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CASE STUDY

Email-assisted guided self-help for binge eating: an illustrative case study

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Abstract

The internet has been increasingly employed in the treatment of binge eating, including to facilitate guided self-help (GSH). However, few studies have investigated provision of GSH over email and there are questions regarding the viability of this approach, and how facilitators might best deliver this treatment. We describe a case study of a woman in her early 50s with a diagnosis of binge-eating disorder (BED) who received email-supported GSH over 12 weeks within a larger randomised controlled trial. At assessment, she presented with regular binge eating episodes (approximately twice a week) in addition to co-morbid medical and psychiatric issues, for which she was prescribed several medications. Treatment, provided within the UK National Health Service, involved provision of a self-help manual (*Overcoming Binge Eating*; Fairburn, 2013) in addition to email support over 12 weeks. A summary of the intervention is provided, along with email excerpts to demonstrate practice, illustrate how treatment might be delivered, and outline the type of interaction that may occur during email support. Consistent with larger studies, improvement on several self-report symptom measures was seen, including eating disorder symptoms, psychosocial impairment, psychological distress, self-esteem, and therapeutic alliance, all of which met criteria for reliable improvement at post-treatment. This case study, which provides data from one individual, demonstrates delivery of GSH with email support for regular binge eating, which could be considered as an alternative to face-to-face treatment. Future work might look to enhance outcomes following GSH, including reducing drop-out, and increase dissemination and uptake of GSH.

Key learning aims

(1) Consider the potential role of email-assisted self-help in the treatment of recurrent binge eating.
(2) Provide guidance to support the delivery of guided self-help, particularly in an online format.
(3) Review an example of using a CBT-based self-help intervention to overcome binge eating in the presence of medical and psychiatric co-morbidity.
(4) Understand how to implement guided self-help for binge eating and use this approach to facilitate a strong therapeutic alliance and symptom change.

Keywords: binge eating; digital intervention; eating disorders; email support; guided self-help

Introduction

In the treatment of recurrent binge eating, a number of clinical trials have demonstrated the effectiveness of guided self-help (GSH) based on cognitive behaviour therapy (CBT) principles

(see Wilson and Zandberg, 2012). In light of the psychosocial (e.g. Egbert *et al.*, 2020) and economic (e.g. Jenkins, 2022; Tannous *et al.*, 2022) impacts of binge-eating disorders, such as binge-eating disorder (BED) and bulimia nervosa (BN), several clinical practice guidelines suggest GSH as a possible first-line treatment (e.g. American Psychiatric Association, 2023; Catalan Agency for Health Technology Assessment and Research, 2009; National Institute for Health and Care Excellence, 2017; see also Beintner *et al.*, 2014). In addition to reductions in the frequency of binge eating, GSH can effect wider changes, such as improved workplace productivity and self-esteem (e.g. Jenkins *et al.*, 2021; Lynch *et al.*, 2010).

Guided self-help programs typically involve use of a manual alongside the support of a facilitator, and have a number of advantages compared with other treatments, such as cost-effectiveness and scalability (for a review, see Wilson and Zandberg, 2012). Typically, GSH is facilitated through face-to-face sessions, although research in areas such as depression and anxiety disorders demonstrates efficacy of support via the telephone and the internet (Newman *et al.*, 2011).

In order to widen access and increase scalability (see Fairburn and Patel, 2014), the internet is increasingly being employed as a means of delivering GSH for binge eating (e.g. for a review, see Ahmadiankalati *et al.*, 2020), with early pilot work suggesting that psychological treatment of binge eating can be successfully conducted over email (Robinson and Serfaty, 2001; Robinson and Serfaty, 2008). Ljotsson and colleagues (2007) investigated the effectiveness of providing support via email alongside use of a written self-help manual in a sample of 73 individuals diagnosed with either BN or BED, who were recruited through media advertisements. Participants also had access to an online private discussion forum. Following 12 weeks of email-supported GSH, significant reductions in eating disorder (ED) symptoms were seen, with changes maintained at 6-month follow-up.

A pragmatic randomised controlled trial (RCT) within the UK National Health Service (NHS) addressing recurrent binge eating (Jenkins *et al.*, 2021) concluded that both face-to-face and email-supported GSH were associated with clinical improvement and, further, likely to be cost-effective treatments. Evidence suggests that email-supported GSH for binge-eating disorders is effective (Wilson and Zandberg, 2012), although there is little guidance for facilitators on how to replicate such an approach successfully, and a recent consensus statement has emphasised the need for focused training on programme-led interventions, such as GSH (Davey *et al.*, 2023). Similarly, whilst GSH is widely practised, comprehensive case studies including detail of facilitator–patient interactions are lacking. There is a need for improved understanding of email treatments in particular, which can provide clinicians with information about what approaches might be helpful in (email) communication with patients (Soucy *et al.*, 2018).

