PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	How do males recover from eating disorders? An interview study
AUTHORS	Pettersen, Gunn; Wallin, Karin; Björk, Tabita

VERSION 1 - REVIEW

REVIEWER	Mae Lynn Reyes-Rodriguez, Ph.D. University of North Carolina at Chapel Hill, United States
REVIEW RETURNED	29-Dec-2015

GENERAL COMMENTS	This study is one of three studies focus on males and with the intention to explore the nature of the recovery process in a sample of males with eating disorder treatment history. The topic of this study is relevant and much needed. The use of a qualitative approach is one of the strengths of the study, considering the lack of gender appropriate measures for eating disorders in males. However, lack of details diminishes the enthusiasm in the manuscript. My appreciation based on their results is that the recovery process is the same for males and females but maybe authors failed to present the whole experience of males when they decided to split the study in three different studies. Introduction 1. Authors devoted much emphasis discussing the female treatment process instead of highlight the information that there are in the literature about males. 2. Authors assume as a fact that the prevalence of eating disorders is low in males without pointing out the bias that all measures and diagnostic criteria have been developed for females, so maybe we are not doing a good job capturing eating disorders in males. 3. The aim of the study “to investigate the nature of the recovery process from a male patient perspective” is very general and ambiguous. What specifically about the recovery process the authors intended to investigate? 4. It would be good if authors contextualize any cultural difference of males in Norway or Sweden from males from other cultures. Methods 5. Authors did not present basic demographic information and background history of ED treatment from participants, etc. 6. Quote needs to be identified by participants’ number. It is not clear from who are the citations. 7. The table at the end of the manuscript does not make sense. Most of the information should be incorporated as part of Methods. 8. It is helpful if the guideline questions used in the in-depth

	interview is included as Appendix or in a Table. 9. Did authors take specific considerations at the moment to develop the interview guidelines because of the sex of the participants? Results 10. It is not clear how many participants are presented in each category. 11. It is confusing and hard to know if these categories were elicited from a preset guideline or if the interview was an open discussion with no guidelines. Discussion 12. Is there any specific reason, more than those related to eating disorders, that could explain the delayed of seeking help in males? Is there any specific gender related issue (i.e., lack of recognition of the disorder by themselves, professionals' bias)? 13. Did patients express additional pressure for their recovery due to their social or family role as a male? 14. The age range is wide; Did the authors find any qualitative differences in the recovery process based on their age?

VERSION 1 – AUTHOR RESPONSE

Reviewer 1	**Comments and actions (in bold)**
1. Authors devoted much emphasis discussing the female treatment process instead of highlight the information that there is in the literature about males.	We agree that the focus of this paper is how male experience a recovery from eating disorders. **We have now incorporated more literature about males in the introduction.**
2. Authors assume as a fact that the prevalence of eating disorders is low in males without pointing out the bias that all measures and diagnostic criteria have been developed for females, so maybe we are not doing a good job capturing eating disorders in males.	We fully agree with respect to the biases related to case identification among males by diagnostic criteria or other approaches (e.g. self-report measures, hospital registers etc.). The prevalence issue is, however not central in this paper Nevertheless, to the best of common knowledge in the field, it is fair to say that there are far fewer males than females with an eating disorder (as it is commonly depicted). This fact points to the core of our argument. **We have now reformulated this in order to convey this argument more precisely (p. 3).**
3. The aim of the study "to investigate the nature of the recovery process from a male patient perspective" is very general and ambiguous. What specifically about the recovery process the authors intended to investigate?	We agree that the aim may be a bit broad in nature. However, such a broad aim does also reflect the nature and purpose of a qualitative, explorative study. **Still, we have shaped this up a bit (p. 5).**
4. It would be good if authors contextualize any cultural difference of males in Norway or Sweden from males from other cultures.	We agree to the importance of contextualization. We are not aware of any cultural differences between Norwegian/Swedish men, and between Scandinavian men and men from other Western countries. As for men outside this cultural sphere such differences may exist, but to explore this possibility will, in our opinion, go beyond the scope of our article. Obviously, while generalization is not the purpose of a qualitative study, applicability and

