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Understanding the ‘guide’ in guided self-help for disordered eating: A qualitative process study

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Short-title: **Guided self-help for disordered eating**

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Abstract:

Objective: This study aimed to explore how guidance contributes to the outcome of guided self-help for disordered eating and for whom such interventions are most suitable. This was done from a client and guides' perspective, with a particular focus on the therapeutic relationship.

Method: Seven clients and 5 guides were interviewed following GSH treatment, as part of a randomised control trial. Guides ranged in background and experience of working with eating disorders. Clients had a range of disordered eating problems pre-treatment. Semi-structured interviews were recorded, transcribed and subjected to a thematic framework analysis.

Results: Four themes emerged. One was the necessity of having a guide and their roles and skills. Features of the therapeutic relationship were contrasted in clients with positive and poor intervention outcomes. These included guide qualities and skills, client characteristics, and rupture. The fourth theme was client suitability.

Conclusions: These findings have implications for the assessment and delivery of GSH interventions for disordered eating. They suggest the value of assessing clients' readiness to change, working with clients with less severe and complex conditions, and the importance of training guides in attending to the therapeutic relationship.

Keywords: Guided self-help, eating disorders, therapeutic relationship, qualitative research, common factors.

Introduction:

Evidence-based self-help is a recommended first stage of treatment for bulimia nervosa and binge eating disorder (BED) (NICE, 2004; American Psychiatric Association, 2006). Self-help materials can be used alone (pure self-help) or with guidance from a mental health professional or layperson (guided self-help, GSH). Guided self-help has generally shown superior outcomes to pure self-help for these disorders (Carter and Fairburn, 1998; Loeb, Wilson et al., 2000; Palmer, Birchall et al., 2002), although there is a lack of explanatory evidence. Studies of efficacy and effectiveness have typically assessed outcome using measures such as the Eating Disorders Examination interview or questionnaire (Fairburn and Cooper, 1993; Fairburn and Beglin, 2008). While these measures are considered the gold standard assessment of eating disorders, they tell us little about the therapeutic processes involved in such interventions and what factors contribute to their effectiveness.

Looking at the utility of self-help approaches for anxiety and depression, it has been suggested that the increased benefit shown in GSH may not be due to specific techniques or manualisation, but to 'common factors' that operate in all psychotherapies regardless of theoretical orientation (Richardson and Richards, 2006). Common factors are believed to account for as much as 30% of improvement compared to only 15% attributed to specific techniques (Lambert et al., 2002). However, DeRubeis (2005) argues this is unlikely to be the case for disorders in which one psychotherapy clearly outperforms another, e.g. obsessive compulsive disorder, panic disorder, post traumatic disorder and social phobia, and that credit must be given to the 'technical maneuvers therapists engage in based upon a specified theoretical orientation' (DeRubeis et al., 2005). This strengthens the argument for the potential role of therapeutic factors in GSH, as the specific factors i.e. the treatment manual, are consistent in both pure and guided interventions and the difference is the addition of therapist guidance.

Much of the work on common factors has focused on the therapeutic relationship: *"the feelings and attitudes that therapist and client have towards one another, and the manner in which these are*

expressed, p.159” (Gelso and Carter, 1985). Cahill and colleagues (2008) suggest an effective therapeutic relationship goes through three stages; establishment, development and maintenance. Therapist factors that help the relationship include the establishment of empathy, collaboration and support early on, and then reflection and security, in nurturing openness and trust. Patient factors thought to moderate both the relationship and outcome are functional impairment, coping style and personality disturbance. They also identified potential threats to the relationship such as therapist intrusiveness, underestimation of the seriousness of the problem, patient resistance and hostility. In the general psychotherapy literature, reviews have consistently shown therapeutic relationship as a moderate predictor of outcome (effect size 0.21-0.26; Horvath and Bedi, 2002; Horvath and Symonds, 1991; Martin et al., 2000). The relationship has typically been assessed using self-report measures such as the Working Alliance Inventory (WAI) or Agnew Relationship Measure (ARM), on which both clients and therapists have only tended to use the top 20-30% of scales, leading to little variation in scores and positively skewed results (Tryon et al., 2008).

There has been little empirical research on the therapeutic processes in eating disorders treatment and what findings exist are mixed (Loeb et al., 2005; Treasure et al., 1999; Wilson et al., 1999). There is even less specifically relating to self-help approaches. Only two studies have examined the processes of GSH (Banasiak et al., 2007; Carrard, Fernandez-Aranda et al, 2010). According to Banasiak et al., the most and least helpful aspects of GSH treatment for bulimia nervosa were assessed using three self-report questions. The treatment manual, improvements in outcome, and the helper characteristics of the general practitioner were the most cited sources of positive commentary.

We conducted a randomised controlled trial (RCT) of GSH for disordered eating (Traviss et al; in press). The intervention comprised a CBT-based pack or written manual (Working to Overcome Eating Difficulties), congruent with a transdiagnostic approach, that was intended as suitable for a range of disordered eating except severe anorexia nervosa. The pack was delivered with guidance from a mental health professional, trained and supervised in its use for six sessions over 12 weeks. GSH led

to reductions in disordered eating behaviours and psychopathology that were maintained for 6 months. However, and in line with previous studies, there was a high drop-out rate during the intervention period (28%).