Despite positive attitudes reported by those potentially eligible to receive GSH (e.g. McClay *et al.*, 2016), a minority of clinicians report having used GSH, with a lack of knowledge cited as a frequent barrier (Plasencia *et al.*, 2024). Illustrating this treatment approach, for instance through verbatim transcripts from a patient and facilitator, might be one way to increase knowledge and develop training in GSH; a detailed account of the course of treatment can illustrate how email-supported GSH can be applied in 'routine' practice and provide data that illustrate some of the processes and interactions involved (Falender and Shafranske, 2010). Such detailed case material, which is rarely provided in larger, cohort studies (such as RCTs), can provide valuable information and contribute to an understanding of how psychological interventions work (Persons and Silberschatz, 1998; Soucy *et al.*, 2018). Case studies may be illustrative in GSH where lack of clinician training and knowledge have been identified as barriers to uptake (Plasencia *et al.*, 2024) and can precede larger studies of self-help interventions, focusing, for instance, on individuals with physical and/or psychological co-morbidity (e.g. BED with Type 2 diabetes; Chevinsky *et al.*, 2020).

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Given the individual and societal burden of binge-eating disorders and the extant barriers to treatment uptake, the aims of the current case study are to provide a detailed summary of how email-assisted GSH has been applied in practice and to offer support for practitioners in the delivery of GSH. By including correspondence between patient and facilitator, this paper will illustrate how email support can be delivered, and also reports data on outcomes from one patient to explore the utility of email-supported GSH for the treatment of binge eating.

Method

Email-supported GSH, using the treatment manual *Overcoming Binge Eating* (Fairburn, 2013), was offered as part of a RCT (see Jenkins *et al*., 2014; Jenkins *et al*., 2021) within a specialist Eating Disorders Service within the UK NHS. Individuals recommended to receive GSH following assessment were screened for inclusion in the study and randomly allocated to one of three conditions, each lasting 12 weeks: waiting list (control condition), where participants do not receive treatment, and are instructed that they will receive an intervention after the waiting period is over; face-to-face GSH; or email-supported GSH. The current study looks at detailed data from one participant allocated to the email group, and can be interpreted alongside findings from the full dataset (Jenkins *et al*., 2021).

Design and setting

Following referral from her General Practitioner, Jane[1] was seen in an out-patient specialist eating disorders service based in a mental health and community NHS Trust in England. An 'AB' design was used, and Jane was identified as appropriate for a case report given that she initially reported high levels of psychological distress and eating-related impairment, engaged in treatment sufficiently to meet the aims of this study, completed all assessments, and provided her informed consent. Jane also demonstrated some complexity (e.g. co-morbidity, relationship issues) which was felt to be characteristic of many patients seen in routine practice.

Presenting problem

At the time of treatment, Jane was aged in her early 50s and had been experiencing symptoms of an eating disorder for around 20 years. She reported her ethnicity as 'White-British' and was married and in steady employment. She received a diagnosis of binge-eating disorder (mild severity; American Psychiatric Association, 2013) following clinical interview and was recommended GSH (see National Institute for Health and Care Excellence, 2017). She was initially randomised to the waiting list condition and then, following a 12-week wait, re-randomised to receive support via email (for details, see Jenkins *et al*., 2014). This afforded the opportunity to study symptom change at four time points: assessment, start-of-treatment, end-of-treatment, and follow-up. The description of Jane's treatment demonstrates key elements of email-supported GSH, offering understanding of how facilitators can support change and collaboratively develop a therapeutic alliance over email. Jane's presentation also highlights issues around 'complexity' (e.g. in terms of physical and psychiatric co-morbidity) which may be common in 'real world' cases, and demonstrates how eating problems can be addressed through low-intensity psychological interventions (see also Mountford *et al*., 2017).

Although identified as 'email treatment', the first session, typically lasting no more than 25 minutes, is conducted in person so that the patient may be given a copy of the treatment manual and meet their facilitator. Expectations for treatment are outlined (e.g. guidance on the frequency of email contact), and the facilitator can discuss the patient's goals for treatment,

[1]Participant details have been anonymised for the purpose of this paper.

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recommend psychoeducational material, and arrange the next session (Fairburn, 1999). Whilst these represent practical reasons for meeting face-to-face, it is possible that this approach facilitates an early alliance (although further study is needed in this area).

Personal background and symptom history

Jane was first assessed by a speciality doctor in psychiatry (a senior doctor with at least 4 years of postgraduate training) due to significant physical and psychiatric co-morbidity. Specifically, Jane had a history of bipolar affective disorder, obesity, hypothyroidism, non-insulin-dependent ('Type 2') diabetes mellitus, and was prescribed a mood stabiliser as well as anti-psychotic and anti-depressant medication. She had recently been seen by a specialist obesity service, who had recommended that she address symptoms of her eating problem before any further input from them. She was working in healthcare and lived with her husband, a relationship which she reported could be difficult at times.

During her assessment, Jane reported episodes of objective binge eating approximately twice a week (see Table 1 for a summary of clinical measures). In one of her early emails, and having read parts of the treatment manual, she reported experiencing both subjective and objective binge eating (e.g. see Niego *et al.*, 1997). She denied compensatory weight control behaviours and reported that she was rarely active. Her body mass index (BMI) at assessment was 39.8 kg m^{-2}, and 38.6 kg m^{-2} at the start of treatment.