	relevance is. **Thus, we have added a sentence underlining that our findings may not be relevant for understanding how males from non-Western cultures experience eating disorder and a recovery process from such disorders (p. 19).**
5. Authors did not present basic demographic information and background history of ED treatment from participants.	**We agree, and have now provided additional contextual information in the "patients and procedure"-section (p. 7) as well as in the Abstract (p.2).**
6. Quote needs to be identified by participants' number. It is not clear from who are the citations.	Agree. **We have now identified quotes as requested, please see result section.**
7. The table at the end of the manuscript does not make sense. Most of the information should be incorporated as part of Methods.	We agree, and **have now deleted the table, and added the information about the main categories in the method section (p. 7).**
8. It is helpful if the guideline questions used in the in-depth interview is included as Appendix or in a Table.	We agree that the guideline questions should be provided, but they were few in number. **Hence we have chosen to incorporate them in the "patients and procedure" section (p. 6).**
9. Did authors take specific considerations at the moment to develop the interview guidelines because of the sex of the participants?	As being (to our knowledge) the first study on males' recovery from eating disorders, our study was explorative. This means that we had no empirically founded reason to skew or twist the guideline question in a particular "male direction". Some previous studies, however, have argued that homosexuality may be overrepresented among males with an eating disorder. We chose not to probe for this, partly for confidential reasons, and partly because we reasoned that a sexual orientation per se could be only remotely associated with experiences of recovery.
10. It is not clear how many participants are presented in each category.	All participants are represented in every category's overarching theme, and **this is now spelled out in the revision. Similarly, we have now also clarified that not all participants are represented in all quote (p. 7).**
11. It is confusing and hard to know if these categories were elicited from a preset guideline or if the interview was an open discussion with no guidelines.	We apologize for this confusion. **In the revised text, we have now made it clear that the categories emerged from the data analysis, and not from the pre-set guideline questions for the interviews (p. 7).**
12. Is there any specific reason, more than those related to eating disorders, that could explain the delayed of seeking help in males? Is there any specific gender related issue (i.e., lack of recognition of the disorder by themselves, professionals' bias)?	A delay in help-seeking may stem from many sources. Some of them are clearly related to the clandestine nature of eating disorders per se (e.g. lack of motivation and fear of change), others may be more secondary (e.g. culture-bound expectations, refusals by professionals due to their lack of detection competence, a fear that help-seeking would disclose their illness to relatives and friends). However, primary and secondary reasons for delay are difficult to entangle, and this is after all not the core issue of our work. We still thank the reviewer for bringing this to our attention.
13. Did patients express additional pressure for their recovery due to their social or family role as a male?	Our data indicate that the participants did not experience a pressure to recover as a result of their social or family role as a male. One reason for this was that relatives and friends in fact were unaware of the presence of the disorder because

	the participants did not want them to know. On the other hand, at least one participant reported having a bad conscience that the eating disorder prevented him from taking on his obligations as a husband and a father. **We have added a sentence in the result section (p. 8) to clarify.**
14. The age range is wide; Did the authors find any qualitative differences in the recovery process based on their age?	Obviously, the wide age range invites speculations about age related differences. We did not explore such possible differences for two reasons: First, differences in the text material could have appeared for other reasons than age per se, or differences may have appeared as an intangible mixture of age, maturity, and past or current life experiences. Secondly, the very nature of our data (qualitative and analogue, and not quantitative and digital) as well as the size of the material make it hard to do specific comparisons without running the risk of speculations.

VERSION 2 – REVIEW

REVIEWER	Mae Lynn Reyes-Rodriguez, Ph.D. University of North Carolina at Chapel Hill, United States
REVIEW RETURNED	10-Mar-2016

GENERAL COMMENTS	This is a first revision of a qualitative study conducted with recovered males with a history of eating disorders. Authors made a good job responding to previous reviewers' comments however, other issues should be addressed. Abstract 1. The first sentence of the conclusions "Our findings indicate that recovery is a demanding process" is very ambiguous and in my perception does not reflect the "take home message" of the study. 2. Not sure why the strengths and limitations of the study are written in a different format. Unless it is a journal format, the abstract should be written in one paragraph. Introduction 3. The first part of the second sentence "ED are relatively common among younger girls" reflects the traditional misconception that EDs only occur in a specific group. The updated literature shows that EDs do not discriminate by age, races/ethnicity, sex, etc. Although I think that is not the intention of the authors, that statement could continue perpetuating this misconception. Methods 4. Authors mention that "The participants included came from all socioeconomics strata." What that means? How did you assess socioeconomic status? 5. Authors listed the treatments that participants received for their EDs, however, it is more accurate if you can provide the percentage of patients who received what type of treatment, especially because this paper is about their recovery experience. 6. Other information that should be included, if it was collected, is

