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A systematic review and meta-synthesis of the effects and experience of mentoring in eating disorders and disordered eating

Sarah Fogarty [a,*], Lucie Ramjan [b,c], Phillipa Hay [d]

[a] University of Western Sydney, Australia
[b] School of Nursing and Midwifery, University of Western Sydney, Australia
[c] Centre for Applied Nursing Research (CANR), Ingham Institute of Applied Medical Research, Australia
[d] School of Medicine, University of Western Sydney, Australia

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ABSTRACT

In this review, we aimed to explore the benefits, effects and experiences of mentoring on those with an eating disorder or disordered eating. After a systematic search of the literature, four papers were included in the review. A qualitative analysis of the papers identified three key themes. The themes were (1) diverse benefits (mentees), (2) finding comfort in belonging (mentees), and (3) affirmation of the transformation they have made (mentors). The experience of mentoring was shown to have value for both mentors and mentees. Mentorship should be further utilized in the areas of eating disorders and disordered eating, as it shows promising reciprocal benefits for both mentor and mentee

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* Corresponding author at: PO Box 2002, Homebush West, NSW 2140, Australia.
E-mail addresses: s.fogarty@westernsydney.edu.au (S. Fogarty), l.ramjan@westernsydney.edu.au (L. Ramjan), P.Hay@westernsydney.edu.au (P. Hay).

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1. Background

Eating disorders according to the DSM-5 include Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED), PICA, Rumination Disorder, Avoidant/Restrictive Food Intake Disorder (ARFID) or Other Specified or Unspecified Feeding or Eating Disorder (OSFED or UFED) (American Psychiatric Association, 2013). OSFED/UFED replaces the Eating Disorder Not Otherwise Specified (EDNOS) category. In the developed world the lifetime prevalence of eating disorders is 1.01% (Hudson, Hiripi, Pope, & Kessler, 2007; Qian et al., 2013) and this appears to be increasing (Mitchison, Hay, Slewa-Younan, & Mond, 2012; Qian et al., 2013). Eating disorders are the second leading cause of disability in females aged 10–24 years in Australia (Hall, Patton, & Degenhardt, 2011). Mortality rates, mainly due to suicide, are twice as high for those with Bulimia Nervosa (BN) and close to six times higher for those with Anorexia Nervosa (AN), when compared to expected population mortality rates (Arcelus, Mitchell, Wales, & Nielsen, 2011). Eating disorders pose a high risk for premature death due to natural and unnatural causes (Harris & Barraclough, 1998). The socio-economic cost of eating disorders is also of concern and includes suffering for individuals and their families and outcomes such as death (including suicide), marriage breakups, stress, social isolation, relocation, heart attacks from stress and loss of careers (Treasure, Claudino, & Zucker, 2010).

Disordered eating is the most common indicator of the development of an eating disorder. Disordered eating can have a destructive impact upon a person's life and has been associated with reduced ability to cope with stressful situations (Ball & Lee, 2002; Ginty, Phillips, Higgs, Heaney, & Carroll, 2012; Thome & Espelage, 2004) and an increased risk of self-harm (Ginty et al., 2012; Wright, Bewick, Barkham, House, & Hill, 2009).

A multidimensional treatment approach is most commonly adopted for the treatment of eating disorders and disordered eating. Multidimensional treatment addresses physical, psychological, psychosocial and family needs of the individual, and involves a multi-disciplinary team including psychiatrists, psychologists, primary care physicians, social workers, nurses and dieticians. Effective treatment involving multi-disciplinary team and a stepped care approach has been identified as important to recovery (Hay et al., 2014; Treasure et al., 2010). Stepped care is about having the right service in the right place, at the right time delivered by the right person, so that effective but less resource intensive treatment is trialed first, prior to a decision to 'step up' or 'step down' services (Unützer, Schoenbaum, Druss, & Katon, 2006). However a stepped care approach can be difficult due to a lack of treatment options for eating disorders across community care settings, difficulty in accessing treatment outside of psychological treatment and a lack of providers who know how to treat eating disorders (Perez, Kroon Van Diest, & Cutts, 2014). There is also a particular need for treatment options for those who have transitioned from inpatient settings back into the community or are not yet in need of inpatient eating disorder care. A stepped care approach is not a single therapeutic approach; it can take multiple forms such as psychological, self-help, computerized treatments and/or mentoring and above all, it may potentially meet the needs of those transitioning from acute care to the community and vice versa.