Measures

In line with the RCT protocol (Jenkins *et al.*, 2014), Jane completed self-report measures of ED symptoms (Eating Disorder Examination-Questionnaire, EDE-Q; Fairburn and Beglin, 1994), psychosocial impairment (Clinical Impairment Assessment questionnaire, CIA; Bohn and Fairburn, 2008), psychological distress (Clinical Outcomes in Routine Evaluation-Outcome Measure, CORE-OM; Barkham *et al.*, 2001), self-esteem (Rosenberg Self-Esteem Scale, RSES; Rosenberg, 1965), and therapeutic alliance (Revised Helping Alliance Questionnaire, HAq-II; Luborsky *et al.*, 1996). All were completed at assessment, after 12 weeks of treatment and again at 6-month follow-up, with the exception of the HAq-II, which was completed only at week 3 and week 12 of treatment. As Jane was initially allocated to the waiting list condition before starting

Table 1. Pre- and post-treatment scores on self-report symptom measures

Measure	RCI min.	Caseness	Assessment	Start	End	Follow-up	Start–end difference	Start–follow-up difference
EDE-Q								
Global	1.61	≥2.3	3.78	4.58	0.97	1.53	3.61**	3.05**
OBE	NA	NA	8	2	0	0	2	2
CORE-OM								
Total mean	7.49	≥10	10.88	13.53	4.12	7.35	9.41**	6.18
Wellbeing	14.17	NA	15.00	17.50	2.50	5.00	15.0*	12.5
Problems	8.59	NA	12.50	16.67	5.83	6.67	10.84*	10.0*
Functioning	10.37	NA	11.67	14.17	5.00	12.50	9.17	1.67
Risk	8.54	NA	3.33	3.33	0.00	0.00	3.33	3.33
RSES	4.97	NA	15	12	27	23	15*	11*
CIA	7.23	≥16	20	27	6	8	21**	19**

CIA, Clinical Impairment Assessment questionnaire; CORE-OM. Clinical Outcomes in Routine Evaluation-Outcome Measure; EDE-Q, Eating Disorder Examination-Questionnaire; OBE, objective binge eating (frequency in the last 28 days); RSES, Rosenberg Self-Esteem Scale; RCI min., minimum required value for reliable change (see text for details); **reliable change and does not meet criteria for caseness; *reliable change only.

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treatment, data are available from assessment, start-of-treatment, post-treatment, and 6-month follow-up.

Course of therapy

The treatment manual is included in the second edition of *Overcoming Binge Eating* (Fairburn, 2013). Participants work through a step-based intervention that is 'additive' in nature, such that 'each step builds upon the previous one' (Fairburn, 2013; p. 127). Participants commit to the strategies indicated in the book, holding regular review sessions to monitor progress and adherence to treatment. Weekly 'summary sheets' are completed, which include a record of behavioural symptoms such as binge-eating episodes and laxative use; these were not collected as part of the larger trial and therefore not available in Jane's case.

Jane's facilitator was a 'para-professional' with an undergraduate degree in Psychology and no specialist eating disorders or psychotherapy training. She was working in an NHS Eating Disorders Service and received regular clinical supervision from a clinical psychologist with experience in CBT, GSH, and eating problems. To prepare for GSH, the facilitator read the treatment manual (Fairburn, 2013) and associated 'therapist's manual' (Fairburn, 1999).

As few guidelines exist on the delivery of email-supported GSH, the methodology of Ljotsson and colleagues (2007) was followed for the parent trial and, therefore, Jane's treatment. Participants were 'instructed to contact their coach [facilitator] at least once a week by email, and they could receive feedback via email twice a week' (Ljotsson *et al.*, 2007; p. 651), with frequency of contact declining towards the end of treatment (Jenkins *et al.*, 2014). As in previous studies of GSH, completing all treatment steps within 12 weeks (which was the end of planned contact) was not necessarily a goal of treatment. Instead, Jane was encouraged to set the pace of treatment and utilise email contact with the facilitator to gain feedback on her progress (see facilitator guidance by Fairburn, 1999).

Jane's facilitator sent a total of 22 emails over the 12-week intervention, and Jane sent 26 (see Supplementary material); some of these were very brief, such as for the purpose of sending self-monitoring forms. Of note, the mean number of email contacts in the larger trial was 7.60 (Jenkins *et al.*, 2021). At some points early in the intervention, Jane sent several emails in quick succession (e.g. four separate emails summarising her dietary intake within 10 minutes). To address this, the facilitator directed Jane to the treatment (e.g. how to complete self-monitoring forms) and confirmed boundaries around email contact (e.g. 'I will check my emails on Tuesday and get back in touch with you').

Step 1: Starting well

The first step emphasises engagement and core treatment components of self-monitoring and weekly weighing (see also Fairburn, 2008), in addition to psychoeducation. Specifically, at the initial session, patients are asked to read Part 1 (pp. 1–115) of *Overcoming Binge Eating* (Fairburn, 2013) as well as Getting Ready (pp. 119–130) and Step 1 (pp. 131–145). The unique expectations of email support (e.g. frequency of contact; see above) are outlined and homework at this stage involves committing to weekly weighing and effective self-monitoring (including daily food and drink intake, binge-eating episodes, and compensatory behaviours, where applicable). Jane was encouraged to hold 'review sessions' as described in the treatment manual (Fairburn, 2013) at least once weekly to monitor her commitment to treatment and to establish whether any patterns in her eating were becoming evident. As part of this, the facilitator supported Jane to review her progress, identify problems, seek solutions, and decide when to move forward with treatment (Fairburn, 1999).

