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RESEARCH ARTICLE

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Therapeutic alliance in two forms of guided self-help for binge eating

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Abstract

The role of therapeutic alliance within psychological treatments for eating disorders (EDs), including those delivered remotely, is well established. However, few studies have investigated alliance in guided self-help, a widely recommended first-line treatment for EDs characterised by regular binge eating. Using data from a randomised controlled trial, the current study examined both facilitator and patient assessments of alliance within e-mail-assisted and face-to-face guided self-help and looked at associations between alliance, ED symptoms and ED-related impairment. One hundred thirteen patients and 11 facilitators completed measures of alliance during and following a course of guided self-help. Whilst ratings were reliable across patients and facilitators, alliance scores were higher both in the patient sample and in the face-to-face condition. Ratings of alliance showed no correlations with ED symptoms at post-treatment, and early alliance was not significantly associated with outcome, which could inform how early symptom change is encouraged in guided self-help.

KEYWORDS
alliance, binge eating, eating disorder, guided self-help

1 | INTRODUCTION

The therapeutic alliance (or, simply, alliance; Horvath & Luborsky, 1993) can be defined as a patient's experience of their therapist as supportive, having a sense of working together and sharing responsibility for working towards treatment goals (e.g., Luborsky, 1976). Alliance is a well-researched predictor of outcome (Horvath et al., 2011), and, within psychological treatments for eating disorders (EDs), early alliance (typically defined as occurring between Sessions 1 and 5) has been found to predict later improvement in symptoms, although notable differences between treatments exist (Graves et al., 2017).

The alliance between patient and therapist is a 'common factor' in psychotherapy (i.e., one that is independent of the type of therapy delivered) and can be seen as distinct from 'specific factors' (i.e., those related to particular approaches). Studies suggest that the therapeutic alliance is responsible, from a statistical perspective, for around 5%–10% of variance in treatment outcome (Graves et al., 2017; Horvath et al., 2011; Probst et al., 2019) and is seen as an essential element in most psychotherapies, itself composed of several parts (Tschacher et al., 2015). However, there are concerns that several common factors, particularly those related to the therapeutic alliance, may be negatively impacted in some modes of treatment delivery, such as telehealth (Lopez et al., 2019).

In the pursuit of making evidence-based treatments more accessible, providing therapeutic support via the Internet has grown in prominence. Whilst some treatments can be delivered online with support from another individual either in-person or virtually, other approaches

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make use of the Internet to provide therapeutic support remotely to patients working through a structured programme (e.g., see Andersson & Titov, 2014). For instance, self-help for EDs can be supplemented by facilitator support (the terms 'guide' and 'therapist' have also been used) provided over the Internet, demonstrating fewer time and location constraints and a likelihood of being cost-effective, particularly when compared to no treatment (e.g., Jenkins, Luck, et al., 2021; König et al., 2018). Nonetheless, clinicians often express concern about developing an effective alliance in a treatment where there are fewer or no nonverbal cues, although this view might reflect a lack of familiarity with online approaches (e.g., see Goss & Anthony, 2009). Whilst expressing concerns about issues such as data security, patients seem particularly supportive when positive attitudes regarding technology are held (e.g., see Cataldo et al., 2021).

Some studies have suggested little difference between alliance ratings in ED treatments with either remote or face-to-face support (Ertelt et al., 2011), and it might be that 'alliance' takes a different form in remote or purely online treatments (e.g., see Brothwood et al., 2021). Patients often provide higher ratings than clinicians (e.g., Knaevelsrud & Maercker, 2007), although there have been few comparisons of the alliance between self-help approaches where support is provided either remotely or face to face. As many contemporary treatments focus on early symptom change, it has been argued that early improvement (e.g., reduction in binge eating) strengthens subsequent alliance and *also* that improved alliance drives further change (Flückiger et al., 2020; Graves et al., 2017). Regarding variables affecting the strength of the relationship between alliance and subsequent symptom change, factors such as age (Graves et al., 2017) and baseline symptom severity (Flückiger et al., 2020) have not been found to affect the strength of this relationship. This is in line with findings that few reliable predictors of treatment outcome have emerged in cognitive behaviour therapy (CBT)-based ED treatments, particularly in transdiagnostic samples (Linardon et al., 2017), and it seems unlikely that ED diagnosis is related to alliance for those with EDs other than anorexia nervosa (Graves et al., 2017).