In order to better understand the processes of change in GSH, qualitative methods have the potential to capture some of the complexity. Qualitative methods enable an examination of aspects of the therapeutic relationship and exploration of other potential contributory factors, in the context of GSH, where self-report methods fall short. The aim of the current study was to explore, from the client and guides' perspective, how guidance contributes to the outcome of self-help approaches for disordered eating, paying particular attention to the therapeutic relationship. Secondly, the study aimed to determine for whom such interventions are most suitable and beneficial. Lending from Cahill's model (Cahill, Barkham et al. 2008), therapist, client, and contextual factors were explored. Based on the existing literature, it was hypothesized that guidance (in particular the therapeutic relationship) was fundamental to the adherence and outcome of the intervention, which was suitable for all mild and moderate disordered eating except low weight anorexia nervosa.

Methods

Participants

Eighty-one clients with disordered eating participated in the Working to Overcome Eating Difficulties RCT (Traviss et al; in press). They received GSH delivered by trained guides, either immediately or following a 12 week wait. For the current study, a sub-sample of 12 participants (5 guides and 7 clients) were selected to represent a range of treatment experiences; 1) guides who had at least one client complete and one drop out of the intervention, 2) clients who completed the GSH intervention, and 3) guides who had no clients complete the intervention. The only group not represented in the sample was clients who dropped out. The sample included three guide-client dyads, which made up half of the total sample.

All participants were White-British females. Guides comprised two graduate mental health workers, a counsellor, and two psychotherapists. Although clients in the main trial were seen in both primary and secondary care, these participants were all working in primary care. Their mean age was 46.6 years (SD=10.5). They represented a range of experience of working with eating disorders (mean=11 years, range=0-25) and of using the GSH pack (mean clients=4.0, range 2-7). Clients were all treatment completers and had a mean age of 44.7 years (SD =13.8) and body mass index (BMI) of 27.3 kg/m² (SD=9.1) at entry into the RCT. Diagnostically, three fulfilled the criteria for binge eating disorder, three had bulimia nervosa (two purging and one non-purging subtype) and one the criteria for EDNOS resembling anorexia nervosa who did not meet the low weight criterion and had not missed three consecutive menstrual cycles. The rationale for inclusion of these clients is outlined in the RCT report (Traviss et al, in press). All clients fell into the 'no diagnosis' category at 6 month follow-up. Four were in full-time employment, one in part-time employment, one was a student and one retired. Pen portraits for all participants are provided in Table 1.

- Table 1. Near here -

Generating qualitative data

Following completion of the GSH intervention, clients (N=33) and guides (N=24) were invited by mail, to take part in one-to-one semi-structured interviews. From respondents, participants were recruited to represent a range of treatment experiences and were interviewed by the first author (GT). The interview schedules for both were based around 10 primary questions (See Table 2) to explore three main areas; the role of the guide, the client-guide relationship, and the GSH pack. Questions based on the therapeutic relationship were developed to explore the three stages of the relationship (establishing, developing and maintaining) described by Cahill et al (2008). Probing and clarifying questions were used to elicit further information on any of the areas if necessary. Interviews lasted approximately 45 minutes, were conducted at the University of Leeds and were recorded using a digital Dictaphone.

Qualitative analysis

All interviews were transcribed verbatim by a third party and assigned a study code to protect participant's identity (prefix 'C' for clients and 'G' for guides). Data were managed and coded using NVivo 8 software package and analysed by GT using a thematic framework analysis (Ritchie and Spencer, 1994). Thematic framework analysis is a matrix-based analytic method which enables systematic and transparent data management. The analysis was conducted in five systematic and visible stages, the fundamental component being the 'thematic framework' which was used to classify and organise data according to key themes, concepts and emergent categories. Themes were organised and presented in charts or matrices which enabled easy retrieval of data. In the current study, the aims were to categorise the interview material in a coherent manner in relation to the key research questions generated from the trial and existing literature (i.e. deductive). A diverse sample was necessary to form an overall picture of the phenomenon from the different perspectives of those involved.

The five key stages of data analysis included; 1) familiarisation of the data, 2) developing a thematic framework, 3) indexing, 4) charting, and 5) mapping and interpretation. During the familiarisation stage, all interview transcripts were reviewed in order to gain an overall picture of the data coverage. During this process, a list of themes and ideas were noted for each interview. These were used to develop an initial thematic coding framework. The themes were sorted and grouped under a smaller number of higher order headings (main themes) which were largely 'theory driven' (Braun and Clarke, 2006), meaning they were informed by the studies' research questions. This initial coding framework was applied to several transcripts and revised to include further emerging issues, using an iterative process. Sub-themes of close similarity were collapsed into one and re-coded accordingly. The final coding framework was then applied to the data. NVivo was used to code/index data which corresponded to each sub-theme. Each main theme was then charted in its own matrix using Microsoft Excel, with columns representing participants, and rows denoting sub-themes. Coded data were lifted from their original context and presented in the relevant matrices according to the appropriate sub-themes. Text was summarised in the matrices, with care to retain the original language. Finally, charts were reviewed in relation to each research question, considering whether certain factors were deemed

more salient than others based on frequency, whether guides and clients experiences were similar or different, and whether there were any associations between concepts from evidence within the data and the existing literature. The analysis process was conducted by a single researcher, therefore steps were taken to ensure the results were a valid interpretation of the data (See below). Finally, themes and sub-themes were organised and presented in separate hierarchical charts to show the key dimensions and characteristics identified in the interviews. A detailed account of the understanding of all themes and sub-themes relevant to the research questions will be provided in the Results section, illustrated using excerpts from the interview.