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The following email excerpts highlight key components from Step 1 (approximate points in treatment are given in square brackets):

Jane [week 1]:

Hi,

Things I have achieved this week: I'm halfway through the reading and feel confident I will have finished what was set by Wednesday. I feel a bit pressured to get it done, but I know what you will say to that: 'do what you can and don't worry about it!' I have completed a few food diaries but not all due to my working patterns and other people being around. Not sure how we can find a way around this – any suggestions?

Facilitator:

Firstly, well done for getting started in reading the book and starting self-monitoring. As Step 1 indicates, self-monitoring will need to become a habit that you commit to throughout treatment as it provides the most helpful information for you to begin to make more sense of your eating and it provides a large part of our email conversation. I understand that it is difficult to complete the forms on a late shift. Do you get breaks when you could perhaps make a note in a diary or on your [mobile/cellular] *phone? Could you even do it in a bathroom break to make sure that you are recording the information? It may require time to test out what seems feasible and what you can manage.*

It sounds like you have had a mixed week . . . but I am pleased that you are feeling motivated to commit to treatment. A great start Jane, well done!

Jane was positive about treatment and reported having around three 'change days' (days where the patient 'did their best to follow the programme'[2]; Fairburn, 2013; p. 144). She was keen to move on to Step 2 and continued to send the facilitator regular emails. However, as Jane had some difficulties with scanning and sending her self-monitoring forms, she began to try 'quicker ways of sharing my food diaries' and wrote her entries as separate emails (including four in one day).

Facilitator [week 2]:

I would not recommend that you monitor in this way as it is a really important part of treatment to monitor as Step 1 describes. It is very important for us to stick to the guidelines of treatment as this is what the evidence suggests is helpful and it is very difficult for me to understand your eating and respond in the same way unless you are following the structure that is outlined in treatment. I understand that this is a new skill that you are trying to adapt into your routine but it is really important for us to stick to the guidelines of treatment. If this new method helps you to monitor on a late shift then perhaps it could be an exception and you could email the information to yourself to add to your self-monitoring forms but this does need to be the exception.

I would suggest that you re-read Step 1 and be clear about the structure of self-monitoring forms and how they are helpful if done as described.

Jane:

OK, I will self-monitor as suggested, starting tomorrow. Currently re-reading chapter 4 and will then re-visit Step 1 and the importance of sticking to the rules (something I don't always do in life!).

As the excerpt above demonstrates, the facilitator reiterated the need to follow the guidance within the self-help manual in order to maintain fidelity to treatment, whilst remaining mindful of potential challenges Jane might face and working collaboratively to generate solutions. Self-monitoring is a skill that is required throughout treatment so it is important to establish

[2]At this point, a Change Day relates to accurate daily self-monitoring and weighing only once per week. As the goals of each stage are different, the definition of a change day will vary (Fairburn, 2013).

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consistency from the outset. The next email from Jane suggested that she was monitoring in the fashion advocated by treatment ('*Back to monitoring on paper as requested and will scan a few days' worth of sheets on Saturday is that ok?*') and both she and her facilitator felt that she was then ready to move on to Step 2.

Step 2: Regular eating

Step 2 aims to establish a pattern of regular eating, based on planning and committing to regular meals and snacks, and also provides advice on overcoming purging (vomiting, diuretic and laxative use). Homework involves continuing with Step 1 (self-monitoring and weekly weighing) and following advice regarding regular eating and purging (although the latter was not relevant to Jane).

Jane [week 5]:

I have attempted to follow Step 2 this week as agreed but haven't managed to do it all perfectly. I have been eating three meals and 2 or 3 snacks most days but forgot to plan ahead when I will eat and just left it to how I was feeling on the day. I realise I cannot do this and need to write at the top of my monitoring sheet the evening before when I will eat the following day. I have programmed a reminder into my calendar every evening so I remember to do this and will do this from now on.

Despite this, I continue to feel very positive about the programme and honestly feel it is all coming together rather well. I can see light at the end of the tunnel as far as my eating disorder is concerned and that has lifted my mood.

Facilitator:

It sounds as if it has been a mixed week for you but that overall you have learned the importance of needing to plan regular eating. As you have seen, planning what you eat in advance can make you much more likely to stick to your plan rather than the in-the-moment decision making which can lead to eating more than planned … Setting an evening reminder is a sensible way to help you to plan in advance.

I thought it was notable last Wednesday when you ate at regular intervals and felt full and comfortable so didn't feel any urges to binge eat. This is a great example of Step 2 in action and how regular eating can reduce those urges.

I think it is also important for you to recognise the times when you have eaten more than planned or not stuck to your plan but have been able to get back on track with your next planned meal or snack, for example on Friday when you experienced a binge eating episode but later ate your evening snack as planned. This is really great progress Jane and something which is particularly difficult to do following the emotions associated with a binge eating episode, so Well Done!