Evidence regarding the alliance–outcome relationship in more 'behavioural' ED treatments (such as CBT or behavioural weight loss treatment) is mixed, although it suggests that alliance scores are lower in these treatments than other approaches (Graves et al., 2017). There is scant research on guided self-help approaches involving facilitators communicating with patients over the Internet (Aardoom et al., 2013; Graves et al., 2017; Probst et al., 2019). Whilst both patients and facilitators in guided self-help identify the necessity of personal support (Traviss et al., 2013), it is not clear how alliance in guided self-help might be affected by different means of facilitator support (such as face to face or via e-mail), nor whether patient or facilitator ratings are quantitatively associated with treatment outcome. Similarly, studies suggest that alliance is related to some aspects of eating pathology but not others (Dölemeyer et al., 2013), and there has been little empirical work looking at the relationship between alliance and subsequent impairment as a result of an eating problem, which is an important treatment aim itself. Furthermore, many studies have looked at either the facilitator's or patient's view of alliance and seldom include a direct comparison of remote and face-to-face approaches. These gaps, alongside conflicting findings (e.g., Puls et al., 2019), suggest the need to look further at associations between alliance, outcome and symptoms.

Key Practitioner Message

- Therapeutic alliance was rated higher by patients than guided self-help facilitators.
- Therapeutic alliance was rated higher in face-to-face guided self-help compared to e-mail-supported guided self-help by both patients and guided self-help facilitators.
- Early alliance was not associated with treatment outcomes.
- Therapeutic alliance was not correlated with either eating pathology or psychosocial impairment at post-treatment.

The current study uses data obtained from a randomised controlled trial (Jenkins, Luck, et al., 2021) comparing guided self-help for binge eating using evidence-based bibliotherapy supported by either face-to-face contact with a facilitator (fGSH) or e-mail contact (eGSH) to address the following aims:

1. compare whether there is a difference between alliance scores for patients and facilitators and between eGSH and fGSH at both early (Session 3) and later stages (after completion) of treatment;
2. examine the degree of reliability between patient and facilitator ratings of alliance;
3. investigate correlations between alliance, ED symptoms and ED-related impairment to inform mechanisms of change; and
4. investigate whether early alliance predicts treatment outcome.

2 | METHODS

2.1 | Participants

The current study reports secondary analysis of a sample of individuals with EDs who participated in a randomised controlled trial of guided self-help for binge eating (Jenkins, Luck, et al., 2021). All were referred to one of several National Health Service ED centres serving a large population in central England. For the parent trial, adults with an ED characterised by recurrent objective or subjective binge eating in the absence of being underweight were considered (see Jenkins, Luck, et al., 2021). Individuals were referred from several sources based in primary or secondary care and were subsequently assessed to determine an appropriate course of treatment; if guided self-help was recommended, individuals were offered participation in the trial.

Within the trial, 120 individuals were allocated to an active treatment—either fGSH or eGSH—and 60 to a waiting-list condition. Seven individuals were excluded from the current study as they did