	the number of hospitalizations. 7. The last sentence of page 6, starting with “Compulsive physical exercise was common…” add a comma after “self-demand.” 8. In the previous review process, identifying participants by number was recommended. Authors decided to put their names so I’m wondering if they have the authorization from participants to identify them by name. Usually the most appropriate way to protect participants’ confidentiality is to assign a number to each of them. Discussion 9. Authors mention as strength that their sample is large which, is not an accurate statement. A sample size of 15 even in qualitative study is still a small sample size. Table 10. Please add a title to the table. 11. It is confusing the way in which the table is organized and some of the topics would make more sense if they were included in the text. I expected to see a table with all categories identified across the interview transcripts and the frequency in which topics were discussed across participants.

VERSION 2 – AUTHOR RESPONSE

1. The first sentence of the conclusions "Our findings indicate that recovery is a demanding process" is very ambiguous and in my perception does not reflect the "take home message" of the study.
It is our impression as interviewers that the word “demanding” seems to be a fair description of the recovery process as both ‘hard’ and ‘rewarding’.

2. Not sure why the strengths and limitations of the study are written in a different format. Unless it is a journal format, the abstract should be written in one paragraph.
We have checked that we comply with the format for abstracts in the Journal, and in particular, the format of the “strengths and limitation” section.

3. The first part of the second sentence "ED are relatively common among younger girls" reflects the traditional misconception that EDs only occur in a specific group. The updated literature shows that EDs do not discriminate by age, races/ethnicity, sex, etc. Although I think that is not the intention of the authors, that statement could continue perpetuating this misconception.
Epidemiology is not at focus in our paper, and there is no intention to review the literature on epidemiology of eating disorders. In order to build up a case for our study, we would simply like to state the fact that historically, eating disorders have been confined to females in terms of theories of aetiology and focus of research. We tried to change the text accordingly, and we do hope that our intentions have been more clearly spelled out in the present revision.

4. Authors mention that "The participants included came from all socioeconomics strata." What that means? How did you assess socioeconomic status?
As for the measurement of socioeconomic strata: The socioeconomic status was not explicitly assessed, but is inferred based on interview statements about current job status, income, present occupation or profession etc. We now include the source of information in the text.

5. Authors listed the treatments that participants received for their EDs, however, it is more accurate if you can provide the percentage of patients who received what type of treatment, especially because this paper is about their recovery experience.

On this point (as for point 6 in the reviewer's list), we simply reiterate our previous response to the reviewer's comment in the first revision. First, it is important to keep in mind that the aim of this study was not to detect treatment effects or "consumer satisfaction" about treatment/treatment parts. Our intention was to study recovery processes, and such processes surpass treatment effects. Then we are unable to understand why the requested information about number of hospitalizations, and about how may who received which kind of treatments might be relevant. Secondly, as previously stated, valid information would be hard to get. Our group of former patients had received a multitude of treatments, often concurrently. In many cases the patients could not specify what kind of treatment they had received only "all kinds of treatments", "some days or so inpatient", later on partly outpatient" and so on. For our study purpose, this was sufficient to contextualize our findings. Hence, any percentages would be neither possible nor feasible to provide.

6. Other information that should be included, if it was collected, is the number of hospitalizations.
Please see # 7

7. The last sentence of page 6, starting with "Compulsive physical exercise was common." add a comma after "self-demand."
Now corrected.

8. In the previous review process, identifying participants by number was recommended. Authors decided to put their names so I'm wondering if they have the authorization from participants to identify them by name. Usually the most appropriate way to protect participants' confidentiality is to assign a number to each of them.
In the first revision, we clarified that all participants are represented in the quotes, not just a "couple of patients". We did so by adding pseudonyms. Others than the reviewer may believe that we used their real names, and thus we have now explicitly added the information that they are just pseudonyms, equal to numbers for the purpose of protecting the participants' confidentiality.