Jane's facilitator gave advice on regular eating, reflecting on elements of Jane's plan to which she was not adhering (e.g. missing snacks). Jane continued to review her self-monitoring records and summary sheets, and reflected on her thoughts and feelings in the appropriate column of her self-monitoring record. Jane reported feeling ready to move on to Step 3.

Step 3: Alternatives to binge eating

This stage of the program helps individuals to resist eating during 'gaps' between meals, provides advice on weight fluctuation, and also gives guidance and instruction for analysing patterns in weight change. Urges to eat can be powerful (e.g. see Abraham and Beumont, 1982) and thus one challenge is to resist these until the impulse passes. Homework focuses on engaging in alternative activities (e.g. browsing the internet, having a bath, speaking with friends) and review sessions include devising a list of activities, using this when needed, and recording urges to engage in binge eating and compensate for such eating episodes (if applicable).

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Jane [week 7]:

I think on the whole my eating behaviour wasn't too bad and felt pretty much under control. I more or less stuck to regular eating and didn't binge like the old days. I did the best I could to retain a regular eating pattern, eating about every 2.5/3 hours to keep my hunger at bay and to maintain my blood sugar levels. Occasionally I sneak in an extra piece of fruit without recording it and realise that I shouldn't do this as it doesn't give a full picture of my eating so I will try hard to avoid doing this. My physical health could be better and I am struggling to do things like the housework which would be an alternative to binge eating, as I find it rewarding and there is always plenty to do around the house with two dogs and two messy humans. I have put my list on my phone and use this as a reminder on a regular basis.

Facilitator:

It is great to hear that you are still implementing regular eating and throughout the weeks it sounds as if you are really appreciating the importance of this. If you are eating between meals and snacks, such as the extra piece of fruit then it will be very helpful to record this, as you should be recording everything that you eat and drink. It will also help us to look at your diet and either you need to consider building up your meals and/or snacks if you are hungry in between? Or you may need to be making use of your alternative activities to 'urge surf', as the book describes, at these times. Well done for making a list of alternative activities and having them on your phone to help you to use them.

Progress in Step 3 is related to a number of review questions, considering: (1) devising a list of alternative activities; (2) recording urges to eat or vomit; (3) using the list of alternative activities when needed; and (4) whether the use of alternative activities could be improved. At this point in treatment, Jane had constructed a list of alternative activities but felt that she needed to remain at this step to improve her use of these strategies (i.e. questions 3 and 4). She mentioned some concern that she was eating too much and needed 'more practice' to record urges to eat.

The facilitator supported Jane's decision to remain at Step 3, encouraging her to '*record urges to binge eat to help you turn to alternative activities when they are needed and most useful*'. The following week, Jane reported back, feeling more positive:

Jane [week 9]:

I think I've had a good week again this week as I haven't had any binges and continue to love my new way of eating. I have also managed to start eating healthier snacks, which has made quite a difference. I truly believe I will carry on eating regularly and more healthily in the future and will resist the urge to eliminate specific foods as Fairburn recommends.

Looking specifically at the Step 3 review questions:

1. *As before, I have compiled a list of alternatives to binge eating and all in all the alternatives appear to be working. This week I felt the urge to weigh mid-week rather than binge but resisted so I am happy with my list of alternatives.*
2. *I haven't felt many urges to binge as mentioned above as eating more nutritious foods regularly now and it makes all the difference.*
3. *I do use my list of alternative activities when required but I feel so much more sated these days I haven't had a great need to use it.*
4. *I find that, when I do need to use alternative strategies to binge eating, it is harder the hungrier I am but as I feel fuller more of the time, alternatives are easier to implement.*

I think I am ready to progress to Step 4 this coming week and hope you agree.

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Step 4: Problem solving

The focus of Step 4 is on developing skills for effective problem solving, with a primary goal of addressing disordered eating that is caused by unpleasant or difficult events (such as arguments, relationship problems, and so on). Homework involves practising problem-solving skills and applying problem-solving steps as outlined in the book. Review sessions at this stage involve critical analysis of problem solving (i.e. its effectiveness) and completing weekly summary sheets; review questions at Step 4 are more numerous but similar in style to those set in Step 3.

Jane was progressing well with Step 4 and the facilitator reinforced this progress [week 10]:

I can see that you have made use of problem solving this week, so it is good to keep practising this, as more practice will help you move towards being a proactive problem solver, as described in Step 4.

Jane:

It's been another good, binge-free week and I definitely have not been dieting, just eating more healthily. I don't think there is really any cause for concern here and not a sign of relapse or anything worrying like that.

Looking specifically at the step 4 review questions:

1. [Am I problem solving frequently enough?] *I have made a concerted effort to note any problems that I could use my problem-solving skills to remedy and have enjoyed the challenge of doing so. I have always had good skills in this area and probably do it a lot of the time automatically but this week I used my skills to solve the problem of not having enough snacks in the house and needing to save money. I have also used my skills in relation to thinking about taking a new job, if I am offered it, as I always like to think ahead. So yes, I have been using my skills often enough and am pleased about that.*
2. [When I am problem solving, am I doing it properly?] *However, I am not following the 6 stages all the time and tend to write done* [sic] *the bare bones of the problem and the problem-solving process so I need to improve on this.*
3. [Am I reviewing my problem solving?] *My recording of times when I am problem solving could indeed be better and this will be one of my goals for the coming week, if you are in agreement.*

However, having said all this, and bearing in mind Fairburn's comments on p. 177 about moving on to the next step, I do think I could move onto this as well and wondered what your thoughts were about this.