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not start treatment or withdrew early and, of the remaining 113, 22/55 (40.0%) completed eGSH and 41/58 (70.7%) completed fGSH, defined as attending all planned sessions over the 12 weeks of treatment. All received a diagnosis of bulimia nervosa ($n = 66$; 58.4%), binge-eating disorder ($n = 26$; 23.0%) or other specified feeding disorder and ED ($n = 21$; 18.6%) following a clinical interview. Specifically, assessing clinicians followed an approach based on that suggested by Fairburn (2008, pp. 36–37) to review symptoms and establish a diagnosis, which was subsequently agreed during a multidisciplinary team discussion. The mean (SD) age was 29.90 years (10.04), 105 participants (92.9%) were identified as female (the remaining 8 were male) and the majority of the sample was identified as White (96; 85.0%). Eighty-two individuals (72.6%) were single, 25 were married or cohabiting, 2 were divorced or separated, 2 were widowed and 2 did not disclose this information. The mean (SD) body mass index (BMI) was 27.67 (9.15) kg/m^2 (range = 18.5–60.5).

2.2 | Treatment

Guided self-help was delivered in line with the guide of Fairburn (2013), an intervention based on a more intensive CBT approach (Fairburn, 2008), addressing issues thought to maintain the eating problem such as dietary restraint and helping generate alternatives to binge eating. In an initial face-to-face meeting with their facilitator, participants received a printed copy of the treatment manual. Participants in fGSH then received up to nine further face-to-face sessions of 20–25 min each, whilst those in eGSH were asked to email their facilitator regarding their progress at least once a week, in lieu of attending in person (see Jenkins, Luck, et al., 2021). Treatments lasted no more than 12 weeks. Facilitators (10 female and 1 male) were provided with training, regular supervision and a written manual detailing their role (Fairburn, 1998). Facilitators had a range of experience, including clinical psychologists with doctoral-level training, qualified nurses with mental health experience and 'paraprofessionals'—those with no specific professional background and no formal CBT-specific training. The mean number of contacts in the current study was 9.62 (eGSH) and 7.86 (fGSH). Both forms of self-help were superior to the waiting-list condition in reducing eating psychopathology and binge eating, although dropout was higher in eGSH compared to the fGSH condition (63.3% vs. 31.7%; see Jenkins, Luck, et al., 2021).

2.3 | Measures

The Eating Disorder Examination Questionnaire (EDE-Q; Fairburn & Beglin, 2008) was used to assess eating pathology over the previous 28 days. Twenty-two items are rated on a 0–6 scale, with higher scores indicating greater psychopathology. A further six items concern disordered eating behaviours and are reported as frequencies (scored on a ratio scale). As this study concerns eating pathology in a range of non-underweight binge-eating disorders and in light of concerns regarding subscale scoring (Jenkins & Rienecke, 2022), the global score (a mean of all 22 attitudinal items) and binge-eating episodes are reported. The frequency of binge eating was dummy coded as a binary variable indicating abstinence (no episodes of binge eating in the previous 28 days) or not; abstinence from binge eating was thus used as an indicator of treatment outcome for this study. McDonald's ω for the EDE-Q Global was 0.912 at pre-treatment and 0.965 at post-treatment.

The Clinical Impairment Assessment questionnaire (CIA; Bohn & Fairburn, 2008) is a measure of psychosocial impairment as a result of eating pathology and consists of 16 items scored on a 0 (*not at all*) to 3 (*a lot*) scale. Higher scores for the total score indicate greater impairment, and a cut-off of 16 can be used to indicate case status (Bohn et al., 2008). McDonald's ω was 0.967 at post-treatment.

The Helping Alliance questionnaire, revised edition (HAq-II; Luborsky et al., 1996), was used to assess the strength of the alliance, with parallel versions completed by patients and facilitators. Nineteen items are rated on a Likert scale of 1 (*strongly disagree*) to 6 (*strongly agree*), four of which are reverse scored. Although two subscales ('Positive Alliance' and 'Negative Alliance') emerged from exploratory factor analysis (Luborsky et al., 1996), the use of the total score (a sum of all items) was recommended and has been used in similar studies (e.g., Raykos et al., 2014). Higher scores (range = 19–114) indicate stronger alliance, and McDonald's ωs in the current study were 0.922 (patient-report at Session 3), 0.934 (facilitator-report at Session 3), 0.939 (patient-report at post-treatment) and 0.953 (facilitator-report at post-treatment), suggesting that the scale can be meaningfully interpreted as unidimensional.