Reliability and validity

The research was conducted in line with guidelines by Elliott and colleagues (1999) for the publication of qualitative research studies in psychology. Given the a priori hypotheses developed by the authors, in order to ensure results were a valid representation of the data, various credibility checks were performed. Themes derived from the data, their descriptions and interpretations were reviewed by two participants, a client and a guide (C7 and G1) and small sections of the coded transcripts were checked by two independent researchers for consistency. In the analysis, every effort was made to ensure both confirmatory and alternative explanations were included, e.g. the role of 'readiness' in the processes of change. Basic descriptive data on participants are provided in the Participants section (Table 1) in order that readers are able to situate the sample. In the Results section, descriptions of all themes and sub-themes are provided, with direct quotes from the transcripts to help ground these in the data. Efforts were made to retain participant's original language and data are presented using figures to depict the hierarchical structure of themes in terms of both importance to the participant and frequency. Finally, the sample was purposive in order to represent the views of the study population overall. The findings should therefore generalise across the larger study and may also be applicable to other GSH studies for disordered eating, and possibly for other difficulties such as depression, anxiety and body image. The only group who were not represented in the sample were clients who dropped out. This should be considered when interpreting the results and is discussed as a limitation in the Discussion.

Results

How does guidance contribute to the effectiveness of GSH?

Necessity of having a guide

Both clients and guides continually described the ‘necessity of having a guide’ who contributed important ‘roles’ and ‘skills’ during the process, which helped clients manage and adhere to the work required (See Theme 1, Figure 1). One client said;

“You can look through and say alright so I need to do that but where you got to like write it down your feelings, the thought process between the actions, and how you think afterwards. You can’t do that without someone sitting there and explaining it to you, and giving you examples and stuff. I don’t think I would have been able to do it.” C7

- Figure 1. Near here –

Roles of the guide

The role of the guide was described as a ‘facilitator not therapist.’ Guides inferred this was in contrast to traditional psychotherapy and was positive in that it gave clients more control over their own recovery. For example;

“I saw myself as a facilitator...I think it was important she had control of booklet...and me just trying to focus her in on a particular area” G5

“The more I act as a guide, rather than a therapist, the better the process seems to go” G4.

Participants described the importance of ‘monitoring’ which was reassuring in case difficulties arose, was motivational and provided an incentive to keep going. In addition, guides also had an active role in encouraging clients to persevere at times of difficulty or impasse.

“Without her, I was going only through the pack. I wouldn’t have felt “oh I have to do the pack” and there was all the time then an incentive to do it, because if you don’t have somebody checking on you, you push things off as you don’t want to confront uh issues” C2.

Participants described the ‘supportive’ function of guides as fundamental, providing both emotional support at times of distress and also in ‘just being there as a sounding board’ G4. A client described this in the following way;

“If I’d done this on my own I would have found it extremely difficult, it raised a lot of issues...I think I would have got so angry I would have just given up” C5.

Three clients also described the benefit of having guides to ‘challenge their behaviours and beliefs.’

Skills of the guide

Participants explained how guides ‘used their additional skills to manage difficulties.’ They drew upon their experience and skills as a therapist, as well as those provided in the GSH training, to explore and explain any difficulties encountered. Two participants (C3 and G5) described receiving/providing additional materials i.e. worksheets, when necessary. Clients and guides identified that prior professional training was necessary in being able to deal with therapeutic issues.

“...would they [a non-therapist] pick up on other things that a therapist would pick up on quite quickly? So things like avoidance, difficulties, lacking motivation, would somebody else who’s not therapeutically trained, have the knowledge in which to do that?” G5.

Guides played an important role in ‘tailoring materials’ to suit client’s individual pathology. This may have been particularly important in the current intervention because it was designed as suitable for all disordered eating.

“Although it might say about unwanted behaviours like being sick and stuff, I think it was more along the lines of...yes you might not do those but what would you see as an unwanted behaviour?...so she might personalise it more to me” C5.

All guides talked about the importance of ‘assessing suitability.’ Firstly they described the necessity of exploring motivational factors in clients, prior to embarking on treatment and also about becoming more skilled at identifying people who might benefit.

Is there an association between the therapeutic relationship, engagement and adherence?

In order to address this research question, the nature of the therapeutic relationship was considered for those with positive and poorer outcomes. The perception of outcome was based on the subjective judgments of participants.

The therapeutic relationship in clients with positive outcomes

Four sub-themes emerged, each with several lower order themes (See Theme 2, Figure 1).