The facilitator reminded Jane of the time-limited nature of treatment (for example: '*Yesterday marked the start of week 10 so we are in the final couple of weeks of treatment*'), whilst also highlighting maintenance factors within binge-eating disorder to reduce the risk of relapse, which is the focus of the next step. As Jane was making good use of treatment, her facilitator reflected that now would be a '*really good opportunity to take stock, Jane, as Step 5 suggests, and reflect on the progress you have made*'.

Step 5: Taking stock

Step 5 involves a review of progress, and represents a good opportunity for patient and facilitator to appraise symptom change and wider achievements, and consider whether there are any barriers that may impede further change. Homework involves re-reading earlier parts of the book, practising what has already been learned (e.g. regular eating, problem solving), and reviewing the relevance of dieting and body image. The Dieting and Body Image modules address additional maintaining factors of an ED, which may be relevant to some, but not all, patients. These modules were not directly relevant to Jane and therefore were not discussed at length in email communication. However, Jane expressed an interest in the Dieting Module due to a desire to lose

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weight after treatment. The facilitator provided more information about this module and encouraged Jane to seek support from her GP regarding dieting, following a period of consolidation post-treatment, to reduce the risk of relapse.

Jane [week 11]:

I'm pleased to report another good week, with no binges and no major problems. I have written very little in the last column as I have literally stopped eating emotionally and am thrilled about this. Thank you for keeping me on the straight and narrow rather [than] *doing my own thing.*

It has been an amazing journey and one I am very proud of. Looking ahead, I think I need to focus on the strict dieting module first of all as, before long, I will need to embark on a weight loss programme, being overweight as well as a former binge-eater. This will be another challenge as I need to be very careful about the kind of programme I follow and must be sure it isn't too strict (e.g. counting calories etc.). I will talk to my GP and anyone else who understands me to find a way forward.

Facilitator:

It is great to hear from you . . . and I am so pleased to hear you sounding so positive. This is a really good opportunity to take stock, as Step 5 suggests, and reflect on the progress you have made. You have been very committed to treatment and made fantastic and very difficult changes to your eating, which it sounds as if you are really benefiting from.

Although treatment is coming to an end next week it is important to think about what you are going to continue to work on to keep yourself well beyond next week. Re-read Step 5 to think more about this and I will be interested in your thoughts.

It is important to note that the Dieting Module is not a guide to dieting or advice on how to diet. It is aimed at patients who restrict their eating which results in them binge eating . . . I think it is really sensible for you to think more about your desire to lose weight with your GP and I would also recommend that you review the www.choosemyplate.gov website which will help you think about portion sizes, variety of food groups, activity levels, etc. I would recommend that you give yourself some time, before committing to weight loss, to consolidate what you have learned and challenged throughout treatment. Remember that it has only been 11 weeks, so give yourself time to consolidate the changes that you have made. I think this is particularly important given that you have a new job and there will be changes that come with this.

Step 6: Ending well

This is the final step of treatment, and involves taking stock of progress so far and dealing with setbacks (akin to relapse prevention). As detailed in the manual (Fairburn, 2013), the last few steps can take some time, perhaps many months, to address fully and therefore recovery will often continue beyond scheduled sessions (e.g. Cockell *et al*., 2004). Rather than expecting change more rapidly than might be desired, or unnecessarily extending the overall number of sessions, the idea can be explored with patients that they might continue to use elements of the programme that were most helpful (Fairburn, 2013). Indeed, the empowering approach of self-help is thought to be one of its main benefits (Williams and Whitfield, 2001). As part of the RCT (and in line with many routine treatments), a 6-month follow-up appointment is arranged in the closing email contact(s).

Results

Scores for assessment, pre-treatment, post-treatment and follow-up are shown in Table 1. Minimal change, including reliable deterioration on some measures, was observed over the 12-week period between assessment and pre-treatment, in line with existing evidence (e.g. Sysko

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and Walsh, 2008). Scores following the 12-week intervention were below accepted criteria for recovery on measures of ED symptoms and impairment (see Bardone-Cone *et al.*, 2010). Scores on the CORE-OM were also below clinical cut-offs by post-treatment, and remained low at 6-month follow-up. Jane's weight remained largely stable over the course of the intervention, with BMIs of 39.0 and 39.4 at post-treatment and follow-up, respectively.

Reliable change indices were calculated following the method of Jacobson and Truax (1991) to evaluate treatment change. For the EDE-Q, psychometric data were taken from Mond *et al.* (2004a, 2004b). Of note, the cut-off reported (an EDE-Q Global score >2.3) for distinguishing 'caseness' of an ED was taken from Mond *et al.* (2004b), who obtained this from a validity study of clinical and non-clinical samples. For the CORE-OM, data were obtained from an ED sample (Jenkins and Turner, 2013), RSES data were from Sinclair *et al.* (2010) and CIA data from Jenkins (2013). Jane's scores at post-treatment and follow-up met criteria for clinically significant improvement (see Table 1).