The EDE-Q was given at baseline, the HAq-II at Session 3 and all measures at post-treatment.

2.4 | Statistical analyses

As nested data (i.e., some patients being seen by the same facilitator and thus having more similar experiences than those seen by different facilitators; Lutz et al., 2015) can violate the assumption of independence of observations, multilevel modelling (MLM) was used (e.g., Kenny & Hoyt, 2009) using SPSS Version 29. Using this approach, a model with two 'levels' (patients at 'Level 1' nested within facilitators at 'Level 2') can be used that can separate variability attributed to facilitator and patient effects; this intraclass coefficient (ICC) is the ratio of the therapist's (or, here, facilitator's) variance to the total variance (Kenny & Hoyt, 2009). For multilevel analyses, restricted maximum likelihood (REML) estimation and the Kenward–Roger correction for standard errors were used (see McNeish, 2017). One facilitator treated only one patient and was not included in MLM analyses. Due to the limited evidence for potential moderators of the alliance–outcome relationship, analyses did not control for the effect of any baseline variables.

Separate models were tested for each dependent variable: alliance scores at Session 3 and alliance scores at post-treatment. To address Aim 1, we conducted MLM for alliance scores between patients and facilitators during eGSH and fGSH. Patient alliance

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scores during eGSH and fGSH were entered at Level 1, and facilitator alliance scores during eGSH and fGSH were entered at Level 2. Fixed effects included rater (patients or facilitators) and condition (eGSH or fGSH).

For Aim 2, the ICC (see Koo & Li, 2016) was used to assess agreement between facilitators and patients regarding alliance using R package *psych* (Revelle, 2021) based on an absolute-agreement, two-way mixed-effects model.

For Aim 3, bivariate multilevel correlations (with the facilitator considered a random effect) were estimated using the *correlation* package (Makowski et al., 2022) in R. Spearman's rho is reported using the sum scores of HAq-II, EDE-Q Global, CIA and the frequency of objective binge episodes.

Aim 4 was addressed through a generalised linear mixed-effects model due to the binomial nature of the dependent variables. Treatment outcome (abstinence from binge eating and treatment completion) was predicted by alliance at Session 3. Alliance scores for patients were modelled at Level 1, and alliance scores for facilitators were modelled at Level 2.

2.4.1 | Missing data

Alliance data were missing from 46.9% of patients and 32.7% of facilitators at Session 3, and 46.9% of patients and 41.6% of facilitators at post-treatment. Using logistic regression, baseline variables (age, BMI, ED diagnosis and eating psychopathology) were not significantly associated with missing alliance data ($ps > 0.06$), adding reassurance that data were missing at random and justifying the use of REML for estimation.

3 | RESULTS

The mean (SD) objective binge eating frequency at baseline, as assessed by the EDE-Q, was 17.0 (11.7) episodes over the last 28 days.

Regarding Aim 1, the model demonstrated that there was a significant main effect of rater on alliance scores at Session 3 ($F[1, 124.84] = 10.14$, $p = 0.002$). Patients (eGSH: M = 81.07, SE = 3.70; fGSH: M = 91.21, SE = 3.26) rated alliance significantly higher compared to facilitators (eGSH: M = 75.21, SE = 3.40; fGSH: M = 85.28, SE = 3.24) across both eGSH and fGSH conditions. There was also a significant main effect of condition ($F[1, 130.11] = 27.20$, $p < 0.001$): Both patients and facilitators rated alliance significantly higher within fGSH (patient: M = 91.21, SE = 3.26; facilitator: M = 85.28, SE = 3.24) compared to eGSH (patient: M = 81.07, SE = 3.70; facilitator: M = 75.21, SE = 3.40). There was not a significant interaction between rater and condition (Rater × Condition: $F[1, 124.55] = 0.00$, $p = 0.99$).