Characteristics of a good relationship

When discussing clients who benefitted from the intervention, all participants (clients and guides) described the relationship as consistently 'strong' and that it 'developed' over the duration of treatment. For example; *"I really do think the relationship got better, right throughout the booklet"* G5. Two guides even suggested being allocated to the 12 week waiting list condition was beneficial and enabled a longer period over which to develop the relationship. Although there was no scheduled contact over this time, some had phone and mail correspondence. Clients described trusting their guides which was fundamental in opening up. Participants highlighted the importance of establishing reciprocal 'openness' in the relationship, in order to address therapeutic issues effectively. One guide said;

"I wanted to make sure we had an understanding...If she couldn't tell me she was angry or upset about something simplistic said during a session, then we were going to struggle with the booklet" G5.

Unlike traditional psychotherapy, successful GSH appeared to be very much a joint venture between client and guide. Two clients described how *"it was almost a collaborative project, which was nice"* C3, *"We'd have the book open between us"* C7. Guides and clients explained how they worked together to resolve issues.

Guide qualities

Both guides and clients suggested that in successful therapeutic relationships, guides were 'respectful and non judgmental.' As described earlier, one of their roles was to simply be there as a 'sounding board,' to listen and be accepting of clients difficulties. It was also identified as important for guides to show genuine feelings of 'interest' in client's personal circumstances and wellbeing. One client explained how this encouraged them to adhere to the program: *"Having someone interested in you, you need that to follow these programs"* C6. Despite this, clients talked about the relationship with their guide being different to that of personal

relationships with friends and family, described as “*a more boundaried relationship*” C6, that was “*caring but professional*” C6. They described the benefit of having someone who had ‘personal and emotional detachment’ and was less reactive and able to attend to issues objectively.

“You need somebody that’s in the caring profession but is detached so there’s no personal level ...they can explain it objectively without getting emotionally involved” C7.

It was identified as necessary for guides to be ‘flexible and responsive’ in relation to adherence with the GSH pack and also in terms of time allocation. This helped clients feel valued in the relationship.

Guide skills in managing the relationship

Guides that established positive relationships were ‘able to identify ruptures’ or misunderstandings in the relationship, in order to deal with them. Guides recognised this as important, identifying that clients often struggled to voice their concerns. One guide described “*using bridging worksheets...basically five questions that say was anything said during the session that upset you or worried you*” G5, as an effective strategy in helping the partnership deal with ruptures.

Client characteristics

Clients who experienced a good therapeutic relationship and more positive treatment outcomes were described as having either ‘realistic or no expectations’ in relation to therapeutic gain (outcome expectations) or anticipated contributions of the guide (role expectations), prior to therapy. For some, this was because it was the first time they had embarked in therapy.

The therapeutic relationship in clients with poor outcomes or drop-outs

Three sub-themes emerged, each made up of a number of lower order themes (See Theme 3, Figure 1).

Characteristics of a poor relationship

The therapeutic relationship with clients who dropped out was established weakly and ‘deteriorated’ throughout the course of therapy. There was little indication as to why guides thought this might have occurred.

While there appears to be an association between the quality of the therapeutic relationship and treatment engagement and outcome in most dyads, the following two sub-themes were described in a minority of cases but they provide alternative explanations for non-engagement and drop-out. Guides reported developing ‘a good relationship but clients were not suitable,’ for example they had anorexic-type symptomatology or else were not ready to change and required additional therapeutic work prior to commencement of GSH. The following sub-theme; ‘good relationship but client cured’ was only reported by one guide, but was included to demonstrate that not all drop-outs were for negative reasons. In this case, the dyad experienced a good guide-client relationship and the client terminated due to the progress made.

“She really seemed to engage in working through the pack...she did say that things were working out the best they ever had in her life and her bulimia was better under control...perhaps she wanted to just shelve it and not come for any more therapy...sometimes, it’s like going backwards if they’ve moved forwards emotionally” G1.

Negative client characteristics

Guides talked about difficulties establishing relationships with clients who were ‘reticent.’

Therapeutic work was difficult with these clients as they were more guarded, withheld information and were described as ‘having a front on’ G4. Consequently guides were unaware of the status of the relationship and had to invest additional effort in trying to unveil the real problem. Some clients demonstrated ‘resistance’ to engage in therapeutic work, sometimes manifest in hostile and confrontational client behavior. This was noted in clients with external

pressures to seek treatment and for those at times of impasse. Although guides were trained to deal with this, resolution was sometimes interpreted as threatening, with consequences for the relationship.

“She would just say things like “I can’t do it, if I could answer that I wouldn’t be here”, so that was the kind of resistance that was very difficult to talk round, ok “so you feel you can’t do it, why is that?” “Well if I could answer that question, why would I be sitting here now”... it became very confrontational” G4.

Clients who were difficult to engage in the relationship were described as having ‘false expectations’ about outcome and the role of the guide. Some were described as being overly expectant and even “*desperate*” G3, whilst others were skeptical about the merits of a brief intervention and expected a more prescriptive therapist, rather than facilitator. Finally, high levels of ‘psychological disturbance’ including signs of borderline personality disorder, delusions, severe depression, chaotic eating and abuse, were reported as impacting on the therapeutic relationship. One guide said;

“I found her level of psychological disturbance quite difficult to work with...it sounds like I’m saying these easy people did really well, I’m not saying that, I think these people [completers] did have very difficult problems but there was less tied into the therapeutic relationship. Whereas with these two [drop-outs], their level of disturbance was very apparent even just in the room and the relationship” G4.