Data from the HAq-II (Luborsky *et al.*, 1996) suggest that there was a significant, positive change in therapeutic alliance, particularly from Jane's perspective. At session 3, Jane scored 88 and the facilitator 97 (HAq-II scores range from 19 to 114, with higher scores indicating stronger alliance). By the end of treatment, Jane's score on the HAq-II had increased to 110 and her facilitator's 99.

Discussion

Principal findings

This case study aimed to provide a detailed account of how CBT-based GSH can be facilitated via email, including verbatim examples of how support is delivered, and responses from a patient, Jane. Outcome data indicated that Jane made good progress over the course of the intervention, with decreases in self-reported ED symptoms and psychosocial impairment, as well as improvements on measures of self-esteem and psychological distress. Scores remained similar at 6-month follow-up. In line with findings from larger, cohort studies (e.g. Jenkins *et al.*, 2021; Wagner *et al.*, 2013), this case study supports the viability of email-supported GSH in the treatment of BED in a large, publicly funded health service.

The results are also encouraging regarding therapeutic alliance; Jane's reported alliance increased markedly during treatment and, as can be seen from the transcripts, she also made a number of positive statements in her correspondence. A concern regarding email-supported GSH is that therapeutic alliance may suffer if communication with one's facilitator is not face-to-face (Cook and Doyle, 2002). The results of this case study, alongside a recent study from this trial (Jenkins and Wake, 2024), indicate that therapeutic alliance can develop quickly and effectively using a predominantly email-based intervention (see Sucala *et al.*, 2012). Whilst therapeutic alliance alone has not been found to uniquely predict outcome (Andersson *et al.*, 2012), the current study provides an example of how a strong therapeutic alliance can be established through a remote treatment modality. Although further study is needed, evidence suggests that alliance in internet-based interventions may be less strongly associated with treatment outcomes than face-to-face approaches (Kaiser *et al.*, 2021), and several factors might affect this. The relationship between facilitator and patient in GSH might differ if additional modes of communication, such as online discussion forums, are used (Cook and Doyle, 2002; see also Ljotsson *et al.*, 2007), and may be influenced by education level, access to technology, or past experiences (e.g. McClay *et al.*, 2016); as such, a lack of information on Jane's education level is a limitation of this study.

Strengths and limitations

Whilst positive outcomes following treatment were seen, in common with studies of CBT for BED in the presence of obesity (e.g. Grilo *et al.*, 2011), there was no apparent effect of this intervention on body weight. Although this is not a goal of psychological treatments for binge eating and would

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not usually be expected (National Institute for Health and Care Excellence, 2017), closer measurement of changes in physical health would have been useful to determine if other indicators of physical health improved as a result (e.g. blood pressure, glycated haemoglobin [HbA1c]).

Consistent with existing work (e.g. Chang *et al*., 2021), rapid response to treatment was seen, although a shortcoming was the lack of inclusion – in this case study and the larger RCT – of session-by-session measures (including weekly symptom monitoring; see Fairburn, 2013; p. 143), which could have added detail regarding the impact of the intervention and active elements of treatment (e.g. Srivastava *et al*., 2023). Early change in the current case was demonstrated in part by a significant decrease in the frequency of binge eating and also adherence to regular eating within the first few weeks, which has been suggested as an important component in reducing ED behaviours (Ellison *et al*., 2016). Jane was able to recognise this association and utilise problem-solving and alternative activities (Fairburn, 2013) to establish a pattern of regular eating. Nonetheless, the lack of clear session-by-session measurement remains a limitation and also precludes conclusions regarding the 'active elements' of treatment (e.g. Barakat *et al*., 2017), an area where further research may be useful.

The facilitator's ability to adhere to treatment guidelines may have contributed to the positive outcomes seen (Waller, 2009), and may have been influenced by the therapeutic alliance developed between patient and facilitator. When Jane deviated from the suggestions of the treatment manual, as described in Step 1, the facilitator played an important role in supporting Jane's adherence to treatment. It is possible that the initial face-to-face meeting helped alliance, although evidence from treatment studies of eating problems suggests that early behavioural change is associated with improved therapeutic alliance (e.g. Raykos *et al*., 2014), and thus supporting early behavioural change is an important role for GSH facilitators (see also Chang *et al*., 2021).

Drop-out rates for CBT-based approaches may be particularly high in studies of internet-based CBT and GSH (e.g. Linardon *et al*., 2018). As Jane engaged well with email contact, it is not clear whether there are features germane to email communication which might have reduced the risk of drop-out, or whether this could reflect higher 'motivation to change' at the start of treatment (e.g. Wagner *et al*., 2015). Further studies might consider how to reduce drop-out, thereby enhancing outcomes, in asynchronous treatments.

