fully quantify CBT-AN-20's effectiveness and to allow further exploration of when change occurs, for whom, and what predicts these changes (i.e. patient characteristics and/or therapy factors).
- Monitor data recording to ensure consistency and enable exploration of a full range of patient outcomes.

- Collect more detailed recruitment data (see Limitations above) to better assess CBT-AN-20's generalisability.
- Collect data using the CIA (Bohn et al., 2008) to explore clinical impairment due to eating disorder symptoms.
- Collect additional acceptability data on patients' ratings of CBT-AN-20's suitability and their confidence in this therapy over time to explore potential associations with change.
- Measure treatment fidelity to ensure patients receive evidence-based, manualised CBT-AN-20 as intended.
- Include quality of life measures to explore the broader impact of treatment (e.g. interpersonal and social functioning).
- Implement a follow-up period of at least one year to ensure the stability of outcomes indicated in this study.
- Calculate recovery rates at follow-up to explore post-treatment effects (e.g. whether changes in EDE-Q global scores for CBT-AN-20 patients catch up with those of CBT-E patients over time).
- Exclude new treatments from being undertaken during follow-up to eliminate the possibility that other treatments contributed to CBT-AN-20 outcomes.
- Expand recruitment to include a broader, more diverse range of patients to determine CBT-AN-20's generalisability (e.g. atypical anorexia nervosa, patients with comorbidities like ASD - Inal-Kaleli et al., 2025).
- Explore whether addressing comorbidities alongside the eating disorder increases treatment adherence and improves patient outcomes (e.g. as suggested for patients with eating disorders and personality disorders - Eilsen et al., 2022; Fioravanti et al., 2025; Simpson et al., 2022).
- Explore cases of treatment non-responders (i.e. patients with post-treatment deterioration, non-engagement, or those who ended treatment early or dropped out) to understand potential adverse therapeutic effects, and to improve recruitment, retention, and patient outcomes. It is important to note that the early review of therapy progress at Session 6 of CBT-AN-20 is designed to give patients the best possible chance of benefitting from therapy by encouraging the early change that is key to positive outcomes in eating disorders (e.g. Chang et al., 2021; Vall & Wade, 2015). Awareness of the forthcoming review ensures that therapists and patients focus on change from the very beginning of therapy (e.g. "We are at Session 3 and your eating and weight have not started changing, so how are we going to get you on track in time for the review in a few weeks' time?") so that they can urgently and appropriately respond to it. If that early focus is unsuccessful, then Sessions 6–8 are used to try to get the patient back on track (e.g. via intensive work with the "anorexic voice"). Patients do not commonly leave CBT-AN-20 at the review stage (as shown in Figure 1), though a few either leave or transfer to another therapy. However, future work should consider ways to enhance retention at the review point and to identify patients who are unlikely to benefit from CBT-AN-20 from the outset, so that they can be offered alternative treatments. The possibility of effective treatment matching is one that has been considered across the eating disorders, but requires development (e.g. Vall & Wade, 2015).
- Conduct replication studies following the release of the treatment manual (Waller et al., 2026) to further explore CBT-AN-20's effectiveness, ideally outside of the team that developed this therapy.
- Conduct studies in different settings (e.g. other countries, private healthcare, charitable organisations) to test this therapy's generalisability.
- Conduct studies comparing CBT-AN-20 with other psychotherapeutic models (e.g. MANTRA, SSCM, FPT) to further contextualise this study's findings.

Finally, it is important to acknowledge that the limited effectiveness of psychotherapies for anorexia nervosa (e.g. APA, 2023; Bulik et al., 2007; Byrne et al., 2017; Hay et al., 2015; NICE, 2017; Solmi et al., 2021) also applies to CBT-AN-20. Ongoing work is needed to develop more effective treatments for anorexia nervosa and improve the effectiveness of existing treatments to deliver better patient outcomes over the long term.

Conclusion

CBT-AN-20 appears to be a feasible, acceptable, and effective treatment for some adult outpatients with anorexia nervosa. Preliminary research shows that this novel therapy may deliver outcomes comparable to longer CBT-E

(Fairburn, 2008; Fairburn et al., 2013; Jenkins et al., 2019) in terms of effect sizes and weight regain, yet requires lower resource levels. Further research is needed to validate CBT-AN-20's effectiveness and to explore who might benefit from this therapy, as well as the factors that predict change. With further development and testing, it is hoped that CBT-AN-20 could help more patients with anorexia nervosa to move towards recovery sooner, reduce service waiting lists and treatment delivery costs, and improve access to care (NICE, 2017).

Author contributions

CRedit: **Heather C. Duggan**: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Writing – original draft, Writing – review & editing; **Hannah Turner**: Conceptualization, Investigation, Supervision, Writing – review & editing; **Charlotte Rose**: Conceptualization, Investigation, Supervision, Writing – review & editing; **Eleanor Ruchpaul**: Data curation, Investigation, Writing – review & editing; **Gillian Adams**: Methodology, Supervision, Writing – review & editing; **Louise Dursley**: Investigation, Writing – review & editing; **Rachel Ebbens**: Investigation, Writing – review & editing; **Molly Gilbert**: Investigation, Writing – review & editing; **Liz May**: Investigation, Writing – review & editing; **Louise Melhuish**: Investigation, Writing – review & editing; **Rebecca Mueller**: Investigation, Writing – review & editing; **Sara Souissi**: Investigation, Writing – review & editing; **Chloe Webster**: Investigation, Writing – review & editing; **Samuel Williams**: Investigation, Writing – review & editing; **Geena Yip**: Investigation, Writing – review & editing; **Glenn Waller**: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Supervision, Writing – original draft, Writing – review & editing.

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Data, materials, and/or code availability statement

Data that support the results of this study will be openly available via the following link in May 2026: <https://doi.org/10.15131/shef.data.29045984>

Data are currently embargoed but can be viewed immediately by the editor and peer reviewers via the following private link: <https://figshare.com/s/08c55c95bdbc7c0dc9f0>

IRB Statement

This study was an evaluation of routine practice and exempt from ethical review (Health Research Authority, n.d.). Ethical approval was obtained from the University of Sheffield (ref. 064046) to analyse this study's dataset.

Open scholarship



This article has earned the Center for Open Science badges for Open Data and Preregistered. The data and materials are openly accessible at <https://doi.org/10.15131/shef.data.29045984> <https://doi.org/10.15131/shef.data.29045984>

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