At post-treatment, the model demonstrated that there was a significant main effect of rater on alliance scores ($F[1, 117.89] = 11.23$, $p = 0.001$). Patients (eGSH: M = 88.40, SE = 3.79; fGSH: M = 96.44, SE = 3.06) rated alliance significantly higher compared to facilitators (eGSH: M = 78.85, SE = 3.58; fGSH: M = 89.58, SE = 3.03) across both eGSH and fGSH conditions. There was also a significant main effect of condition ($F[1, 120.21] = 14.12$, $p < 0.001$): Both patients and facilitators rated alliance significantly higher within fGSH (patients: M = 96.44, SE = 3.06; facilitators: M = 89.58, SE = 3.03) compared to eGSH (patients: M = 88.40, SE = 3.79; facilitators: M = 78.85, SE = 3.58). There was not a significant interaction between rater and condition (Rater × Condition: $F[1, 117.94] = 0.30$, $p = 0.58$). Table 1 summarises the alliance scores at Session 3 and post-treatment.

To look further at the reliability of ratings (Aim 2), ICCs between facilitators and patients suggested generally good agreement and consistency across Session 3 and post-treatment (ICCs both 0.80, $ps < 0.001$). As detailed in Table 2, ratings of alliance (at both time points) showed no significant association with eating psychopathology, frequency of binge eating at post-treatment or psychosocial impairment (Aim 3).

Regarding Aim 4, there was not a significant main effect of alliance scores at Session 3 on abstinence ($F[1, 66] = 0.89$, $p = 0.35$). Further, there were no significant interactions between alliance scores at Session 3 and treatment condition (eGSH vs. fGSH) (Alliance × Condition: $F[1, 66] = 2.13$, $p = 0.15$) or alliance scores and rater (patient vs. facilitator) (Alliance × Rater: $F[1, 66] = 0.02$, $p = 0.90$) when predicting abstinence.

Similarly, there was not a significant main effect of alliance scores at Session 3 on treatment completion ($F[1, 84] = 2.49$, $p = 0.12$). There

TABLE 1 Alliance scores (HAq-II) of facilitators and patients at Session 3 and post-treatment, including the difference (post-treatment–Session 3).

	Session 3		Post-treatment		Difference	
	n	Mean (SD, range)	*n*	Mean (SD, range)	*n*	Mean (SD)
fGSH						
Facilitator	48	88.62 (11.86, 66–110)	44	91.43 (12.10, 66–112)	42	3.48 (11.79)
Patient	45	94.20 (13.24, 68–114)	44	97.57 (12.04, 74–114)	39	5.05 (9.38)
eGSH						
Facilitator	31	81.55 (12.70, 54–104)	22	80.86 (17.43, 45–109)	18	−2.11 (10.07)
Patient	23	85.83 (15.49, 54–110)	20	89.15 (17.77, 53–114)	13	6.38 (11.91)

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TABLE 2 Bivariate multilevel correlations (r_s) between alliance (at Session 3 and post-treatment) and eating disorder symptoms and psychosocial impairment at post-treatment.

	Facilitator Session 3	Patient post-treatment	Facilitator post-treatment	EDE-Q Global	Binge days	CIA total
Patient Session 3	0.35	0.57**	0.43	0.12	0.19	−0.25
Facilitator Session 3	-	0.11	0.07	−0.51	0.11	−0.12
Patient post-treatment		-	0.72***	−0.45	0.08	−0.48
Facilitator post-treatment			-	−0.29	0.09	−0.36

**$p < 0.01$, and ***$p < 0.001$.

were no significant interactions between alliance scores at Session 3 and treatment condition (eGSH vs. fGSH) (Alliance × Condition: $F[1, 84] = 1.59$, $p = 0.21$) or alliance scores and rater (patient vs. facilitator) (Alliance × Rater: $F[1, 84] = 0.66$, $p = 0.42$) when predicting treatment completion.