Another guide suggested the need to lengthen treatment in these cases, to provide additional time to develop a sound relationship.

Rupture

On two occasions, guides described encounters that were perceived by clients as ‘betrayal.’ The first was in requesting a client to get weighed to confirm their accuracy in self-reporting and the second was after asking a client to see her general practitioner to check physical health. One guide acknowledged that her inexperience in dealing with such issues may have caused rupture in the relationship.

“maybe I scared her off...I think back to the way I said it and I think could I have said it in another way that maybe she’d have engaged” G5.

Having a break during the intervention was described as counterproductive for the therapeutic relationship. Whether clients missed sessions or were randomised to the waiting list condition, some guides described an ‘interruption to the relationship’ and loss of impetus with treatment.

For whom is GSH a suitable and beneficial treatment approach?

The main theme of ‘suitability’ comprised eight sub-themes (See Theme 4). ‘Readiness’ was afforded higher order status due to its perceived importance.

Readiness

Clients’ level of ‘readiness’ (also referred to as motivation to change) was the most frequently described determinant of suitability and was considered by three clients and all guides as the key to success or failure of the intervention. The theme related to clients’ readiness to become actively involved in the therapeutic process. One guide explained; *“first and foremost sort of checking out they were ready to do it, I think that was the key factor that made the difference” G3.*

Clients who dropped out expressed conflicting desires to change.

Client characteristics

Guides observed that clients with bulimia nervosa, binge eating and bulimic-type EDNOS tended to make better progress than those whose symptoms resembled anorexia. Although, none of the clients in the RCT met full diagnostic criteria for anorexia nervosa, primarily due to the low weight criterion, there were several with anorexic-type EDNOS. One guide suggested anorexia was more complex to deal with and was often associated with co-morbid conditions. Guides also described these clients as struggling with some exercises in the GSH pack, namely calculating the body mass index, completing the food diary and the binge-purge cycle, and also being required to read irrelevant sections on unwanted behaviours.

“I think because they were both anorexic, I think maybe anorexia is a lot harder to deal with than maybe bulimia or binge eating...It’s that thing of being weighed. Maybe anorexia goes with more severe mental health problems?” G3.

The intervention was deemed less suitable for clients with severe or long standing eating disorders or for those who were significantly underweight. Interviews suggested that in these cases, brief interventions were insufficient and more intensive treatments were warranted. Similarly, guides experienced problems working with clients with high levels of psychological disturbance suggesting they had difficulties planning and completing exercises. One guide said;

“The last client had borderline [personality disorder]. She had read it ahead, but hadn’t always, yes she hadn’t always done it as conscientiously as the others because she was a more chaotic type of person” G2.

Three guides spoke about ‘problems outside therapy’ as compromising the therapeutic relationship and contributing to non-engagement and drop-out. The most frequently discussed difficulty related to personal relationships, however, drug use, family problems and abuse were also highlighted.

The workload involved in the intervention was demanding in terms of client time and effort and it was recognised by five clients that ‘having sufficient time’ to fully engage in therapy and complete the required homework was crucial. For example; *“Anybody who has a very busy lifestyle would probably struggle in the timescale” C5.* Guides identified that those who achieved greater treatment benefits were more ‘willing to take responsibility’ compared with individuals who expected the guide to *“wave a magic wand and cure them” G3.* Three clients talked about a sense of *“empowerment” C5, C6, C7* as a result. Finally, ‘treatment preference’ was deemed important. Clients who initially requested alternative treatment such as counseling or CBT did less well. They reportedly had low expectations and negative attitudes towards GSH, which were considered major determinants of early termination.

Discussion

Overall, guides were central to this intervention. Their main role was that of a facilitator not therapist and involved monitoring, motivating, supporting and challenging the behaviours of clients. However, their additional skills as a therapist were beneficial in clarifying information in the GSH pack and helping clients deal with difficulties. They also enabled guides to tailor the materials to individual needs. With experience, guides became better able to identify clients who were likely to benefit from GSH. These roles and skills together helped suitable clients to stay with and make best use of the intervention.

In line with previous literature (Horvath & Symonds, 1991; Martin *et al.*, 2000) and hypotheses, the interviews suggested an association between the quality of the therapeutic relationship and outcome. In those with positive outcomes, the relationship was strong, open and collaborative. Positive relational experiences were attributed largely to qualities and skills of guides who were respectful, interested, flexible and responsive to clients needs. These qualities have been shown to reduce patient hostility and submissive behaviour and increase affiliation (Bedics *et al.*, 2005), which has been associated with engagement in therapy and positive outcome (Stiles *et al.*, 1998; Tryon & Winograd, 2001). Guides also played a role in establishing and maintaining a good relationship by being able to identify and repair ruptures that occurred. In contrast, the nature of the relationship in less successful cases was weak and deteriorated. Guides attributed this failing largely to negative characteristics of the client, i.e. reticence, resistance, false expectations and psychological disturbance, as opposed to their own relational abilities. This is not surprising given what is known about external attribution and the characteristics identified, provide further support for Cahill's model (Cahill *et al.*, 2008).