9. Authors mention as strength that their sample is large which, is not an accurate statement. A sample size of 15 even in qualitative study is still a small sample size.
The statement is corrected.

10. Please add a title to the table.
We have now removed the table

11. It is confusing the way in which the table is organized and some of the topics would make more sense if they were included in the text. I expected to see a table with all categories identified across the interview transcripts and the frequency in which topics were discussed across participants.
No longer relevant.

VERSION 3 - REVIEW

REVIEWER	Mae Lynn Reyes-Rodriguez, Ph.D. University of North Carolina at Chapel Hill, U.S.A.
REVIEW RETURNED	12-Jun-2016

GENERAL COMMENTS	This is a second revision of a qualitative study conducted with recovered males with a history of eating disorders. I appreciate authors' effort to answer most of the concerns raised by reviewers. I'm requesting some additional information for more clarity of the study.

	Introduction 1. In the last paragraph, authors added information about their previous publications based on the same sample. It is not clear if in the same interview, they asked three different questions in order to address the three research questions or if they conducted three different interviews. If was one interview, how did you separate the topics in the interview? How did you handle overlapping on the questions? Methods 2. Authors mention that patients completed their treatment for a DSM-IV ED but then they said that no formal interview was conducted at any point and diagnoses were based on clinical judgement. Did clinicians provide a diagnosis in the clinic? Did they document DSM criteria? Did they have any internal procedure for documenting the diagnosis and then the recovery process? What was the "external clinical evaluation"? Do participants reported multiple ED's diagnosis? 3. I'm wondering if authors collect information about co-morbid conditions and how that played into the recovery experience. 4. Could you please specify the time-frame in which the data were collected? How long took you to have the sample size? 5. Since the analysis was guided by Graneheim and Lundman's principles, please add a brief description of those principles. Results 6. Please make sure that you have more than one "quote" per category and from different participants.

VERSION 3 – AUTHOR RESPONSE

(Reviewer 1 ML Reyes-Rodriguez) Reviewers comment is lined up first.

1. In the last paragraph, authors added information about their previous publications based on the same sample. It is not clear if in the same interview, they asked three different questions in order to address the three research questions or if they conducted three different interviews. If was one interview, how did you separate the topics in the interview? How did you handle overlapping on the questions?

Response: We interviewed every participant once, and with three separate lines of questioning corresponding to the focus of the three papers. Overlaps were handled by consensus discussions in the research team. This is now clarified in the revised manuscript.

2. Authors mention that patients completed their treatment for a DSM-IV ED but then they said that no formal interview was conducted at any point and diagnoses were based on clinical judgement. Did clinicians provide a diagnosis in the clinic? Did they document DSM criteria? Did they have any internal procedure for documenting the diagnosis and then the recovery process? What was the "external clinical evaluation"?

Response: We did not ask specialised ED-treatment centres for documentation for diagnosing ED. For this reason, and because the patients had experienced recovery we deemed it unnecessary and out-of-focus to conduct a formal diagnostic interview for the purpose of the current study. This is now spelled out in the revised manuscript, and we fully agree that the expression "external clinical evaluation" was confusing and has been removed for clarity.

3. Do participants reported multiple ED's diagnoses?

Response: A very few of the participants had experience with more that one ED diagnoses under the course of illness- this is included in the text.

4. I'm wondering if authors collect information about co-morbid conditions and how that played into the recovery experience.

Response: No, we did not ask about co-morbid conditions. However, the many patients reported compulsive exercise, along with low self –esteem and depressive episodes, and this information is already present in the manuscript.

5. Could you please specify the time-frame in which the data were collected? How long took you to have the sample size?

Response: Data collection lasted for about two years starting in 2010 and lasted to spring 2011, due to geographical distances and practical reasons. This is information now inserted in the revised manuscript.

6. Since the analysis was guided by Graneheim and Lundman's principles, please add a brief description of those principles.

Response: It might be more appropriate to write: the analysis was guided by a five-step content analysis. We have now clarified the "five-step analysis" in the revised manuscript.

7. Please make sure that you have more than one "quote" per category and from different participants.

Response: In the revised manuscript all categories have now more than one quote.