'Hope is a powerful thing' (King, 1982). It is powerful because according to the Hope Theory, hope involves *agency* and *pathways* which is the goal-directed energy, determination and planning to obtain the desired outcome (Snyder, 2002). Hasson-Ohayon, Kravetz, Meir, and Rozencwaig (2009), Hawro et al. (2014) and Yadav (2010) have shown hope to be linked positively to quality of life (Hasson-Ohayon et al., 2009; Hawro et al., 2014; Yadav, 2010) and lack of hope has been identified as a major obstacle for 'recovery' from chronic anorexia nervosa (Dawson, Rhodes, & Touyz, 2014). People with an eating disorder have stressed the importance of hope for treatment and recovery (Dawson, Rhodes, & Touyz, 2014; Hay & Cho, 2013; Lindgren, Enmark, Bohman, & Lundström, 2015; Wright & Hacking, 2012). There is evidence that those with an eating disorder find it beneficial (to varying degrees) to hear about others who have had an eating disorder, who are now 'healthy' as this provides hope and increases motivation (Dawson, Rhodes, Mullan, et al., 2014; Dawson, Rhodes, & Touyz, 2014; Lindgren et al., 2015).

Mentoring is a term used to "describe a relationship between a less experienced individual (the mentee), and a more experienced individual known as a mentor (Collins Dictionary of the English Language, 1979). Mentoring in eating disorders has been used primarily as a prevention initiative that assists with increasing self-esteem and improving body image (Lippi, 2000; McCarroll, 2012; McVey et al., 2010; Perez et al., 2014). Mentoring has been used successfully in healthcare for conditions such as alcoholism and overeating, professionally in teaching and vocationally (Perez et al., 2014) however there has been limited use of mentors in recovery from eating disorders and disordered eating. The aim of this systematic review is to undertake a critical review of studies in order to better understand the benefits, effects and experiences of mentoring on those with an eating disorder or disordered eating. More specifically, the objectives are to identify: the benefits of mentoring on those with eating disorders or disordered eating and the meaningfulness/experience of mentoring on those with eating disorders or disordered eating.

2. Materials and methods

The authors have followed the structured process of PRISMA in this systematic review (Moher, Liberati, Tetzlaff, & Altman, 2009).

2.1. Types of participants

This review considered studies that included participants with eating disorders or disordered eating. Disordered eating is defined as: "…troublesome eating behaviors, such as purgative practices, binging, food restriction, and other inadequate methods to lose or control weight, which occur less frequently or are less severe than those required to meet the full criteria for the diagnosis of an ED" (Pereira & Alvarenga, 2007, p. 142).

2.2. Types of intervention(s)/phenomena of interest

2.2.1. Inclusion criteria

This review considered studies and literature that investigated the use of mentoring for those with an eating disorder or disordered eating.

2.2.2. Types of outcomes

This review considered studies or literature that reports the experience and/or benefit of mentoring for those with an eating disorder or disordered eating.

2.2.3. Exclusion criteria

This review did not review publications or literature using mentoring for the prevention of eating disorders or disordered eating. Textual papers selected for retrieval were assessed by the first two authors independently for authenticity prior to inclusion in the review. Research published prior to 1980 and in languages other than English was also excluded from this review.

2.2.4. Types of studies

The review considered descriptive epidemiological study designs including case series, individual case reports and descriptive cross sectional studies for inclusion as well as studies that focused on qualitative data including, but not limited to, designs such as phenomenology, grounded theory, ethnography, action research and feminist research.

This review considered mixed methods, experimental and/or epidemiological study designs including randomized controlled trials, non-randomized controlled trials, quasi-experimental, prospective and