Client expectations were also an important factor. Those who reported positive relationship experiences were those with realistic or no prior expectations, whereas individuals in less successful relationships often had unrealistically high or low expectations of therapy. An abundance of literature

suggests expectancies are positively associated with outcome and are the best predictor of alliance, over and above therapist variables, client adjustment and symptoms (Rizvi *et al.*, 2000).

Some researchers have questioned whether the therapeutic relationship can be as intense in brief interventions as in long-term therapy. The current findings are in line with those of Kokotovic *et al* (1990) who suggest it is not only possible to establish a good therapeutic relationship, but that the clear structure and discrete time period in fact encourages co-operation, adherence and additional effort to make the most of the time available (Hudson-Allez, 1997).

Interviews shed some light on the characteristics of clients for whom GSH may be a suitable. Clients' readiness and motivation to change were the most frequently cited factors. This is not new in eating disorders research. Several studies have shown readiness to change as a significant predictor of treatment outcome in this client group, particularly in anorexia nervosa (Bewell & Carter, 2008; Geller *et al.*, 2004). However, the current study suggests an association between client suitability and the therapeutic relationship. Clients who were ready and motivated to make behavioural changes appeared to develop better relationships and consequently gained greater treatment benefits. Those who were identified as not suitable (e.g. not ready, too severe, high level of psychological disturbance) were reported to have poorer therapeutic relationships. There is evidence to suggest that levels of motivation, symptom severity, various types of psychological disturbance and incongruent expectations, all effect the therapeutic alliance (Derisley & Reynolds, 2000; Gaston *et al.*, 1998; Rizvi *et al*, 2000; Tyrell, 1999; Zuroff *et al*, 2000). Similarly, there is a well established link between the alliance and outcome. A possible explanation could be that the therapeutic relationship was in fact a mediating factor between client suitability and outcome. This is in line with previous research which showed pre-treatment contemplation and action scores to be positively associated with the quality of the therapeutic alliance and treatment adherence (Derisley & Reynolds, 2000; Treasure *et al.*, 1999). These findings argue for assessing clients' readiness or 'stage of change' in order to inform their willingness and ability to engage successfully with a GSH intervention, and help guides adopt

appropriate relational stances to aid clients' in progressing to a stage of 'preparation' or 'action.' Some may require preparatory work, prior to treatment commencement.

The intervention was perceived as most suitable for clients with mild to moderate binge-related disorders. This is consistent with previous GSH studies (Banasiak *et al.*, 2005; Carter & Fairburn, 1998; Ghaderi & Scott 2003; Loeb *et al.*, 2000; Palmer *et al.*, 2002), but contrary to assumptions of the transdiagnostic approach, on which the pack was based (Fairburn *et al.*, 2003). Extreme low weight has been associated with depression, negativity, obsessional features and mild cognitive impairment (American Psychiatric Association, 2006) which do not fit well with the requirements of GSH. Furthermore, guides suggested that clients with anorexia type presentations seemed to struggle completing various sections of the pack. This has implications for the content of the GSH pack which may require adaptation for this client group. Anorexic clients also have a tendency to be more unwilling and resistant, which can produce strong feelings of negativity and countertransference from their therapists (Hudson-Allez, 1997). The primary aim of treatment for anorexia nervosa is weight restoration which is typically achieved through dietetic advice and supported meals in either an inpatient or outpatient setting. Therefore, GSH may be suitable as a second stage of treatment for anorexia nervosa, following commencement of weight restoration. For bulimia nervosa, a longer version is being trialed for those who are significantly underweight. The same may be beneficial for individuals with anorexia nervosa.

The intervention was also identified as problematic with clients who have high levels of psychiatric disturbance, particularly those with personality disorders, a past history of abuse or severe depression. Research has shown that individuals with serious psychiatric disturbance have different attachment states of mind to those without (Tyrrell *et al.*, 1999). These are associated with different approaches to interpersonal relationships and emotion regulation strategies which guides have to be skilled to recognise and modify. According to attachment theory, individuals with a past history of abuse often develop insecure or disorganised internal working models of attachment based on previous unhealthy

relationships which leads them to believe that their attachment needs will be met with rejecting, intrusive or violently aggressive responses (Liotti, 2007). A longer duration of treatment is suggested for these individuals. Similarly, depression has been linked with impaired concentration, judgment, low self-efficacy and negative expectations which have been linked with poor outcome and are not amenable to utilizing a largely self-directed approach (Dew & Bickman, 2005; Schmidt & Treasure, 1997). Anti-depression medication should be considered to reduce levels of depression and increase client engagement.

The current research is the first to explore both client's and guide's perspectives of the therapeutic relationship in time-limited therapy such as GSH, in the field of eating disorders. The heterogeneous sample enabled a wide array of experiences to be examined. However, there are several limitations to this research. It is important to acknowledge that all clients who took part in interviews were treatment completers and had no diagnosis at 6-month follow-up. Therefore, it is possible that accounts of the relationship may be influenced by their positive treatment experiences and outcome, referred to as the 'halo effect' (Horvath & Bedi, 2002). There is a possibility that poor relationships were not solely a result of negative client characteristics but also failings on the part of the guide. The views of clients who terminated treatment would have provided a more balanced view. However due to the ethical issues of contacting these patients after completion of the RCT, this was not possible. The relationship and client expectations change during therapy and so measuring these after follow-up may not accurately reflect the clients actual experiences during the intervention. The standardization of the pack and training, and reliance on attribution in interviews, means we were unable to tell whether the positive therapist characteristics were as a result of the intervention training and supervision or prior therapeutic experience.