4 | DISCUSSION

The current study looked at the therapeutic alliance between e-mail-assisted and face-to-face forms of guided self-help for binge eating, using patient- and facilitator-rated data obtained as part of a randomised controlled trial. Therapeutic alliance was consistently rated as higher in the face-to-face condition, in line with existing work across distinct mental health problems (see Norwood et al., 2018). Also in line with work looking at face-to-face and remote treatments (e.g., Ertelt et al., 2011; Lopez et al., 2019), patients rated the alliance higher than facilitators did, independent of the modality of treatment. Regarding the alliance–outcome relationship, the study adds to existing work in this area, although there are inconsistencies in the reported findings. For example, in their 2018 review, Pihlaja et al. (2018) summarise research examining adults suffering from depressive or anxiety disorders within a guided Internet-based CBT context as 'scarce' (p. 6). More recently, some findings suggest that alliance scores fail to predict later symptoms of anxiety disorders and dropout within Internet-delivered CBT with therapist support (Zalaznik et al., 2021). Conversely, early ratings of alliance have been found to predict treatment outcomes in Internet-based cognitive therapy for social anxiety disorder (Clark et al., 2023).

Taken alongside a large body of evidence supporting the effectiveness of technology-supported interventions (e.g., Barak et al., 2008; Haderlein, 2022), reluctance amongst facilitators seems to persist and serves to highlight the apparent 'discrepancy between the promise of eMental health tools and the documented reality of their use' (Feijt et al., 2018, discussion, para 1). Whilst the current study did not explore reasons for this, interventions delivered remotely offer several therapeutic benefits over face-to-face treatments (Andersson, 2018), and overall alliance ratings in this study were comparable to those reported in a review of alliance measures across individual psychotherapy studies (Tryon et al., 2008), suggesting that effective alliance can be established in remotely supported guided self-help, albeit rated lower than an in-person alternative.

That clinicians typically rate alliance lower than patients do, particularly in the early stages of treatment, might be related to social desirability and is perhaps exemplified within guided self-help, a relatively short CBT-based treatment (see Tryon et al., 2007). Whilst various sources of variation (e.g., see Hartmann et al., 2015) could explain this, agreement between patients and facilitators was nonetheless high, in line with previous studies (e.g., Accurso & Garland, 2015), and may suggest that patients and facilitators are judging the alliance based on slightly different heuristics (Ormhaug et al., 2015).

In line with a 2017 meta-analysis including individuals with EDs receiving CBT (Graves et al., 2017), early ratings of alliance were not significantly associated with outcomes following guided self-help. This finding is consistent with existing studies of guided self-help interventions in EDs, noting few associations between alliance and later symptom change (e.g., Albano et al., 2021; Dodd et al., 2022). Several factors, such as the nature of the facilitator and the measures used, might explain this (see Albano et al., 2021), although this 'null finding' might also reflect the nature of guided self-help, a treatment that focuses less on alliance as an agent of change than behavioural change itself. In a qualitative analysis of interviews with both patients and facilitators, Traviss et al. (2013) highlighted the specific role of the GSH facilitator, noting it to differ from 'traditional psychotherapy' and affording patients 'more control over their own recovery' (p. 93). Facilitator skills (e.g., being non-judgemental) were also identified as important and possibly associated with improvements in the alliance over the course of GSH, demonstrating the capacity to establish strong alliances in this treatment (Traviss et al., 2013).

It remains possible that positive outcomes are related to closer involvement of the facilitator, with a combination of guidance types (e.g., e-mail and telephone calls) being associated with greater symptom improvement in treatments for depression than one form alone (Mamukashvili-Delau et al., 2022). In the current study, the proportion of those completing treatment within the face-to-face condition was in line with that frequently observed in CBT for EDs (Linardon et al., 2018), although the number of individuals failing to complete eGSH was particularly high. Whilst supporting the interpretation that the medium of guidance matters in outcome (see Farrand & Woodford, 2013, for a review), this phenomenon may confound the variables of outcome and alliance (Graves et al., 2017). For example, it may be that individuals in the eGSH condition developed a poorer relationship with their facilitators and were more likely to drop out of treatment.