Cases such as that described above are rare in the literature and are limited by reporting only one experience. Whilst rich in detail and an account of 'real world' practice, Jane's treatment occurred at a given point in time and is thus 'bounded' (Miles, 2015). For instance, Jane's alliance scores were above the mean for the RCT sample (see Jenkins and Wake, 2024) and she was able to complete the full course of treatment. The outcomes here may not be generalisable to all of those eligible for GSH and thus inherent restrictions exist on the conclusions that can be drawn. As noted above, Jane was comfortable with technology and was able to make good use of the flexible (asynchronous) approach to support. She thus represents an individual who engaged well in email-supported GSH and may evidence possible bias in the selection of Jane as a case study. Whilst several difficulties were encountered during treatment (e.g. sharing self-monitoring forms, consistency of email contact), the approach taken might be different for those who offer alternative challenges (e.g. infrequent responding). Clinicians should be mindful, however, of mounting evidence reflecting the positive views of patients regarding technology (e.g. Cataldo *et al*., 2021; McClay *et al*., 2016) and consider different modes of support which now exist.

Clinically significant and reliable changes were seen on a number of symptom measures, including a control (pre-treatment) phase where improvement was not observed, supporting findings from the larger RCT (Jenkins *et al*., 2021) and work in other countries (e.g. Ljotsson *et al*., 2007). Maintenance of symptom change at 6-month follow-up is in line with larger studies (e.g. Lynch *et al*., 2010; Peterson *et al*., 2001), although long-term follow-up studies of GSH are needed and the lack of measurement of subjective binge eating episodes was a limitation of this

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study. One final point of note regards the use of technology; Jane was clearly comfortable using email to communicate but also made use of applications such as reminders on her smartphone. Whilst this approach may not suit all individuals, it speaks to how technological advances can support application of psychological treatments.

Conclusions

Use of the internet in psychological therapy is a relatively new development that may offer an accessible, cost-effective, and flexible way to deliver evidence-based treatment (e.g. Ahmadiankalati *et al.*, 2020; Jenkins *et al.*, 2021; Wagner *et al.*, 2013); given this, it is important to provide support for clinicians and GSH facilitators. This study provides an example of email-supported GSH delivered in an NHS out-patient service and may serve as a resource for applying this approach in practice – particularly when face-to-face support is not desired or available. Email excerpts demonstrate the facilitator's role in marshalling progress through this 'programme-led' treatment, encouraging both consolidation of new knowledge and skills, while promoting continued engagement.

The case illustrates how a low-intensity intervention can be delivered through a printed manual, combined with email support from a para-professional and with the patient dictating the pace of treatment (Fairburn, 1999). It describes dyadic interactions within a potentially cost-effective treatment (Jenkins *et al.*, 2021) that is scalable and relatively accessible as delivery of treatment does not require synchronous contact (Palmqvist *et al.*, 2007). Due to the limitations of the case study design, further studies are needed to establish the acceptability and relative cost-effectiveness of internet-delivered GSH, given that it has been shown to perform well against treatment as usual and is comparable to similar treatments in other areas, such as depression (Lynch *et al.*, 2010).

Recommendations and implications

We recommend that therapists and services working with recurrent binge eating consider GSH as a brief, evidence-based intervention that can be delivered through a variety of different media. There is growing support for its scalability and flexibility, and the current study provides some examples of how this support can be delivered. It also highlights some potential difficulties, such as frequent email contact, and ways in which this can be managed within the framework and philosophy of GSH.

One concern might be that therapeutic alliance can be negatively impacted through email communication, given, for instance, difficulties in conveying emotion (see Paul *et al.*, 2017). However, evidence from this field, including the data presented here, suggests that strong alliance can be established in email-supported treatments (Jenkins and Wake, 2024; Sucala *et al.*, 2012) and that patients are generally positive about such approaches. As with any manual-based intervention, clinicians might also be concerned about perceived inflexibility in the treatment, and we hope that those reading this case study can see how GSH for binge eating can be tailored to individuals and their needs.

Future case studies and cohort studies might consider use of session-by-session measurement and exploring whether both subjective and objective binge eating is addressed with CBT-based GSH. Application to younger people is largely unknown (e.g. see Davey *et al.*, 2025) and this is a potential area for further work to consider.

In summary, this case study offers a detailed exploration of an individual's journey through GSH for binge eating, with support provided via email. Taken alongside cohort studies and RCTs, there now exists increasing evidence for the effectiveness of GSH approaches, even for those with apparent 'complexity'. The material provided here can be used to support (potential) facilitators in improving their delivery of GSH.

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Key practice points

(1) Email-assisted self-help (based on CBT principles) can be implemented to effect change in eating problems, including in the presence of 'complex' or co-morbid difficulties.
(2) Strong therapeutic alliance can be established through online support.
(3) Examples are given on how to maintain fidelity to treatment during guided self-help.

Further reading

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Data availability statement. Further data are not available due to information that could compromise the privacy of the individual described in this study.

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Author contributions. **Paul Jenkins:** Conceptualization (lead), Data curation (equal), Formal analysis (equal), Methodology (lead), Supervision (lead), Writing - original draft (lead), Writing - review & editing (equal); **Jessica Cardy:** Data curation (equal), Formal analysis (equal), Investigation (equal), Writing - original draft (supporting), Writing - review & editing (equal).

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