All interviews were conducted by the first author (GT) which ensured standardization. Participants may however have been less open due to the fact that the author had no prior contact with clients. All correspondence had been via their guide. Every effort was made to ensure a good rapport was built

with participants and reaffirm confidentiality. In addition, credibility checks were performed to ensure validity of the results.

Despite these issues, the current findings have implications for the future delivery of GSH interventions for disordered eating. They suggest such approaches may be most appropriately delivered to those with less severe and complex conditions and therefore, if detected early, the intervention may be used as part of an indicated or secondary prevention strategy. There is need for work to adapt the intervention for use with anorexia type presentations. Furthermore, individual treatment benefits and cost-effectiveness of services may be optimized by assessing clients' readiness to change prior to treatment. Therapist variables are fundamental in the assessment, development and delivery of GSH approaches and should not be overlooked in favour of the manualisation process. These findings should be used to inform the training of guides, including education on how to identify suitable clients, implement motivational strategies, establish and nurture a good relationship and deal with difficult clients. Finally, with an increased understanding for whom GSH is beneficial, it may also be possible to educate health care professionals such as General Practitioners, to identify suitable clients and inform future referral decisions.

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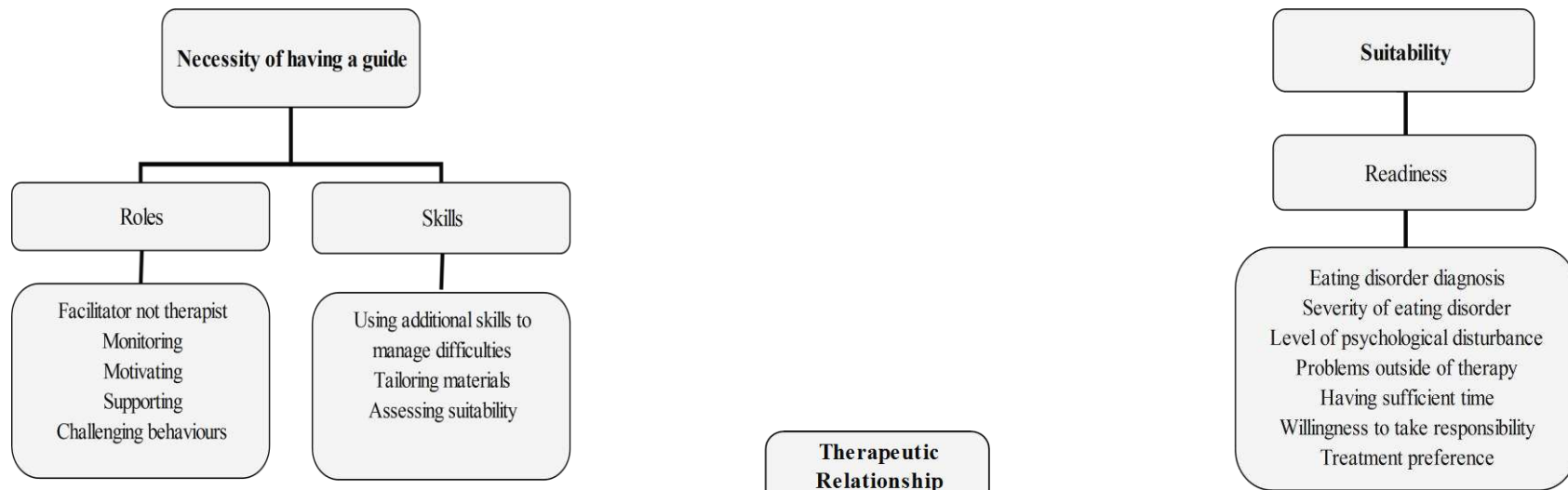
Tables & Figures

Table 1. Pen portraits of participants

Participant	Individual Characteristics
C1	Female in 50's, FT employed. Diagnosed with BN, body mass classified as overweight. Received treatment in the past, randomised to waiting list condition in RCT
C2	Female in 40's, FT employed. Diagnosed with BN, body mass in healthy range. Received treatment in the past, randomised to waiting list condition in RCT
C3	Female in 30's, FT employed. Diagnosed with BED, body mass classified as overweight. No past treatment, randomised to waiting list condition in RCT
C4	Female in 40's, PT employed. No diagnosis according to DSM, body mass in healthy range. Received treatment in the past, randomised to GSH condition in RCT
C5	Female in 50's, currently unemployed. Diagnosed with BED, body mass classified as severely obese. No past treatment, randomised to waiting list condition in RCT
C6	Female in 60's, retired. Diagnosed with BED, body mass classified as overweight. No past treatment, randomised to GSH condition in RCT
C7	Female in 20's, student. Diagnosed with BN, body mass in healthy range. No past treatment, randomised to waiting list condition in RCT
G1	Female in 50's, counsellor with 25 yrs experience of working with ED's
G2	Female in 60's, psychological therapist with 20 yrs experience
G3	Female in 40's, graduate mental health worker with 2 yrs experience
G4	Female in 40's, CBT therapist with 8 yrs experience
G5	Female in 30's, graduate mental health worker with no experience