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Whilst speculative, the findings also offer indirect support for the theory that positive alliance follows symptom change (Turner et al., 2015; see also Graves et al., 2017); it has been suggested that changes in alliance and symptoms drive one another (Flückiger et al., 2020), whilst others have argued that alliance is an epiphenomenon of early symptom change (Dodd et al., 2022). The lack of associations between alliance ratings (both during and after treatment) and eating psychopathology, the frequency of binge eating at post-treatment and psychosocial impairment also suggest that other factors determine outcomes following CBT-based treatments. The finding that early alliance was not associated with either treatment completion or post-treatment abstinence from binge eating is also in line with this conclusion and suggests that clinicians in CBT-based guided self-help should be mindful of the alliance and focus on early symptom change as a means of effecting positive outcomes (e.g., Jenkins, Smith, & Morgan, 2021).

Strengths of the study include the direct comparison of two 'active' treatments with patients randomised to one or the other, limiting bias. Further, data were obtained from both completers and non-completers, and the study provided estimates of patient- and facilitator-rated alliances. The study was, however, limited by attrition, leading to relatively small samples in eGSH at post-treatment, which may have resulted in findings not being sufficiently powered to detect a difference between eGSH and fGSH groups when predicting the effect of alliance on treatment completion. The sample was predominantly White, single, and taken from a UK outpatient setting (e.g., see Flückiger et al., 2018, for a discussion of the potential influence of geography and ethnic diversity on therapeutic alliance), although the mean age in the current study was towards the higher end of that represented in ED psychotherapy trials (Burnette et al., 2022).

In future studies, the addition of more measurement points, making use of session-by-session measures, might be helpful, as alliance may proceed in a non-linear fashion (e.g., Maxwell et al., 2018), and the current study did not deconstruct possible aspects of alliance (e.g., see Krause et al., 2011). Similarly, such an approach can also afford to control prior levels of symptoms and alliance (e.g., Tasca et al., 2016), which was not possible in the current study. Studies in this area should also acknowledge difficulties with the assessment of alliance. For instance, such assessment is complicated by factors such as social desirability and the effect of time and treatment length, such that a relatively high alliance beyond Session 3 'may reflect an ongoing investment in the therapeutic collaboration' (Tryon et al., 2008, p. 549). 'Widespread' (Meier & Feeley, 2022, p. 235; see also Tryon et al., 2008) ceiling effects of alliance measures, constraining the distribution of scores, could have affected findings, and the current study did not differentiate between alliance with the facilitator and alliance with the treatment (e.g., see Zalaznik et al., 2021), an effect that might be particularly pronounced in 'programme-led' treatments such as GSH for binge eating. Finally, recruitment was completed prior to the Covid-19 pandemic, which was associated with rapid shifts towards technology-supported interventions and increasingly positive attitudes and experiences on behalf of clinicians (e.g., Békés & Aafjes-van Doorn, 2020; Humer et al., 2020), which might have resulted in different alliance ratings.

5 | CONCLUSIONS

The current study is perhaps the first to look at both patient- and facilitator-rated alliances in remotely assisted guided self-help for EDs. In so doing, it supported previous work suggesting that patient-rated alliance is more highly rated than facilitator-rated alliance and that clinicians might underestimate the therapeutic value of online treatments. Further work is required to understand the temporal relationship between alliance and outcome using sessional measures for both and to determine why attrition rates are often low in remotely supported treatments. An additional aim is to establish the extent to which a focus on early symptom change can improve treatment outcomes, including adherence.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request. Data are not publicly available due to privacy or ethical restrictions (participants were not informed that this would be the case).

ETHICS STATEMENT

This research complied with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration. Informed consent was obtained from all participants.

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