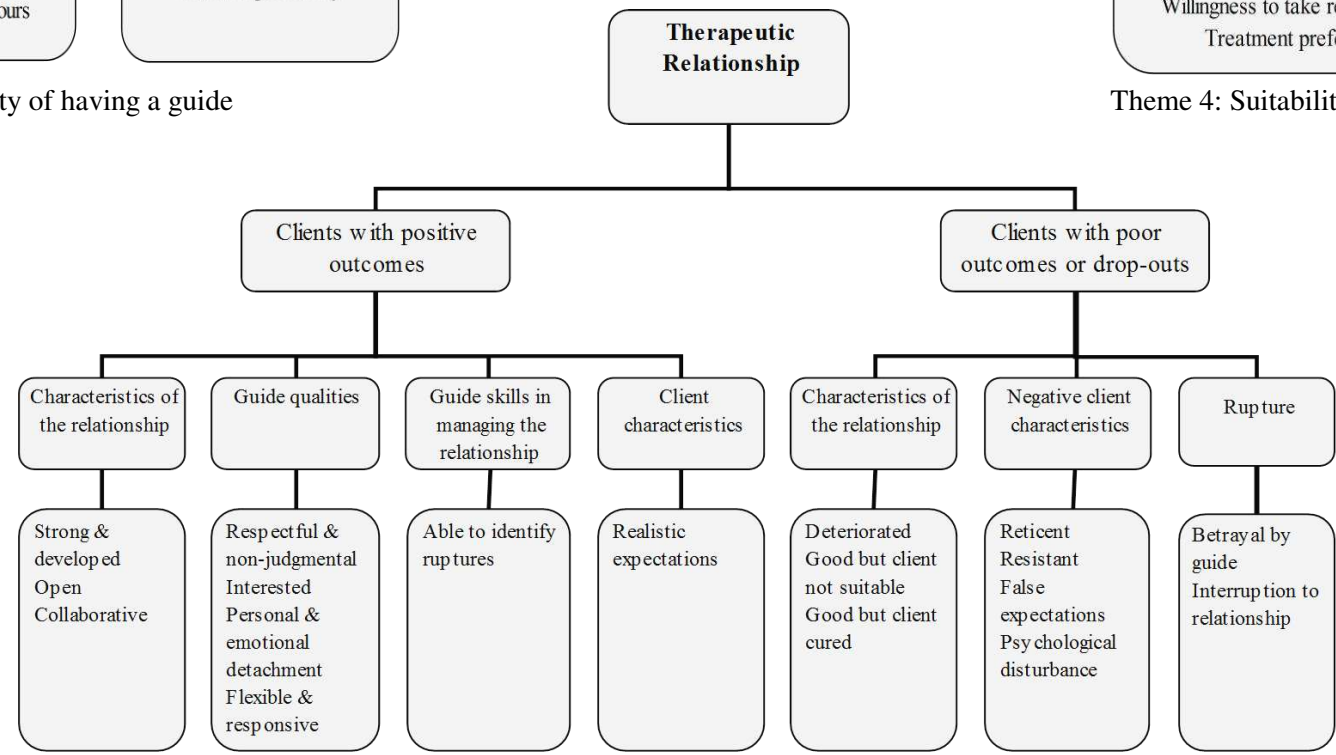
Table 2. Interview Schedule

Topic Area	Client	Guide
Guide	What role did your guide play in the GSH intervention	What role did you play as a guide in the GSH intervention
Guide	Most/least helpful aspects of working with your guide	Most/least helpful aspects for client(s) of working with a guide
Guide	Do you feel you could have done this without the help of your guide	Do you feel your client(s) could have done this without the help of a guide
Relationship (developing)	Describe your relationship with your guide at the beginning of the intervention	Describe your relationship with your client(s) at the beginning of the intervention
Relationship (establishing)	Anything that could have helped you establish a more positive relationship with your guide	Anything that could have helped you establish a more positive relationship with your client(s)
Relationship (maintaining)	Did your relationship with your guide change at all over the course of the treatment	Did your relationship with your client(s) change at all over the course of the treatment
Relationship (ending)	How did you feel about ending the intervention	How did your client(s) feel about ending the intervention
GSH Pack	Did you experience any difficulties during the process	Did your client(s) experience any difficulties during the process
GSH Pack	How helpful was the pack in achieving your outcomes	What were the main factors that influenced; a) treatment adherence and b) drop-out
GSH Pack	Is there anything about the GSH pack that you would like to comment on	Is there anything about the GSH pack that you would like to comment on



Theme 1: Necessity of having a guide

Theme 4: Suitability of clients



Themes 2 and 3: Nature of the therapeutic relationship in clients with positive and poorer outcomes

Figure 1. Diagrammatical representations of themes and sub-themes